ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
MAY 7, 2019 – 5:30 p.m.
MEDICAL CENTER HOSPITAL BOARD ROOM (2ND FLOOR)
500 W 4TH STREET, ODESSA, TEXAS

AGENDA

I. CALL TO ORDER ..... Mary Thompson, President

II. INVOCATION ..... Chaplain Farrell Ard

III. PLEDGE OF ALLEGIANCE ..... Mary Thompson

IV. MISSION/VISION/VALUES OF MEDICAL CENTER HEALTH SYSTEM .... Mary Thompson, p.4

V. AWARDS AND RECOGNITIONS

A. May 2019 Associates of the Month ..... Rick Napper
- Clinical: Mitchelle Rendon, Occupational Therapist, Physical Medicine and Rehabilitation
- Non-Clinical: Maria "Isela" Garcia, Patient Registration Specialist, MCH ProCare Gastroenterology Clinic
- Nurse: Dianne Stevenson, RN, Charge Nurse, Labor and Delivery

B. April 2019 Patient Satisfaction Winners ..... Rick Napper
- Medical Practice: Audiology, 98th Percentile
- Inpatient: 4 East Postpartum, 83rd Percentile
- Outpatient: Health and Wellness Radiology, 99th Percentile

C. Medical Staff Foundation Check Presentations to MCH Auxiliary and Nursing Education.....Dr. Fernando Boccalandro

D. MCHS Check Presentation to March of Dimes.....Christin Timmons

VI. CONSENT AGENDA..... Mary Thompson, p. 5-36
(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, April 2, 2019
B. Consider Approval of Special Meeting Minutes, April 12, 2019
C. Consider Approval of Special Meeting Minutes, May 2, 2019
D. Consider Approval of Federally Qualified Health Center Monthly Report, March 2019

E. Joint Conference Committee April 23, 2019

1. Medical Staff or AHP Initial Appointment/Reappointment
2. Change in Clinical Privileges/or Scope of Practice/or Supervisor
3. Change in Medical Staff or AHP Staff Status
4. Change in Medical Staff or AHP Staff Category
5. Medical Staff Privilege Criteria
   a. Advanced Registered Nurse Practitioner
   b. Physician Assistant

VII. COMMITTEE REPORTS

A. Consider Approval of Medical Staff Bylaws and Documents .. Dr. Fernando Boccalandro

1. Medical Staff Bylaws .....p. 37-98
2. Credentials Policy .....p. 99-176
3. Medical Staff Organization Manual .....p. 177-198
4. Medical Staff Practitioner Health and Wellness Policy .....p. 199-218
5. Medical Staff Code of Conduct Policy.....p. 219-251

B. Finance Committee ..... David Dunn, p. 252-345

1. Quarterly Investment Report – Quarter 2, FY 2019
2. Quarterly Investment Officer's Certification
3. Financial Report for Month Ended March 31, 2019
4. Consent Agenda
   a. Consider Approval of Capital Expenditure Request: UDI Tracker (Tissue Tracking / Management)
   b. Consider Approval of Capital Expenditure Request: Medtronic ValleyLab Electrosurgical Units
5. Capital Expenditure Requests
   a. Consider Approval of Capital Lease 18 Draeger Perseus A500 Anesthesia Machines
   b. Consider Approval of 3T Verio MRI Evolve Upgrade
   c. Consider Approval of Sonosite X-porte Ultrasound Unit

VIII. TTUHSC AT THE PERMIAN BASIN REPORT..... Gary Ventolini, MD

IX. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS..... Rick Napper

A. Fitch Bond Rating Update .....p. 346-355

X. 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 exchange, lease, or value of real property pursuant to 551.072 of the Texas Government Code. (3) Deliberation and evaluation of officers and employees of Ector County Hospital District pursuant to Section 551.074 of the Texas Government Code; (4) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; (5) Information that, if released or disclosed, would give advantage to a competitor as per Section 552.104 of the Texas Government Code; and (6) Advice, recommendations, opinions, or other material reflecting the policymaking processes of the Ector County Hospital District as per Section 552.111 of the Texas Government Code.

XI. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

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

XII. ADJOURNMENT ..... Mary Thompson

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
APRIL 2, 2019 – 5:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT:
Mary Thompson, President
David Dunn, Vice President
Mary Lou Anderson
Bryn Dodd
Don Hallmark
Richard Herrera
Ben Quiroz

OTHERS PRESENT:
Rick Napper, President/Chief Executive Officer
Robert Abernethy, Chief Financial Officer
Christin Timmons, Interim Chief Nursing Officer
Heather Bulman, Chief Experience Officer
Dr. Sari Nabulsi, Chief Medical Officer
Dr. Fernando Boccalandro, Chief of Staff
Dr. Donald Davenport, Vice Chief of Staff
Ellie Bane, Chief Legal Counsel
Jan Ramos, ECHD Board Secretary
Dr. Rama Chemitiganti, TTUHSC Permian Basin
Various other interested members of the Medical Staff, Employees, and Citizens

I. CALL TO ORDER

Mary Thompson, President, called the meeting to order at 5:30 p.m. in the Board Room of Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

II. INVOCATION

Chaplain Farrell Ard offered the invocation.

III. PLEDGE OF ALLEGIANCE

Mary Thompson led the Pledge of Allegiance to the United States and Texas flags.

IV. MISSION/VISION OF MEDICAL CENTER HEALTH SYSTEM

Mary Thompson presented the Mission, Vision and Values of Medical Center Health System.

V. AWARDS AND RECOGNITIONS

A. April 2019 Associates of the Month

Rick Napper introduced the April 2019 Associates of the Month as follows:

- Clinical: Miriam Emerick, Registered Lead US/Vascular Technologist, Radiology Ultrasound
- Non-Clinical: Jennifer Nunez, Performance Improvement Specialist Performance Improvement
- Nurse: Hilda Ramirez, Charge RN, Radiology

B. Emergency Department Throughput Improvements Presentation

David Graham, Unit Director Emergency Department, provided a presentation on the improvements that have been made in the throughput process in that department.

This presentation was for information only. No action was taken.

C. March Patient Satisfaction Winners

The following units were recognized for their Net Promoter scores:

- Medical Practice: Internal Medicine
- Inpatient: 6 West
- Outpatient: Outpatient/Physical/Speech Therapy

D. United Way of Odessa Presentation

Hank Herrick, Executive Director United Way of Odessa, thanked the ECHD Board of Directors and employees of Medical Center Health System for raising $171,461 for United Way of Odessa, nearly $50,000 more than was raised in the same time frame last year.

This presentation was for information only. No action was taken.

VI. CONSENT AGENDA

A. Consider Approval of Regular Meeting Minutes, March 12, 2019
B. Consider Approval of Joint Conference Committee, March 26, 2019

Ben Quiroz moved and Mary Lou Anderson seconded the motion to approve the items listed on the Consent Agenda as presented. The motion carried unanimously.

VII. COMMITTEE REPORTS

A. Finance Committee

1. Financial Report for Month Ended February 28, 2019

   David Dunn moved and Don Hallmark seconded the motion to approve the Financial Report for Month Ended February 28, 2019 as presented. The motion carried unanimously.

2. Consent Agenda

   a. Consider Approval of HealthSure Insurance Consulting Extension Agreements

   David Dunn moved and Bryn Dodd seconded the motion to approve the Consent Agenda as presented. The motion carried unanimously.

3. Consider Approval of Bid for Central Tower Isolation Room Mechanical Upgrades

   David Dunn moved and Mary Lou Anderson seconded the motion to approve the Bid for Central Tower Isolation Room Mechanical Upgrades. The motion carried unanimously.

4. Consider Approval of Bid for MCH ProCare Administration Offices

   David Dunn moved and Mary Lou Anderson seconded the motion to approve the Bid for MCH ProCare Administration Offices. The motion carried unanimously.

VIII. CONSIDER APPROVAL OF ENDOWMENT FUNDS DISTRIBUTION

Robert Abernethy, Chief Financial Officer, presented the Endowment Funds Distribution Agreement from Prosperity Bank for approval.

As noted in the investment agreement, the total net income for the Odessa Junior College Trust is $19,451.77. Ninety percent of that amount is $17,506.59 and this will be the amount paid to Odessa Junior College. Ten percent, $1,945.18 will be retained as an addition to principal.

The total net income for the TTUHSC-PB Trust is $67,558.80. Ninety percent of that amount is $60,802.92 and this amount will be paid to TTUHSC-PB. Ten percent, $6,755.88 will be retained as an addition to principal.

The total net income for the University of Texas-PB Trust is $12,234.08. Ninety percent of that amount is $11,010.67 and this amount will be paid to University of Texas-PB. Ten percent, $1,223.41 will be retained as an addition to principal.

Richard Herrera moved and Mary Lou Anderson seconded the motion to approve the Endowment Funds Distribution Agreement from Prosperity Bank as presented. The motion carried unanimously.

IX. TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER AT THE PERMIAN BASIN REPORT

Dr. Rama Chemitiganti provided the TTUHSC at the Permian Basin Report for information only. No action was taken.

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

A. CMS Star Rating Presentation

Heather Bulman, Chief Patient Experience Officer, and Dr. Sari Nabulsi, Chief Medical Officer, presented a quality update focused on the Centers for Medicare and Medicaid Services Five-Star Rating System, including how the rating is calculated, and when the ratings are updated.

This report was for information only. No action was taken.

XI. CONSIDER APPROVAL OF PREMIER STAFFING MANAGEMENT TOOL

Christin Timmons, Interim Chief Nursing Officer, presented the Premier Staffing Management Tool, the recommendation of the Productivity Team, to standardize the practices of labor management and drive efficiency.

Ben Quiroz moved and Mary Lou Anderson seconded the motion to approve the Premier Staffing Management Tool as presented. The motion carried unanimously.

XII. CONSIDER APPROVAL OF OBERON SOLAR IB TAX ABATEMENT AGREEMENT

Jason Garewal, Director of Project Development, 174 Power Global Corporation, and Wesley Burnett, Director of Economic Development, Odessa Chamber of Commerce, presented a tax abatement agreement with Oberon Solar, LLC. ECHD entered into an agreement with Oberon Solar, LLC in September 2018 for the first phase of the project. This agreement is for a second nearly identical phase.

David Dunn moved and Richard Herrera seconded the motion to approve the Oberon Solar IB, LLC tax abatement agreement as presented. The motion carried unanimously.

XIII. EXECUTIVE SESSION

Mary Thompson 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 exchange, lease, or value of real property pursuant to 551.072 of the Texas Government Code. (3) Deliberation and evaluation of officers and employees of Ector County Hospital District pursuant to Section 551.074 of the Texas Government Code; (4) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; (5) Information that, if released or disclosed, would give advantage to a competitor as per Section 552.104 of the Texas Government Code; and (6)

Advice, recommendations, opinions, or other material reflecting the policymaking processes of the Ector County Hospital District as per Section 552.111 of the Texas Government Code.

The individuals present during the entire Executive Session were Mary Thompson, David Dunn, Mary Lou Anderson, Bryn Dodd, Don Hallmark, Richard Herrera, Ben Quiroz, Robert Abernethy, and Ellie Bane.

Rick Napper, reported to the Board of Directors during Executive Session then excused himself.

Jan Ramos was in attendance when Adiel Alvarado and Matt Collins reported to the Board of Directors during Executive Session. They were each excused after reporting.

Executive Session began at 6:26 pm.
Executive Session ended at 8:02 p.m.

No action was taken during Executive Session.

XIV. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

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

Mary Thompson presented a contract amendment for MidWest Anesthesia Alliance, LLC and a three year Gastroenterology renewal for Sindhu Kaitha, M.D.

Don Hallmark moved and David Dunn seconded the motion to approve the MCH ProCare provider agreements as presented. The motion carried unanimously.

XV. ADJOURNMENT

There being no further business to come before the Board, Mary Thompson adjourned the meeting at 8:03 p.m.

Respectfully submitted,

Jan Ramos, Secretary
Ector County Hospital District Board of Directors

Medical Center Health System
Your One Source for Health

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS
SPECIAL MEETING
APRIL 12, 2019 – 1:00 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT: Mary Thompson
David Dunn
Mary Lou Anderson
Bryn Dodd
Don Hallmark
Richard Herrera
Ben Quiroz

OTHERS PRESENT: Robert Abernethy, Chief Financial Officer
Ellie Bane, Chief Legal Counsel
Dr. Fernando Boccalandro, Chief of Staff
Dr. Donald Davenport, Vice Chief of Staff
Dr. Gregory Shipkey, Past Chief of Staff
Jan Ramos, ECHD Board Secretary

I. CALL TO ORDER

Mary Thompson called the meeting to order at 1:08 p.m. in Administration Conference Room A of Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

a. Ms. Thompson then read the following notice:

A special meeting of the Ector County Hospital District Board of Directors is scheduled for Friday, April 12, 2019 at 1:00 p.m. in Administration Conference Room A of Medical Center Hospital.

II. NEW MEDICAL STAFF BYLAWS UPDATE AND SUMMARY

Dr. Fernando Boccalandro and Ellie Bane provided those in attendance a summary of the changes to the Medical Staff Bylaws and let them know that these changes had been approved by 75% of the medical staff on April 8, 2019. The bylaws will be presented and recommended for approval by the full ECHD Board of Directors on May 7, 2019.

III. EXECUTIVE/CLOSED SESSION

Mary Thompson stated that the Board would go into Executive Session for a meeting held in closed session as to consultation with attorney regarding legal matters and legal issues pursuant to Sections 551.071 and 551.074 of the Texas Government Code.

The individuals present during Executive Session were Mary Thompson, David Dunn, Mary Lou Anderson, Bryn Dodd, Don Hallmark, Richard Herrera, Ben Quiroz, Robert Abernethy, Ellie Bane, Dr. Fernando Boccalandro, Dr. Donald Davenport, and Dr. Gregory Shipkey.

Executive Session began at 1:40 p.m.

Drs. Boccalandro, Davenport, and Shipkey excused themselves from the remainder of the meeting at 2:20.

Executive Session ended at 3:10 p.m.

No action was taken during Executive Session.

IV. ADJOURNMENT

There being no further business to come before the Executive Committee, the meeting was adjourned at 3:10 p.m.

Respectfully submitted,

Jan Ramos, Secretary
Ector County Hospital District Board of Directors

Medical Center Health System
Your One Source for Health

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS
SPECIAL MEETING
MAY 2, 2019 – 6:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT: Mary Thompson
David Dunn
Mary Lou Anderson
Bryn Dodd
Don Hallmark
Richard Herrera
Ben Quiroz

OTHERS PRESENT: Rick Napper, President/Chief Executive Officer
Ellie Bane, Chief Legal Counsel
Robert Abernethy, Chief Financial Officer

I. CALL TO ORDER

Mary Thompson called the meeting to order at 6:30 p.m. in Administration Conference Room A of Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

a. Ms. Thompson then read the following notice:

A special meeting of the Ector County Hospital District Board of Directors is scheduled for Thursday, May 2, 2019 at 6:30 p.m. in Administration Conference Room A of Medical Center Hospital.

II. EXECUTIVE/CLOSED SESSION

Mary Thompson stated that the Board would go into Executive Session for a meeting held in closed session as to consultation with attorney regarding legal matters and legal issues pursuant to Sections 551.071 and 551.074 of the Texas Government Code.

The individuals present during Executive Session were Mary Thompson, David Dunn, Mary Lou Anderson, Bryn Dodd, Don Hallmark, Richard Herrera, Ben Quiroz, Rick Napper, Ellie Bane, and Robert Abernethy.

Executive Session began at 6:30 p.m.

Bryn Dodd excused herself at 7:20 p.m.

Executive Session ended at 7:42 p.m.

No action was taken during Executive Session.

III. ADJOURNMENT

There being no further business to come before the Executive Committee, the meeting was adjourned at 7:42 p.m.

Respectfully submitted,

Jan Ramos, Secretary
Ector County Hospital District Board of Directors

Medical Center Health System
Your One Source for Health

Date: April 30, 2019

To: Board of Directors-Family Health Clinic

From: Grant Trollope, MCH Controller/FHC Director of Finance

Subject: Combined Financial Report for the Month Ended March 31, 2019

Visits

Combined clinic visits for March were 1,438 comparing unfavorably to the budgeted total of 1,733 and unfavorably to the prior year's 1,761 by 17.0% and 18.3% respectively. Combined medical visits for March totaled 1,438 under the budgeted amount of 1,502 and under the 1,532 visits from prior year. There were no optometry visits in the month of March.

Revenues and Revenue Deductions

Combined patient revenue for March totaled $516,427, comparing unfavorably to the combined budget of $701,356 by 26.4% and under prior year's total of $686,033 by 24.7%.

Combined revenue deductions for March were $285,143 comparing favorably to the combined budgeted amount of $443,127 and favorably to prior year's total of $569,313.

Combined net operating revenue for March was $245,875, comparing unfavorably to the combined budget amount of $259,573 and favorably to the prior year amount of $116,720.

Operating Expenses

Combined operating expenses for March totaled $341,468, comparing favorably to a combined budget of $405,762 and favorably prior year's expenses of $380,377.

Combined salaries and wages expense for March were $121,853, comparing favorably to a combined budget of $128,824 and favorably to prior year's $147,268. Trends in salaries, wages, and benefits resulted from operations, which are now running with 30.5 Full Time Equivalents (FTEs) for March, compared to a budget of 35.9 FTEs and prior year's 32.9 FTEs.

Combined purchased services (Provider salaries) for March totaled $139,798, comparing favorably to a budgeted amount of $204,890 and prior year's amount of $140,963.

Combined supplies expense for March totaled $17,157 comparing unfavorably to budgeted supply expense of $9,142 and prior year's amount of $7,225.

Combined Repairs and Maintenance expense for March totaled $575, comparing favorably to a budgeted amount of $4,451 and favorable prior year amount of $4,440.

Operating Results

Combined operating results for the month of March resulted in a Net Loss of $ 140,831, comparing favorably to the combined budgeted deficit of $191,429, and to prior year loss of $308,960.

Revenue and Payments by Payor

For the month of March, Medicaid patients represented the largest revenue financial class, followed by Self-Pay, and Commercial. Clinics combined, Medicaid revenue accounted for 39.2%, Self-Pay 26.1%, Commercial 18.5%, Medicare 16.0%, FAP 0.0%, and Other for 0.2% of the Clinic's monthly revenue.

Combined payments for the month of March year to date totaled $885,768 compared to the prior year YTD amount of $537,256.

ECTOR COUNTY HOSPITAL DISTRICT
CENTERS FOR PRIMARY CARE COMBINED - OPERATIONS SUMMARY
MARCH 2019

	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	$ 516,427	$ 701,376	-26.4%	$ 686,033	-24.7%	$ 4,024,029	$ 4,117,301	-2.3%	$ 4,188,761	-3.9%
TOTAL PATIENT REVENUE	$ 516,427	$ 701,376	-26.4%	$ 686,033	-24.7%	$ 4,024,029	$ 4,117,301	-2.3%	$ 4,188,761	-3.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ (47,018)	$ 130,953	-135.9%	$ (170,759)	-72.5%	$ 71,230	$ 756,394	-90.6%	$ 1,430,169	-95.0%
Self Pay Adjustments	(10,926)	26,511	-141.2%	(53,021)	-79.4%	1,107	153,128	-99.3%	272,877	-99.6%
Bad Debts	343,087	285,663	20.1%	793,094	-56.7%	1,977,315	1,650,007	19.8%	1,797,438	10.0%
TOTAL REVENUE DEDUCTIONS	$ 285,143	$ 443,127	-35.7%	$ 569,313	-49.9%	$ 2,049,652	$ 2,559,529	-19.9%	$ 3,500,484	-41.4%
	55.21%	63.18%		82.99%		50.94%	62.17%		83.57%	
NET PATIENT REVENUE	$ 231,284	$ 258,249	-10.4%	$ 116,720	98.2%	$ 1,974,377	$ 1,557,772	26.7%	$ 688,277	186.9%
OTHER REVENUE										
FHC Other Revenue	$ 14,591	$ 1,324	1002.0%	$ -	100.0%	$ 81,410	$ 7,944	924.8%	$ 10,595	668.4%
TOTAL OTHER REVENUE	$ 14,591	$ 1,324	1002.0%	$ -	0.0%	$ 81,410	$ 7,944	924.8%	$ 10,595	668.4%
NET OPERATING REVENUE	$ 245,875	$ 259,573	-5.3%	$ 116,720	110.7%	$ 2,055,787	$ 1,565,716	31.3%	$ 698,872	194.2%
OPERATING EXPENSE										
Salaries and Wages	$ 121,853	$ 128,824	-5.4%	$ 147,268	-17.3%	$ 709,428	$ 756,237	-6.2%	$ 302,461	134.6%
Benefits	32,902	41,155	-20.1%	59,706	-44.9%	195,623	239,589	-18.4%	110,024	77.8%
Physician Services	139,798	204,890	-31.8%	140,963	-0.8%	873,919	1,568,493	-44.3%	1,545,267	-43.4%
Cost of Drugs Sold	23,942	9,178	160.9%	10,445	129.2%	61,118	53,878	13.4%	48,133	27.0%
Supplies	17,157	9,142	87.7%	7,225	137.5%	70,732	53,891	31.3%	50,841	39.1%
Utilities	2,983	6,316	-52.8%	8,246	-63.8%	31,053	37,516	-17.2%	40,699	-23.7%
Repairs and Maintenance	575	4,451	-87.1%	4,440	-87.0%	4,736	26,706	-82.3%	35,047	-86.5%
Leases and Rentals	378	380	-0.7%	355	6.4%	2,553	2,280	12.0%	2,329	9.6%
Other Expense	1,880	1,426	31.8%	1,728	8.8%	10,278	8,842	16.2%	7,089	45.0%
TOTAL OPERATING EXPENSES	$ 341,468	$ 405,762	-15.8%	$ 380,377	-10.2%	$ 1,959,441	$ 2,747,432	-28.7%	$ 2,141,890	-8.5%
Depreciation/Amortization	$ 45,238	$ 45,240	0.0%	$ 45,304	-0.1%	$ 271,429	$ 271,440	0.0%	$ 271,656	-0.1%
TOTAL OPERATING COSTS	$ 386,706	$ 451,002	-14.3%	$ 425,680	-9.2%	$ 2,230,870	$ 3,018,872	-26.1%	$ 2,413,546	-7.6%
NET GAIN (LOSS) FROM OPERATIONS	**$ (140,831)**	**$ (191,429)**	**-26.4%**	**$ (308,960)**	**-54.4%**	**$ (175,083)**	**$(1,453,156)**	**-88.0%**	**$(1,714,674)**	**-89.8%**
Operating Margin	-57.28%	-73.75%	-22.3%	-264.70%	-78.4%	-8.52%	-92.81%	-90.8%	-245.35%	-96.5%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	1,438	1,502	-4.3%	1,532	-6.1%	10,222	9,554	7.0%	9,750	4.8%
Optometry Visits	-	231	-100.0%	229	-100.0%	1,115	1,563	-28.7%	1,551	-28.1%
Total Visits	1,438	1,733	-17.0%	1,761	-18.3%	11,337	11,117	2.0%	11,301	0.3%
Average Revenue per Office Visit	359.13	404.72	-11.3%	389.57	-7.8%	354.95	370.37	-4.2%	370.65	-4.2%
Hospital FTE's (Salaries and Wages)	30.5	35.9	-15.1%	41.0	-25.6%	31.4	35.9	-12.6%	10.5	197.6%
Clinic FTE's - (Physician Services)	-	-	0.0%	(8.1)	-100.0%	-	-	0.0%	25.7	-100.0%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE CLEMENTS - OPERATIONS SUMMARY
MARCH 2019

	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	$ 412,459	$ 367,974	12.1%	$ 339,950	21.3%	$ 2,673,932	$ 2,160,107	23.8%	$ 2,182,300	22.5%
TOTAL PATIENT REVENUE	$ 412,459	$ 367,974	12.1%	$ 339,950	21.3%	$ 2,673,932	$ 2,160,107	23.8%	$ 2,182,300	22.5%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ (5,817)	$ 73,801	-107.9%	$ (131,017)	-95.6%	$ 196,717	$ 426,280	-53.9%	$ 792,233	-75.2%
Self Pay Adjustments	(1,181)	17,033	-106.9%	(46,913)	-97.5%	37,042	98,383	-62.3%	181,246	-79.6%
Bad Debts	225,602	128,080	76.1%	446,151	-49.4%	1,001,419	739,798	35.4%	778,572	28.6%
TOTAL REVENUE DEDUCTIONS	$ 218,603	$ 218,914	-0.1%	$ 268,221	-18.5%	$ 1,235,178	$ 1,264,461	-2.3%	$ 1,752,051	-29.5%
	53.0%	59.5%		78.9%		46.2%	58.5%		80.3%	
NET PATIENT REVENUE	$ 193,856	$ 149,060	30.1%	$ 71,729	170.3%	$ 1,438,754	$ 895,646	60.6%	$ 430,249	234.4%
OTHER REVENUE										
FHC Other Revenue	$ 14,591	$ 1,324	0.0%	$ -	0.0%	$ 81,410	$ 7,944	0.0%	$ 10,595	668.4%
TOTAL OTHER REVENUE	$ 14,591	$ 1,324	1002.0%	$ -	0.0%	$ 81,410	$ 7,944	924.8%	$ 10,595	668.4%
NET OPERATING REVENUE	$ 208,447	$ 150,384	38.6%	$ 71,729	190.6%	$ 1,520,164	$ 903,590	68.2%	$ 440,844	244.8%
OPERATING EXPENSE										
Salaries and Wages	$ 88,418	$ 83,983	5.3%	$ 94,698	-6.6%	$ 517,991	$ 493,004	5.1%	$ 232,788	122.5%
Benefits	23,874	26,830	-11.0%	38,393	-37.8%	142,835	156,192	-8.6%	84,680	68.7%
Physician Services	112,259	122,968	-8.7%	74,145	51.4%	598,342	956,096	-37.4%	947,647	-36.9%
Cost of Drugs Sold	25,894	6,031	329.4%	5,779	348.1%	49,873	35,404	40.9%	28,824	73.0%
Supplies	6,792	3,172	114.1%	3,074	121.0%	30,208	18,763	61.0%	22,446	34.6%
Utilities	602	3,722	-83.8%	5,898	-89.8%	16,209	22,241	-27.1%	25,109	-35.4%
Repairs and Maintenance	575	3,974	-85.5%	1,942	-70.4%	4,736	23,844	-80.1%	31,233	-84.8%
Leases and Rentals	378	380	-0.7%	355	6.4%	2,553	2,280	12.0%	2,329	9.6%
Other Expense	1,880	1,416	32.8%	1,728	8.8%	10,278	8,782	17.0%	7,089	45.0%
TOTAL OPERATING EXPENSES	$ 260,672	$ 252,476	3.2%	$ 226,012	15.3%	$ 1,373,025	$ 1,716,606	-20.0%	$ 1,382,145	-0.7%
Depreciation/Amortization	$ 5,121	$ 5,122	0.0%	$ 5,150	-0.6%	$ 30,726	$ 30,732	0.0%	$ 31,072	-1.1%
TOTAL OPERATING COSTS	$ 265,793	$ 257,598	3.2%	$ 231,162	15.0%	$ 1,403,751	$ 1,747,338	-19.7%	$ 1,413,217	-0.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (57,346)**	**$ (107,214)**	**-46.5%**	**$ (159,433)**	**-64.0%**	**$ 116,413**	**$ (843,748)**	**-113.8%**	**$ (972,373)**	**-112.0%**
Operating Margin	-27.51%	-71.29%	-61.4%	-222.27%	-87.6%	7.66%	-93.38%	-108.2%	-220.57%	-103.5%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	1,145	853	34.2%	903	26.8%	7,204	5,462	31.9%	5,784	24.6%
Dental Visits	-	-	0.0%	-	0.0%	-	-	0.0%	350	-100.0%
Total Visits	1,145	853	34.2%	903	26.8%	7,204	5,462	31.9%	6,134	17.4%
Average Revenue per Office Visit	360.23	431.39	-16.5%	376.47	-4.3%	371.17	395.48	-6.1%	355.77	4.3%
Hospital FTE's (Salaries and Wages)	21.5	21.9	-2.1%	24.6	-12.5%	22.2	21.9	1.3%	6.9	220.7%
Clinic FTE's - (Physician Services)	-	-	0.0%	(5.9)	-100.0%	-	-	0.0%	14.3	-100.0%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE WEST UNIVERSITY - OPERATIONS SUMMARY
MARCH 2019

	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	$ 103,968	$ 333,402	-68.8%	$ 346,083	-70.0%	$ 1,350,097	$ 1,957,194	-31.0%	$ 2,006,461	-32.7%
TOTAL PATIENT REVENUE	$ 103,968	$ 333,402	-68.8%	$ 346,083	-70.0%	$ 1,350,097	$ 1,957,194	-31.0%	$ 2,006,461	-32.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ (41,201)	$ 57,152	-172.1%	$ (39,743)	3.7%	$ (125,487)	$ 330,114	-138.0%	$ 637,937	-119.7%
Self Pay Adjustments	(9,744)	9,478	-202.8%	(6,108)	59.5%	(35,935)	54,745	-165.6%	91,630	-139.2%
Bad Debts	117,485	157,583	-25.4%	346,943	-66.1%	975,896	910,209	7.2%	1,018,865	-4.2%
TOTAL REVENUE DEDUCTIONS	$ 66,540	$ 224,213	-70.3%	$ 301,092	-77.9%	$ 814,474	$ 1,295,068	-37.1%	$ 1,748,433	-53.4%
	64.00%	67.25%		87.00%		60.33%	66.17%		87.14%	
NET PATIENT REVENUE	$ 37,428	$ 109,189	-65.7%	$ 44,991	-16.8%	$ 535,623	$ 662,126	-19.1%	$ 258,028	107.6%
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	$ 37,428	$ 109,189	-65.7%	$ 44,991	-16.8%	$ 535,623	$ 662,126	-19.1%	$ 258,028	107.6%
OPERATING EXPENSE										
Salaries and Wages	$ 33,435	$ 44,841	-25.4%	$ 52,570	-36.4%	$ 191,437	$ 263,233	-27.3%	$ 69,673	174.8%
Benefits	9,028	14,325	-37.0%	21,313	-57.6%	52,788	83,397	-36.7%	25,344	108.3%
Physician Services	27,539	81,922	-66.4%	66,819	-58.8%	275,577	612,397	-55.0%	597,621	-53.9%
Cost of Drugs Sold	(1,952)	3,147	-162.0%	4,666	-141.8%	11,245	18,474	-39.1%	19,309	-41.8%
Supplies	10,365	5,970	73.6%	4,151	149.7%	40,525	35,128	15.4%	28,395	42.7%
Utilities	2,381	2,594	-8.2%	2,348	1.4%	14,844	15,275	-2.8%	15,590	-4.8%
Repairs and Maintenance	-	477	-100.0%	2,498	-100.0%	-	2,862	-100.0%	3,814	-100.0%
Other Expense	-	10	-100.0%	-	0.0%	-	60	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 80,796	$ 153,286	-47.3%	$ 154,364	-47.7%	$ 586,415	$ 1,030,826	-43.1%	$ 759,745	-22.8%
Depreciation/Amortization	$ 40,117	$ 40,118	0.0%	$ 40,154	-0.1%	$ 240,703	$ 240,708	0.0%	$ 240,584	0.0%
TOTAL OPERATING COSTS	$ 120,913	$ 193,404	-37.5%	$ 194,518	-37.8%	$ 827,118	$ 1,271,534	-35.0%	$ 1,000,329	-17.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (83,485)**	**$ (84,215)**	**-0.9%**	**$ (149,527)**	**-44.2%**	**$ (291,496)**	**$ (609,408)**	**-52.2%**	**$ (742,301)**	**-60.7%**
Operating Margin	-223.06%	-77.13%	189.2%	-332.35%	-32.9%	-54.42%	-92.04%	-40.9%	-287.68%	-81.1%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	293	649	-54.9%	629	-53.4%	3,018	4,092	-26.2%	3,966	-23.9%
Optometry Visits	-	231	-100.0%	229	-100.0%	1,115	1,563	-28.7%	1,551	-28.1%
Total Visits	293	880	-66.7%	858	-65.9%	4,133	5,655	-26.9%	5,517	-25.1%
Average Revenue per Office Visit	354.84	378.87	-6.3%	403.36	-12.0%	326.66	346.11	-5.6%	363.69	-10.2%
Hospital FTE's (Salaries and Wages)	9.0	14.0	-35.5%	16.4	-45.2%	9.2	14.0	-34.4%	3.6	153.2%
Clinic FTE's - (Physician Services)	-	-	0.0%	(2.2)	-100.0%	-	-	0.0%	11.4	-100.0%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC COMBINED
MARCH 2019

	MONTHLY REVENUE				YTD REVENUE			
	Clements	**West**	**Total**	**%**	**Clements**	**West**	**Total**	**%**
Medicare	$ 59,267	$ 23,431	$ 82,698	16.0%	$ 376,053	$ 224,602	$ 600,655	14.9%
Medicaid	178,897	23,494	202,392	39.2%	1,145,803	534,760	1,680,563	41.8%
FAP	-	-	-	0.0%	-	-	-	0.0%
Commercial	79,310	16,254	95,564	18.5%	519,387	263,919	783,307	19.5%
Self Pay	94,141	40,788	134,929	26.1%	626,309	326,521	952,830	23.7%
Other	844	-	844	0.2%	6,380	294	6,674	0.2%
Total	**$ 412,459**	**$ 103,968**	**$ 516,427**	**100.0%**	**$ 2,673,932**	**$ 1,350,097**	**$ 4,024,029**	**100.0%**

	MONTHLY PAYMENTS				YEAR TO DATE PAYMENTS			
	Clements	**West**	**Total**	**%**	**Clements**	**West**	**Total**	**%**
Medicare	$ 6,166	$ 8,501	$ 14,667	10.3%	$ 39,271	$ 55,404	$ 94,675	10.7%
Medicaid	53,979	9,016	62,995	44.1%	254,719	127,909	382,628	43.2%
FAP	-	-	-	0.0%	-	-	-	0.0%
Commercial	32,023	12,090	44,112	30.9%	159,653	92,905	252,558	28.5%
Self Pay	16,455	4,695	21,150	14.8%	113,058	42,528	155,586	17.6%
Other	-	16	16	0.0%	305	16	321	0.0%
Total	**$ 108,624**	**$ 34,317**	**$ 142,941**	**100.0%**	**$ 567,006**	**$ 318,763**	**$ 885,768**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
MARCH 2019

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	$ 59,267	14.4%	$ 23,651	7.0%	$ 376,053	14.1%	$ 209,472	9.6%
Medicaid	178,897	43.4%	147,758	43.4%	1,145,803	42.9%	820,008	37.6%
PHC	-	0.0%	-	0.0%	-	0.0%	26,649	1.2%
Commercial	79,310	19.2%	67,725	19.9%	519,387	19.4%	440,339	20.2%
Self Pay	94,141	22.8%	100,244	29.5%	626,309	23.4%	681,963	31.2%
Other	844	0.2%	572	0.2%	6,380	0.2%	3,870	0.2%
TOTAL	**$ 412,459**	**100.0%**	**$ 339,950**	**100.0%**	**$ 2,673,932**	**100.0%**	**$ 2,182,300**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 6,166	5.7%	$ 2,250	2.2%	$ 39,271	6.9%	$ 16,111	4.5%
Medicaid	53,979	49.7%	33,913	33.7%	254,719	44.9%	103,260	28.9%
PHC	-	0.0%	-	0.0%	-	0.0%	5,631	1.6%
Commercial	32,023	29.5%	46,103	45.8%	159,653	28.2%	123,014	34.5%
Self Pay	16,455	15.1%	18,257	18.1%	113,058	19.9%	108,452	30.4%
Other	-	0.0%	199	0.2%	305	0.1%	512	0.1%
TOTAL	**$ 108,624**	**100.0%**	**$ 100,721**	**100.0%**	**$ 567,006**	**100.0%**	**$ 356,981**	**100.0%**
TOTAL NET REVENUE	193,856		71,729		1,438,754		430,249	
% OF GROSS REVENUE	47.0%		21.1%		53.8%		19.7%	
VARIANCE	(85,233)		28,992		(871,748)		(73,268)	
% VARIANCE TO CASH COLLECTIONS	-44.0%		40.4%		-60.6%		-17.0%	

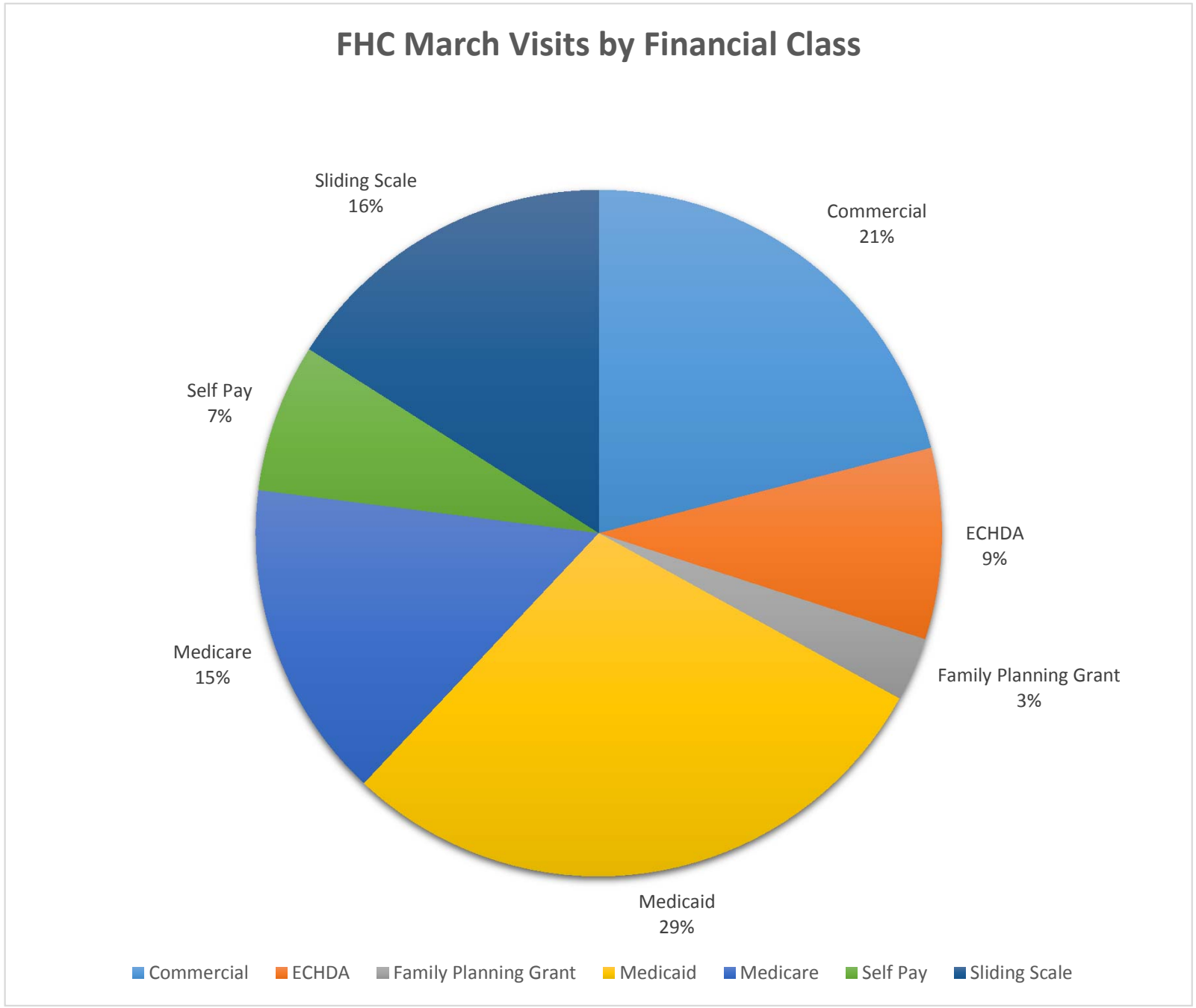
ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
MARCH 2019

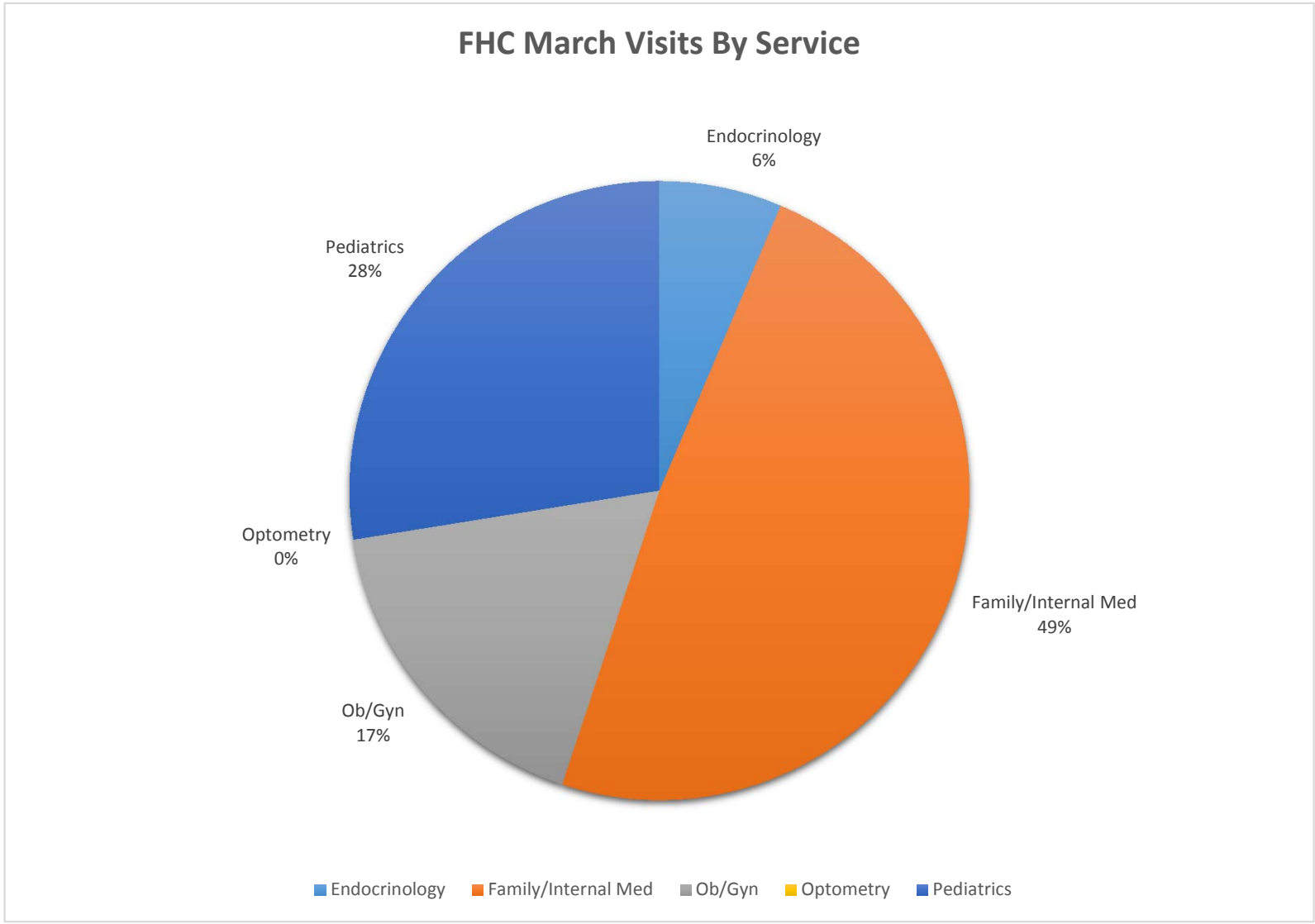
REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 23,431	22.5%	$ 45,622	13.2%	$ 224,602	16.6%	$ 245,362	12.2%
Medicaid	23,494	22.6%	$ 154,633	44.7%	534,760	39.7%	921,848	45.9%
PHC	-	0.0%	$ 10,004	2.9%	-	0.0%	58,382	2.9%
Commercial	16,254	15.6%	$ 62,676	18.1%	263,919	19.5%	383,543	19.1%
Self Pay	40,788	39.3%	$ 71,900	20.8%	326,521	24.2%	392,426	19.6%
Other	-	0.0%	$ 1,249	0.4%	294	0.0%	4,899	0.2%
TOTAL	**$ 103,968**	**100.0%**	**$ 346,083**	**100.0%**	**$ 1,350,097**	**100.0%**	**$ 2,006,461**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 8,501	24.8%	$ 1,142	2.6%	$ 55,404	17.4%	$ 9,239	5.1%
Medicaid	9,016	26.3%	12,870	29.4%	127,909	40.1%	48,465	26.9%
PHC	-	0.0%	-	0.0%	-	0.0%	3,496	1.9%
Commercial	12,090	35.2%	15,158	34.6%	92,905	29.2%	50,792	28.2%
Self Pay	4,695	13.7%	14,532	33.2%	42,528	13.3%	67,704	37.6%
Other	16	0.0%	118	0.3%	16	0.0%	578	0.3%
TOTAL	**$ 34,317**	**100.0%**	**$ 43,820**	**100.0%**	**$ 318,763**	**100.0%**	**$ 180,275**	**100.0%**
TOTAL NET REVENUE	37,428		44,991		535,623		258,028	
% OF GROSS REVENUE	36.0%		13.0%		39.7%		12.9%	
VARIANCE	(3,111)		(1,171)		(216,860)		(77,753)	
% VARIANCE TO CASH COLLECTIONS	-8.3%		-2.6%		-40.5%		-30.1%	


FHC March Visits by Financial Class
Sliding Scale
16%
Commercial
21%
Self Pay
7%
ECHDA
9%
Medicare
15%
Family Planning Grant
3%
Medicaid
29%
Commercial
ECHDA
Family Planning Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC March Visits By Service
Endocrinology
6%
Pediatrics
28%
Optometry
0%
Ob/Gyn
17%
Family/Internal Med
49%
Endocrinology
Family/Internal Med
Ob/Gyn
Optometry
Pediatrics

FHC Executive Director's Report- May 2019

- **Provider Update**: The Family Health Clinic is in search of the following providers for our West University location: Optometrist and Pediatric Nurse Practitioner. Dr Mavis, Family Medicine-West University, will return from maternity leave on May 1, 2019.
- **Staffing Update**: The Family Health Clinic is currently searching for the following positions: 1 LVN, 1 Medical Assistant, and a Clinic Manager position.
- **Community Events/Outreach**: The Family Health Clinic participated in the YMCAs Healthy Kids Day on Saturday April 27, 2019. FHC provided blood pressure checks and information about the Clinic's services and providers.
- **National Health Service Corps (NHSC) Visit:** The Family Health Clinic will had an onsite visit from the National Health Service Corps on Wednesday April 24, 2019. This was the first NHSC site visit for the Family Health Clinic, the purpose of the visit was to review our compliance with NHSC program requirements. NHSC provides loan repayment programs to primary care providers in eligible disciplines. As a Federally Qualified Health Center Look-A-Like, the Family Health Clinic is a designated NHSC-approved site.

Medical Center Hospital
A Member of Medical Center Health System

May 7, 2019

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 Sections 4.1-4 and 6.2-6 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
None				

Allied Health:

Applicant	Department	Specialty/Privileges	Group	Sponsoring Physician(s)	Dates
*Raymond Marquis, CCP	Surgery	Allied Health Professional		Dr. Kirit Patel and Dr. Staton Awtrey	05/07/2019 – 05/06/2021
*Kailea Walker, NP	Cardiology	Allied Health Professional	ProCare	Dr. Boccalandro, Dr. Angirekula, Dr. Farber, Dr. Patel, Dr. Amaram	05/07/2019 – 05/06/2021

*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.

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

May 7, 2019

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 Medical Staff Bylaws sections 4.4-4 and 6.6-3.

Medical Staff:

Applicant	Department	Staff Category	Specialty/Privileges	Group	Changes to Privileges	Dates
Michael Dragun, MD	Surgery	Active	Urology	West Texas Urology	None	06/01/2019 – 05/31/2021
Santiago Giraldo, MD	Medicine	Active	Internal Medicine	ProCare	None	06/01/2019 – 05/31/2021
Ashtosh Gupta, MD	Medicine	Active	Gastroenterology	ProCare	None	06/01/2019 – 05/31/2021
Manjula Mudduluru, MD	Pediatrics	Active	Neonatal/Perinatal	TTUHSC	None	06/01/2019 – 05/31/2021
John Staub, MD	Surgery	Active	Urology	West Texas Urology	None	06/01/2019 – 05/31/2021
Brian Taylor, DO	Emergency Medicine	Active	Emergency Medicine	BEPO	None	06/01/2019 – 05/31/2021
Robert Bennett, MD	Pediatrics	Active	Neonatal/Perinatal	TTUHSC	None	07/01/2019 – 06/30/2021
Eileen Li, MD	Pediatrics	Affiliate	Pediatrics		None	07/01/2019 – 06/30/2021
Christopher Maguire, DO	OB/GYN	Active	OB/GYN	TTUHSC	None	07/01/2019 – 06/30/2021
Vinh Nguyen, MD	Pediatrics	Active	Pediatrics		None	07/01/2019 – 06/30/2021
Victor Ramos, MD	Pediatrics	Active	Pediatrics		None	07/01/2019 – 06/30/2021
Eileen Sheridan-Shayeb, MD	Pediatrics	Active	Pediatrics	ProCare	None	07/01/2019 – 06/30/2021

Allied Health Professionals:

Applicant	Department	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Sissy Hinojos, PA	Family Medicine	Allied Health Professional	ProCare	Dr. Auringer	None	07/01/2019 – 06/30/2021
Lauren Williams, CRNA	Anesthesia	Certified Registered Nurse Anesthetist	MidWest Anesthesia	Dr. Gillala, Dr. Price, Dr. Bhari, and Dr. Bryan	None	05/31/2019 – 05/31/2021

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.

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

Medical Center Hospital
A Member of Medical Center Health System

May 7, 2019

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 Medical Staff Bylaws sections 4.2-11.

Change in Clinical Privileges:

Staff Member	Department	Privilege
Joseph Cox, FNP	Emergency Medicine	**REMOVE: Wound Care**
Beverly Gifford, FNP	Family Medicine	**REMOVE:ACLS**
Lawrence Voesack, MD	Family Medicine	**REMOVE: Umbilical line catheter; Vasectomy; Exercise Stress ECG Testing; Flexible sigmoidoscopy; Moderate sedation, administer; Pulmonary artery catheterization; Hemodynamic, invasive- monitoring of; Pregnancy, emergency complications- management of**

Proctoring Completed:

Staff Member	Department	Privilege(s)
Cindy Chavez, NP	Pediatrics	**Proctor Completion: NICU of Umbilical arterial catherization, Umbilical Venous catherization, Intubation and Peripheral insertion of central catheter.**
Lindsay Wheatley, NP	Pediatrics	**Proctor Completion: NICU of Umbilical arterial catherization, Umbilical Venous catherization, Intubation and Peripheral insertion of central catheter.**

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.

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

May 7, 2019

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/lapse of privileges are recommendations made pursuant to and in accordance with the Medical Staff Bylaws section 4.4-4.

Resignation/ Lapse of Privileges:

Staff Member	Staff Category	Department	Effective Date	Action
Joy Anderson, MD	Active	OB/GYN	06-30-2019	Resignation
Kevin Benson, MD	Active	Pediatrics	04-02-2019	Resignation
April Hendryx, DO	Active	Pathology	02/28/2019	Termination of Privileges
Gary Chase Jackson, OD	AHP	Surgery	02-20-2019	Resignation
John Jennings, MD	Affiliate	OB/GYN	04-30-2019	Resignation
Danielle King, PA	AHP	Cardiology	03-04-2019	Resignation
Adriana Nur, MD	Active	Medicine	04-15-2019	Resignation
Ben Parker, CRNA	AHP	Anesthesia	03-15-2019	Resignation
Sing Dy Uy, MD	Active	Pediatrics	06/30/2019	Lapse in Privileges

Advice, Opinions, Recommendations and Motion:

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

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

May 7, 2019

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
Cho, Parina MD	Radiology	Removal of Provisional Status
Hansen, Robert MD	Radiology	Removal of Provisional Status
McFadden, Sara MD	Radiology	Removal of Provisional Status
Roemhildt, Louis MD	Radiology	Removal of Provisional Status
Aminsharifi, Jamie MD	Radiology	Removal of Provisional Status
Tortorelli, Cynthia MD	Radiology	Removal of Provisional Status

Change in Credentialing Date:

NONE

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.

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

May 7, 2019

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Medical Staff Bylaws /Policies / Privilege Criteria

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommend approval of the following Medical Staff Bylaws/ Policies / Privilege Criteria. The respective departments determined that the practitioners have complied with all Bylaws requirements and are eligible for the change as noted below.

Medical Staff Bylaws/ Policies / Privilege Criteria

- Advance Reg. Nurse Privilege form and Criteria
- Physician Assistant Privilege form and Criteria
- Bylaws and Documents

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 privilege form and criteria and the Bylaws and Documents.

Fernando Boccalandro, MD, Chief of Staff
Executive Committee Chair
/TL

Ector County Hospital District - Medical Center

Delineation of Clinical Privileges and Procedures

Specialty: Advanced Registered Nurse Practitioner
Basic Education: RN or NP

Minimal Formal Training & Experience/Specialty Description

BOD: 9/08, 4/18
Rev: 3/10, 6/12

RN with post-baccalaureate academic preparation, evidenced by successful completion of a Nurse Practitioner (NP) master's degree (accredited by the American Academy of Nurse Practitioners), in a nursing program in the applicant's specialty area;
12 months of clinical practice within the NP's area of specialization; within the past five years;
AND
Current certification by the Board of Nurse Examiners for the State of Texas to practice as an Advanced Practice Nurse;
AND
Evidence of adequate professional liability insurance consistent with Medical Center Hospital policy;
AND
Evidence of physical and mental health status allowing applicant to participate in privileges delineated;

PHYSICIAN SUPERVISION
Must be a physician(s) who is currently appointed to the Medical Center Hospital Medical Staff and has appropriate privileges, and according to a written agreement, this physician will:

1. Supervise the NP's practice in accordance with MCH Medical Staff Bylaws.
2. Be available continuously or provide an alternate, providing consultation when requested and/or intervening when necessary.
3. When requested by NP, required by policy, or in interest of patient care, assume total responsibility for patient care.

Note: An NP granted privileges at Medical Center Hospital may provide patient care under the supervision and sponsorship of a physician(s) with appropriate privileges at Medical Center Hospital. [Medical Center Hospital Medical Staff Bylaws, Article 6]

Reappointment:
1. Must provide ongoing continuing education specific to your scope of practice. For Obstetrics, must be specific to maternal care, pregnant and postpartum patients including complicated and critical conditions.

Core Privileges - Advanced Registered Nurse Practitioner

Management Privileges

Requested	Granted Y/N	Privilege Description
		Obtain medical histories and perform physical examinations (Entries in the health record made by an Allied Health Professional must be co-signed by supervising physician in accordance with MCH Bylaws; section B, Article 3, paragraph 2)
		ACLS (advanced cardiac life support) Required for all PA's/APN's in Emergency Medicine Department and CRNA's. PALS/NPR certification as appropriate
		Develop a patient education plan
		Develop a treatment plan
		Diagnose and treat acute health problems
		Diagnose and treat chronic diseases
		Make appropriate referrals to other health professionals and/or community agencies
		Order, perform, and interpret diagnostic studies
		Prescribe treatments
		Prescribe medications (must provide a supervisor-signed "Notice of Prescriptive Authority" which requires current DPS/ DEA/TMB registration)

Core Privileges - Advanced Registered Nurse Practitioner

Procedure Privileges

Requested	Granted Y/N	Privilege Description
		Acute traumatic wound management and closure.
		Assist in surgery

Special Privileges - Must provide evidence of competency and number of procedures performed or documentation of special training

Requested	Granted Y/N	Privilege Description
		Exercise Stress ECG Testing (PA and APN)
		Wound care (NP only)
		[NICU Only] -Umbilical arterial catheterization
		[NICU Only] - Umbilical venous catheterization
		[NICU Only] – Intubation
		{NICU Only] – Peripheral insertion of central catheter

Applicant Signature_____ Date_____

Department Assessment:
Approved as Requested: _____
Approved as Amended: _____
Comments:

Department Signature_____ Date_____

Maternal Medical Director Assessment:
Approved as Requested: _____
Approved as Amended: _____
Comments:

Maternal Medical Director Signature_____ Date_____

The credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented below.

Privileges Reviewed and Recommended By:

Signature_____ Date_____

Exceptions/Conditions:

Ector County Hospital District - Medical Center

Delineation of Clinical Privileges and Procedures

Specialty: Physician Assistant
Basic Education: PA

Minimal Formal Training & Experience/Specialty Description

BOD: 9/08, 06/15
Rev: 2/09, 3/10, 06/15

Successful completion from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or by one of its predecessor agencies (The Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.
AND
Certification by the National Commission on Certification of Physician Assistants (NCCPA). (NCCPA Certification is required for initial licensure in Texas but not for renewal of an active Texas Physician Assistant License);
AND
Current state licensure by the Texas State Board of Physician Assistants Examiners.
Current DPS & DEA certificates.
Information on state regulations can be found at the American Academy of Physician Assistants (http://www.aapa.org/grandp/statereg.html)
Current
AND

PHYSICIAN SUPERVISION
Supervision by a physician(s) who is currently appointed to the Medical Center Hospital Medical Staff; and has appropriate privileges at MCH; and according to written agreement, this physician will:
1. Supervise the PAs' practice as stated in hospital and MCH Medical Staff Bylaws;
2. Be available continuously or provide an alternate, providing consultation when requested and/or intervening when necessary.
3. When requested by the PA, required by this policy, or in interest of patient care, assume total responsibility for patient care;
4. Co-sign all orders entered by PA on medical records of all patients seen or treated by PA.

Reappointment:
1. Must provide ongoing continuing education specific to your scope of practice. For Obstetrics, must be specific to maternal care, pregnant and postpartum patients including complicated and critical conditions.

Core Privileges - Physician Assistant

Management Privileges

Requested	Granted Y/N	Privilege Description
		Obtain medical histories and perform physical examinations (entries in the health record made by an Allied Health Professional must be co-signed by the supervising physician in accordance with MCH Bylaws; section B, Article 3, paragraph2)
		Develop and implement a treatment plan
		Formulate a working diagnosis
		Issue orders for medications, treatments, laboratory tests, etc. (countersigned by supervising physician)
		Make appropriate referrals
		Medication prescriptions (must provide a supervisor-signed "Notice of Prescriptive Authority" which includes current DEA/DPS and TMB registration)
		Monitor the effectiveness of therapeutic interventions
		Patient counseling/education

Core Privileges - Physician Assistant

Procedure Privileges

Requested	Granted Y/N	Privilege Description
		ACLS (Applicable only to CRNA's and ED PA's) Required for all PA's/APN's in Emergency Medicine department and CRNA's. PALS/NPR certification as appropriate.
		Acute traumatic wound management and closure
		Assist in Surgery

Special Privileges

Requested	Granted Y/N	Privilege Description
		Exercise Stress ECG Testing (PA and APN)

Applicant Signature_____ Date_____

Department Assessment:
Approved as Requested: _____
Approved as Amended: _____
Comments:

Department Signature_____ Date_____

Maternal Medical Director Assessment:
Approved as Requested: _____
Approved as Amended: _____
Comments:

Maternal Medical Director Signature_____ Date_____

The credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented below.

Privileges Reviewed and Recommended By:

Signature_____ Date_____

Exceptions/Conditions:

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

Confidential - Redacted

MEDICAL CENTER HOSPITAL

MEDICAL STAFF BYLAWS

Final Draft
March 22, 2019

Horty, Springer & Mattern, P.C.

MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

PAGE

PAGE

PAGE

PAGE

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff Leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of the Hospital Administration, by a member of the Medical Staff, or by a committee of the Medical Staff, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

(2) When a member of the Medical Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Medical Staff dues will be as recommended by the Medical Executive Committee and may vary by category.

(2) Dues will be payable annually upon request. Failure to pay dues, within a reasonable time as determined by the Medical Executive Committee, will result in ineligibility for continued appointment and privileges.

(3) Signatories to the Hospital's Medical Staff account will be the Chief of Staff and Vice Chief of Staff.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

2.A. GENERAL

(1) Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and Allied Health Staff set forth in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. The categories, along with the respective prerogatives and responsibilities, are summarized in the chart attached as Appendix A to these Bylaws.

(2) The qualifications, prerogatives and responsibilities set forth below are general in nature and may be subject to revision or modification upon recommendation of the Medical Executive Committee and approval by the Board.

(3) At reappointment, any member of the Medical Staff or the Allied Health Staff who has not had sufficient patient activity at the Hospital may be requested to provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentials Policy.

2.B. ACTIVE STAFF

2.B.1. Qualifications:

The Active Staff will consist of members of the Medical Staff who:

(a) are involved in at least 40 patient contacts at the Hospital during the two-year appointment term; OR

(b) do not meet the activity requirements of this category, but have demonstrated a commitment to the Medical Staff through service on Medical Staff or Hospital committees or active participation in performance/quality improvement functions for at least 20 documented hours during the two-year appointment term; AND

(c) have served on the Associate Staff for at least two years.

2.B.2. Prerogatives:

Active Staff members may:

(a) attend and vote in general and special meetings of the Medical Staff and applicable department and committee meetings;

(b) hold office, serve on Medical Staff committees, and serve as department chairperson and committee chairperson; and

(c) exercise clinical privileges granted.

2.B.3. Responsibilities:

Active Staff members must assume all the responsibilities of the Active Staff, including:

(a) serving on committees, as requested;

(b) serving on the on-call schedule for the Emergency Department for unassigned patients and accepting referrals from the Emergency Department for follow-up care of patients, based on the needs of the Hospital as determined by the Medical Executive Committee and the Board;

(c) participating in the professional practice evaluation and performance improvement processes;

(d) accepting inpatient consultations, when requested and on call;

(e) arranging for appropriate consultation or admission for an established patient who presents to the Emergency Department or has been admitted to the Hospital;

(f) attending Medical Staff, and applicable department and committee, meetings; and

(g) paying application fees, dues, and assessments.

2.B.4. Senior Active Status:

(a) Members of the Active Staff who are 65 years of age or older and/or have provided 30 years of service at the Hospital may request Senior Active status. Members who have been granted Senior Active status may be excused from rotational obligations, including serving on the on-call schedule and serving on committees.

(b) The request will be reviewed by the department chairperson and a recommendation made to the Medical Executive Committee. In reviewing a request for Senior Active status, consideration will be given to the needs of the Hospital as determined by the Medical Executive Committee. The Medical Executive Committee's recommendation will be subject to final action by the Board.

(c) A member who is granted Senior Active status may be required to resume serving on the on-call schedule if the Board determines, at a later date, that call coverage in the member's specialty area is not adequate.

2.C. ASSOCIATE STAFF

2.C.1. Qualifications:

(a) The Associate Staff consists of members who are in the process of becoming eligible for appointment to the Active Staff, Courtesy Staff, or Consulting Staff.

(b) Upon completing two years on the Associate Staff, individuals who meet the applicable qualifications may seek to be transferred to another staff category.

(c) Appointment to the Associate Staff may be extended for up to two additional years upon the recommendation of the department chairperson or the Credentials Committee, subject to approval by the Medical Executive Committee and the Board.

2.C.2. Prerogatives:

Associate Staff members:

(a) may attend Medical Staff meetings (without vote), applicable department meetings (without vote), and committee meetings (with vote);

(b) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department for vote;

(c) may not hold office or serve as a chairperson of a department or a chairperson of a committee; and

(d) may exercise clinical privileges granted.

2.C.3. Responsibilities:

Associate Staff members must:

(a) serve on committees, as requested;

(b) serve on the on-call schedule for the Emergency Department for unassigned patients and accept referrals from the Emergency Department for follow-up care of patients, based on the needs of the Hospital as determined by the Medical Executive Committee and the Board;

(c) participate in the professional practice evaluation and performance improvement processes;

(d) accept inpatient consultations, when requested and on call;

(e) arrange for appropriate consultation or admission for an established patient who presents to the Emergency Department;

(f) attend Medical Staff, and applicable department and committee, meetings; and

(g) pay application fees, dues, and assessments.

2.D. COURTESY STAFF

2.D.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who:

(a) are involved in fewer than 40 patient contacts during the two-year appointment term (involvement in a greater number of patient contacts may result in transfer to the Active Staff) (treatment of or consulting on any patient as a result of serving on the on-call schedule will not count towards the 40 patient contact limit); and

(b) are members of the active staff or associate staff at another hospital, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

2.D.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(b) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(c) may be invited to serve on committees (with vote);

(d) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Board;

(e) may exercise clinical privileges as are granted;

(f) may be excused from serving on the on-call schedule, but may also be required to serve on the on-call schedule based on the needs of the Hospital as determined by the Medical Executive Committee and the Board;

(g) must cooperate in the professional practice evaluation and performance improvement processes;

(h) arrange for appropriate consultation or admission for an established patient who presents to the Emergency Department; and

(i) must pay application fees, dues, and assessments.

2.E. CONSULTING STAFF

2.E.1. Qualifications:

The Consulting Staff will consist of members of the Medical Staff who:

(a) are of demonstrated professional ability and expertise and provide a service not otherwise available on the Active Staff;

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) are members of the active or associate staff at another Hospital, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

2.E.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(c) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(d) may be invited to serve on committees (with vote);

(e) may not hold office or serve as department chairperson, or committee chairperson, unless waived by the Medical Executive Committee and the Board;

(f) may exercise clinical privileges granted;

(g) are generally excused from serving on the on-call schedule, but may be required to serve on the on-call schedule based on the needs of the Hospital as determined by the Medical Executive Committee;

(h) must cooperate in the professional practice evaluation and performance improvement processes; and

(i) must pay application fees, dues, and assessments.

2.F. AFFILIATE STAFF

2.F.1. Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish a practice at, this Hospital;

(b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital; and

(c) satisfy the qualifications for appointment set forth in the Credentials Policy, but are exempt from the qualifications pertaining to response times, location within the geographic service area, and coverage arrangements.

2.F.2. Prerogatives and Responsibilities:

Affiliate Staff members:

(a) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(b) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(c) may not hold office or serve as department chairperson unless waived by the Medical Executive Committee and Board because the member had previously been appointed to the Active Staff for a period of at least four years and had only transitioned to the Affiliate Staff in response to changes in that individual's clinical practice patterns;

(d) may serve on committees (with vote), including as committee chairperson;

(e) may attend educational activities sponsored by the Medical Staff and the Hospital;

(f) may refer patients to members of the Medical Staff for admission and care and are encouraged to communicate directly with members about the care of any patients referred;

(g) may visit patients in the Hospital and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) are not granted clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

(k) are required to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(l) must pay application fees, dues, and assessments.

The grant of appointment to the Affiliate Staff is a courtesy only, which may be lifted by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

2.G. HONORARY STAFF

2.G.1. Qualifications:

(a) The Honorary Staff will consist of members of the Medical Staff who:

(1) have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine and, in the discretion of the Medical Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; or

(2) are recognized for outstanding or noteworthy contributions to the medical sciences.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2.G.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) are not granted clinical privileges and therefore they may not consult, admit, or attend to patients;

(b) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(c) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(d) may not hold office or serve as department chairperson;

(e) may be appointed to serve on committees, including as committee chairperson (with vote);

(f) are entitled to attend educational programs of the Medical Staff and the Hospital; and

(g) are not required to pay application fees, dues, or assessments.

2.H. TELEMEDICINE STAFF

2.H.1. Qualifications:

The Telemedicine Staff will consist of members of the Medical Staff who:

(a) satisfy the qualifications for appointment to the Medical Staff, but are exempt from the eligibility criteria set forth in the Credentials Policy pertaining to response times, location within the geographic service area, residence, service on the on-call schedule, and coverage arrangement; and

(b) solely limit their practice at the Hospital exclusively to providing telemedicine services.

2.H.2. Prerogatives and Responsibilities:

Telemedicine Staff members:

(a) may not admit patients;

(b) may not attend or otherwise participate in Medical Staff or department meetings;

(c) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(d) will not be invited to serve on Medical Staff committees; and

(e) must pay application fees, dues, and assessments.

2.I. PROFESSOR STAFF

2.I.1. Qualifications:

The Professor Staff will consist of members who are serving in administrative roles and who may be involved in affiliated educational programs at the Hospital. This category applies to any faculty member of the Medical School, with whom the Hospital has an affiliation, and who serves in an administrative role.

2.I.2. Prerogatives and Responsibilities:

Professor Staff members:

(a) may attend and vote at general or special meetings of the Medical Staff and applicable department meetings;

(b) may be invited to serve on committees (with vote);

(c) may not hold office or serve as a department or committee chairperson;

(d) may exercise clinical privileges granted; and

(e) must pay application fees, dues and assessments.

2.J. AMBULATORY STAFF

2.J.1. Qualifications:

The Ambulatory Staff will consist of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish an inpatient practice at, the Hospital;

(b) are interested in pursuing professional and educational opportunities, including continuing medical education available at the Hospital; and

(c) satisfy the qualifications for appointment set forth in the Credentials Policy, but are exempt from the qualifications pertaining to location within the geographic service area.

2.J.2. Prerogatives and Responsibilities:

Ambulatory Staff members:

(a) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(b) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(c) may not hold office or serve as department chairperson unless waived by the Medical Executive Committee and Board because the member had previously been appointed to the Active Staff for a period of at least four years and had only transitioned to the Ambulatory Staff in response to changes in that individual's clinical practice patterns;

(d) may serve on committees (with vote), including as committee chairperson;

(e) may attend educational activities sponsored by the Medical Staff and the Hospital;

(f) may refer patients to members of the Medical Staff for admission and care and are encouraged to communicate directly with members about the care of any patients referred;

(g) may visit patients in the Hospital and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) are not granted inpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to inpatients at the Hospital;

(k) have been granted appropriate clinical privileges for ambulatory care;

(l) must participate in the professional practice evaluation and performance improvement processes;

(m) are required to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(n) must pay application fees, dues, and assessments.

2.K. ALLIED HEALTH STAFF

2.K.1. Qualifications:

The Allied Health Staff consists of allied health professionals who are granted clinical privileges and are appointed to the Allied Health Staff. The Allied Health Staff is not a category of the Medical Staff, but is included in this Article for convenient reference.

2.K.2. Prerogatives and Responsibilities:

Allied Health Staff members:

(a) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);

(b) may not vote in the election of Medical Staff officers, department chairpersons, or for an amendment to the bylaws, policies, rules and regulations or for any other matter presented to the Medical Staff or department;

(c) may not hold office or serve as department chairperson or committee chairperson;

(d) may be invited to serve on committees (with vote);

(e) must cooperate in the professional practice evaluation and performance improvement processes;

(f) may exercise such clinical privileges as granted; and

(g) must pay application fees and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

(1) Chief of Staff;

(2) Vice Chief of Staff; and

(3) Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board). They must:

(1) have served on the Active Staff for at least three years;

(2) have no pending adverse recommendations concerning appointment or clinical privileges;

(3) not presently be serving as a Medical Staff officer, Board member, or department chairperson at any other hospital and will not so serve during their terms of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have some experience in a leadership position or other involvement in performance improvement functions for at least two years;

(6) participate in Medical Staff Leadership training as determined by the Medical Executive Committee; and

(7) disclose any financial conflict of interest (i.e., an ownership or investment interest in or compensation arrangement) with a hospital or hospital-affiliated entity within Ector County or within 100 miles of the Hospital campus to the nominating committee for evaluation. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff will:

(a) act in coordination and cooperation with the Chief Medical Officer, the Chief Executive Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and the Board;

(c) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the Medical Executive Committee;

(d) serve as a member of the Medical Executive Committee and may attend all other Medical Staff committee meetings (with vote);

(e) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(f) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice Chief of Staff:

The Vice Chief of Staff will:

(a) assume the duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee;

(c) serve as a member of the Medical Executive Committee;

(d) cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff;

(e) oversee the collection of and accounting for any Medical Staff funds and make disbursements authorized by the Medical Executive Committee; and

(f) automatically succeed the Chief of Staff at the beginning of the next Medical Staff year or sooner should the office become vacated for any reason during the Chief of Staff's term of office.

3.C.3. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff will:

(a) serve as an advisor to other Medical Staff Leaders;

(b) serve as a member of the Medical Executive Committee (without vote, i.e., for amendments to the bylaws or officers); and

(c) perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Process:

(a) Not less than 60 days prior to the annual meeting of the Medical Staff, the Nominating Committee will prepare a slate of nominees for the office of Vice Chief of Staff that will be vacant. Notice of the nominees will be provided to the Medical Staff at least 45 days prior to the election.

(b) Additional nominations may be submitted, in writing, by a petition signed by at least 15 voting members of the Medical Staff. The petition must be presented to the chairperson of the Nominating Committee at least 15 days prior to the annual meeting.

(c) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Nominating Committee, satisfy the qualifications in Section 3.B of these Bylaws.

(d) Prior to approving a nominee, the Nominating Committee will review and evaluate disclosure of any financial conflict of interest (i.e., an ownership or investment interest in or compensation arrangement) with a hospital or hospital-affiliated entity within Ector County. If the Nominating Committee decides that there is a financial relationship that is likely to adversely impact the Medical Staff, the Nominating Committee will recommend that the nominee not be included on the ballot. This recommendation will be reviewed and acted on by the Medical Executive Committee.

(e) Nominations from the floor will not be accepted.

3.D.2. Voting:

(a) Voting will be by ballot sent to each voting member of the Medical Staff. Each ballot will contain the names of the nominees approved by the Nominating Committee and any deadlines for voting and returning the ballot to the Medical Staff Office.

(b) Each ballot will be consecutively numbered and each number randomly assigned to a voting member. Each ballot will also contain an original security stamp or mark and no ballot may be copied or duplicated. A lost ballot may be replaced by a new original ballot with a new number. A new number will be assigned to the voting member with the lost ballot and the number on the lost ballot will be canceled.

(c) Only original ballots properly marked and received by the Medical Staff Office by the designated deadline shall be counted. Within five days of the designated deadline, ballots will be counted by the Medical Staff Coordinator and a member of Administration. The results of the vote, if completed in time, will be announced at the annual Medical Staff meeting or the results will be mailed to each of the voting members within ten days after completion of the election process.

(d) The candidates receiving a majority of the votes cast will be elected, subject to Board confirmation.

(e) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1. Term of Office:

(a) Officers will assume office on the first day of the Medical Staff year.

(b) Officers will serve a two-year term.

3.E.2. Vacancies:

(a) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve until the end of the unexpired term of the Chief of Staff.

(b) If there is a vacancy in the office of Vice Chief of Staff, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the office. The appointment will be effective upon approval by the Board.

3.E.3. Removal:

(a) Removal of an elected officer may be effectuated by a two-thirds vote of the Medical Staff or a three-fourths vote of the Medical Executive Committee, or by the Board in consultation with the Medical Executive Committee for:

(1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, Medical Executive Committee or the Board will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Executive Committee, the Active Staff, or the Board, as applicable, prior to a vote on removal.

(d) Removal will be effective when approved by the Board.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1. Organization of Departments:

(a) The Medical Staff may be organized into the clinical departments and service lines as listed in the Medical Staff Organization Manual.

(b) Subject to the approval of the Board, the Medical Executive Committee may create or eliminate departments or otherwise reorganize the department structure, including but not limited to the creation of service lines.

4.A.2. Assignment to Departments:

(a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(b) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.A.3. Functions of Departments:

The departments are organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the department; (ii) to monitor the practice of individuals with clinical privileges in a given department; and (iii) to provide appropriate specialty coverage for educational and service needs for inpatients, outpatient clinics and for the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.B. DEPARTMENT CHAIRPERSON

4.B.1. Qualifications:

Each department chairperson will:

(a) be an Active Staff member unless an exception is recommended by the Medical Executive Committee and approved by the Board;

(b) be certified by an appropriate specialty board and maintain certification as defined in the Credentials Policy; and

(c) satisfy the eligibility criteria in Section 3.B, as applicable.

4.B.2. Selection and Term of Department Chairperson:

(a) Except as otherwise provided by contract, when there is or will be a vacancy in a department chairperson position, or in the position for an additional department representation on the Medical Executive Committee, or a new department is created, the department will recommend nominations to the Medical Executive Committee of an individual(s) eligible to serve. The Medical Executive Committee will serve as the Nominating Committee for this purpose and review and determine whether to accept the department's recommendation. If accepted, the recommendation will be presented to the department at least 60 days prior to the meeting during which the vote will take place. If the department fails to submit a nomination, the Medical Executive Committee will make a nomination for the vacant position.

(b) Additional nominations for department chairperson, and/or department representative, may be submitted, in writing, by a petition signed by at least three voting members of the department. The petition must be presented to the Medical Executive Committee at least 30 days prior to the meeting during which the vote will take place.

(c) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Medical Executive Committee, satisfy the qualifications in Section 3.B of these Bylaws.

(d) Two weeks prior to the meeting, the final slate of nominees will be sent to the department members. No nominations will be accepted from the floor.

(e) Departments will hold elections every two years with approximately half of the departments holding elections during odd years and the remaining departments holding elections during even years.

(f) Department chairpersons, and department representatives, will serve a two-year term and may be elected to serve additional two-year terms.

4.B.3. Removal of Chairperson of a Department:

(a) Removal of a department chairperson, and a department representative, may be effectuated by a two-thirds vote of the department or a three-fourths vote of the Medical Executive Committee, or by the Board, in consultation with the Medical Executive Committee, for:

(1) failure to comply with the Bylaws or applicable policies, or rules and regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a member of the department, the Medical Executive Committee, or the Board will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the department, the Medical Executive Committee, or the Board, as applicable, prior to a vote on removal.

(d) Removal of a department chairperson, and a department representative, will be effective when approved by the Board.

4.B.4. Duties of Department Chairperson:

Each department chairperson is responsible for the following functions, either individually or in collaboration with Hospital personnel:

(a) all clinically-related activities of the department;

(b) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(c) continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(g) the integration of the department into the primary functions of the Hospital;

(h) the coordination and integration of interdepartment and intradepartment services;

(i) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;

(j) recommendations for a sufficient number of qualified and competent individuals to provide care, treatment, and services;

(k) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(l) continuous assessment and improvement of the quality of care, treatment, and services provided;

(m) maintenance of quality monitoring programs, as appropriate;

(n) the orientation and continuing education of members in the department;

(o) recommendations for space and other resources needed by the department; and

(p) performing functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1. Appointment:

(a) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(b) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, the Chief of Staff and Vice Chief of Staff will, in consultation with the Chief Medical Officer, appoint the members and the chairperson of each Medical Staff committee. Committee chairpersons must satisfy the criteria in Section 3.B of these Bylaws. The Chief of Staff will also recommend Medical Staff representatives to Hospital committees.

(c) The Chief Medical Officer will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.

(d) Chairpersons and members of standing committees will be appointed for an initial term of two years, but may be reappointed for additional terms.

(e) Chairpersons and members of standing committees may be removed and vacancies filled at the discretion of the person who appointed them.

(f) The Chief of Staff will be an *ex officio* member, with vote, on all Medical Staff committees.

(g) The Chief Medical Officer and Chief Executive Officer will be *ex officio* members, without vote, on all Medical Staff committees.

5.A.2. Meetings, Minutes, Reports and Recommendations:

Except as otherwise provided, Medical Staff committees will meet as necessary to accomplish their functions. Medical Staff committees will maintain minutes which include their findings, proceedings, and actions. Medical Staff committees will make timely written reports to the Medical Executive Committee. Minutes of the meetings will be kept and maintained under the supervision of the Medical Staff Office.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1. Composition:

(a) The Medical Executive Committee will include:

(1) Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff;

(2) the clinical department chairpersons for all clinical departments with 12 or fewer voting staff members;

(3) the department chairpersons and an additional department representative, to be reviewed by the Medical Executive Committee, serving as a Nominating Committee, and elected by the members of that department, for all clinical departments with greater than 12 voting staff members;

(4) the Medical Directors of the Radiology, Critical Care, Hospitalist, Anesthesiology, Cardiology, and Emergency Departments, without vote; and

(5) Chief Executive Officer, the Chief Medical Officer, the Medical Director of Quality Assurance/Utilization Review, and the Regional Dean of Texas Tech University Health Sciences Center at Odessa *ex officio*, without vote.

(b) The Chief of Staff will serve as chairperson of the Medical Executive Committee, with vote.

(c) The chairperson of the Board, or another Board member, may attend meetings of the Medical Executive Committee, *ex officio*, without vote.

(d) The Medical Executive Committee may, in its discretion, invite Medical Directors of clinical services to serve as members of the committee.

(e) Other individuals may be invited to Medical Executive Committee meetings as guests, without vote.

5.B.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws and related policies. The Medical Executive Committee is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which appointment to the Medical Staff and Allied Health Staff may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with Administration on quality-related aspects of contracts for patient care services;

(d) providing oversight and guidance with respect to continuing medical education activities;

(e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) approving Medical Staff policies and procedures;

(i) ensuring that, at least every three years, the Bylaws and applicable policies are reviewed and updated;

(j) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;

(k) recommending clinical services, if any, to be provided by telemedicine;

(l) recommending action to the Administrator on medico-administrative matters;

(m) making recommendations on Hospital management matters (for example, long-range planning) to the Board;

(n) keeping the Medical Staff abreast of the accreditation program and informed of the Hospital's accreditation status;

(o) reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines; and

(p) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

5.B.3. Meetings:

The Medical Executive Committee will meet at least ten times a year and more often if necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) healthcare associated infections;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of patients' medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

(2) A description of the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

(1) In accordance with the amendment provisions in the Medical Staff Organization Manual, the Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The Medical Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

(2) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Executive Committee.

(3) Special task forces will be created and their members and chairperson will be appointed by the Chief of Staff and the Medical Executive Committee. Such task forces will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. GENERAL

6.A.1. Meetings:

(a) The Medical Staff year is January 1 to December 31.

(b) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department and committee will meet as often as needed to perform their designated functions.

6.A.2. Regular Meetings:

(a) The Chief of Staff, the chairperson of each department, and the chairperson of each committee will schedule regular meetings.

(b) The Medical Staff will meet at least once a year. The annual meeting of the Medical Staff will be the last meeting before the end of the year.

(c) Except as otherwise provided, departments will hold regular meetings at least quarterly.

6.A.3. Special Meetings:

(a) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the Medical Executive Committee, the Chief Executive Officer, the chairperson of the Board, or by a petition signed by at least 10% of the voting members of the Medical Staff.

(b) A special meeting of any department or committee may be called by the Chief of Staff, the department chairperson, the committee chairperson, or by a petition signed by at least 10% of the voting members of the department or committee but in no event fewer than two members.

(c) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Prerogatives of the Presiding Officer:

(a) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, or committee.

(b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

(c) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings and elections.

6.B.2. Notice:

(a) Notice of regular meetings of the Medical Staff and regular meetings of departments and committees will be provided via regular U.S. mail, e-mail, or Hospital mail or by posting in a designated location at least 14 days in advance of the meeting. Notice of meetings may also be provided by annual resolution, providing the time and location for regular meetings, in which case no other notice shall be required.

(b) Notice of a special meeting of the Medical Staff, department, or committee will be provided via regular U.S. mail, e-mail, or Hospital mail or by posting in a designated location. The notice period for special meetings will be 72 hours.

(c) Notices will state the date, time, and place of the meetings.

(d) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.3. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two members) will constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the Medical Executive Committee and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting committee members will constitute a quorum;

(2) for meetings of the Credentials Committee, the presence of at least 30% of the voting committee members will constitute a quorum; and

(3) for any amendments to these Medical Staff Bylaws, at least 25% of the voting members will constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.

(c) Recommendations and actions taken by the Medical Staff or by any department or committee will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members.

(d) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes will be the number of responses returned to the Presiding Officer by the date indicated. The question raised will be determined in the affirmative and will be binding if a majority of the responses returned has so indicated.

(e) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

(f) There shall be no proxy voting.

6.B.4. Minutes:

(a) Minutes of Medical Staff, department, and committee meetings will be prepared and signed by the Presiding Officer.

(b) Minutes will include a record of the attendance of members and the recommendations made.

(c) Minutes of meetings of the Medical Staff, departments, and committees will be forwarded to the Medical Executive Committee and a copy will be provided to the Chief Executive Officer.

(d) The Board will be kept apprised of and act on the recommendations of the Medical Staff.

(e) A permanent file of the minutes of meetings will be maintained by the Hospital.

6.B.5. Confidentiality:

(a) Medical Staff business conducted by departments and committees is considered confidential and should be treated as such.

(b) Members of the Medical Staff who have access to, or are the subject of, credentialing or peer review information must agree to maintain the confidentiality of the information.

(c) Credentialing and peer review documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy.

(d) A breach of confidentiality may result in the imposition of disciplinary action.

6.C. ATTENDANCE

6.C.1. Regular and Special Meetings:

(a) Members of the Medical Staff are encouraged to attend Medical Staff and applicable department and committee meetings.

(b) Members of the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee are required to attend at least 50% of the regular meetings of their assigned committee. Failure to attend the required number of meetings may result in the member being removed from the committee, subject to approval by the Medical Executive Committee.

ARTICLE 7

BASIC STEPS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or the Allied Health Staff, or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in detail in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

(1) Complete applications for appointment and clinical privileges will be transmitted to the applicable department chairperson and, where applicable, the Chief Medical Officer and the Chief Nursing Officer, upon request, who will review the individual's education, training, and experience and prepare a written report stating whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.

(2) The Credentials Committee will review the report from the department chairperson and, where applicable, the Chief Medical Officer and the Chief Nursing Officer, the application, and supporting materials and will make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson's report, to the Medical Executive Committee for review and recommendation.

(3) The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee is to grant appointment, or reappointment, and clinical privileges, it will be forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual will be notified by the Chief Executive Officer of the right to request a hearing.

(4) When the disaster plan has been implemented, the Chief Executive Officer or the Chief of Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

7.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND CLINICAL PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) attend a required meeting to discuss issues or concerns;

(v) complete and comply with educational or training requirements;

(vi) comply with request for fitness for practice evaluation;

(vii) comply with request for competency assessment;

(viii) satisfy clinical activity requirements during initial competency evaluation period; or

(ix) notify the Chief of Staff or Chief Executive Officer of any change in any information on the application form;

(b) is arrested, charged, indicted, informed, convicted, or pleads guilty or no contest pertaining to any felony or misdemeanor involving the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse;

(c) makes a misstatement or omission on an application form; or

(d) in the case of an allied health professional, fails, for any reason, to maintain an appropriate supervision/collaborative relationship with a Supervising Physician as defined in the Credentials Policy.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable. The Medical Executive Committee has the discretion to determine the effective date of an automatic relinquishment to ensure continuity of patient care.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee.

(3) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

7.E. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges, or other actions, based on concerns about (a) clinical competence or practice; (b) the safety or proper care being provided to patients; (c) known or suspected violation of ethical standards or the Bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital, undermines the Hospital's culture of safety or is disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Staff.

7.F. HEARING AND APPEAL PROCESS

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; and (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and request documentary evidence.

(8) The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by 35% of the voting members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee.

(2) Proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide notice of proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting member of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.

(3) The proposed amendments may be voted upon at any meeting of the Medical Staff if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting members of the Medical Staff.

(4) In the alternative, the Medical Executive Committee may present any proposed amendments to the voting members of the Medical Staff by written or electronic ballot, returned to the Medical Staff Services by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.

(5) The Medical Executive Committee will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(6) Amendments will be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request.

(8) Neither the Medical Executive Committee, nor the Medical Staff, nor the Board can unilaterally amend these Bylaws.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and rules and regulations that are applicable to members and other individuals who have been granted clinical privileges.

(2) An amendment to the Credentials Policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may be made by a majority vote of the Medical Executive Committee. Notice of any proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee.

(3) Amendments to the Credentials Policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may also be proposed by a petition signed by at least 35% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 45 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.

(4) Other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

(5) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

(6) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(7) Amendments to Medical Staff policies are to be distributed or otherwise made available to members of the Medical Staff and the Allied Health Staff, in a timely and effective manner.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 35% of the voting members of the Medical Staff, with regard to:

(a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule and Regulation; or

(b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

(2) If the differences cannot be resolved at the meeting, the Medical Executive Committee will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual members of the Medical Staff from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from members of the Medical Staff to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Board chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the Chief of Staff of such exchanges. The Board chairperson will determine the manner and method of the Board's response to the members of the Medical Staff.

ARTICLE 9

HISTORY AND PHYSICAL

(a) A complete medical history and physical examination shall be recorded on the patient's chart within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services, by a member of the Medical Staff. The history and physical must reflect a comprehensive current physical assessment conducted by the Medical Staff member. Allied health practitioners may also be granted privileges by the Hospital to perform histories or physicals. When a resident performs the history and physical, the attending physician must countersign the patient's medical record within 24 hours.

(b) If a history and physical has been performed within 30 days prior to admission, a durable, legible copy of the history and physical may be used in the Hospital medical record. A documented plan of treatment should be included in the history and physical or the progress notes.

(c) If the history and physical has been completed prior to admission or readmission, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after registration or inpatient admission or readmission and prior to surgery or a procedure requiring anesthesia services to reflect any changes in the patient's condition since the date of the original history and physical or to state that there have been no changes in the patient's condition. All updates must be timed, dated and signed.

(d) The medical record shall document a current, thorough physical examination prior to the performance of an operative/invasive procedure. When the history and physical examination are not recorded before an operative/invasive procedure or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending Medical Staff member states in writing that an emergency situation exists or that any such delay would be detrimental to the patient.

(e) For outpatient surgery, the history shall include documentation of the indications and symptoms warranting the procedure, listing of the patient's current medications, any existing co-morbid conditions and previous surgeries, and social history or conditions which would have an impact on the patient's care upon discharge from the facility following the procedure.

(f) In the case of readmission of a patient, all previous records shall be available for use by the attending Medical Staff member.

(g) In the case of emergency surgery, where the patient is received directly from the Emergency Department, the ED physician's dictated ED note may be used as the history and physical in order to perform the surgery. However, the attending

physician must dictate his or her own history and physical within 24 hours of patient admission.

ARTICLE 10

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter contained herein.

Adopted by the Medical Staff on:

Date: _____

_____
Chief of Staff

Approved by the Board:

Date: _____

_____
Chairperson, Board of Directors

APPENDIX A

	Active	Associate	Courtesy	Consulting	Affiliate	Honorary	Telemedicine	Professor	Allied Health	Ambulatory
BASIC REQUIREMENTS										
Number of patient contacts/2-year appointment term	≥ 40 patient contacts	NA	<40 patient contacts	NA	NA	NA	NA	NA	NA	NA
Documented hours of service/2-year appointment term	≥ 20 hours	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other	Served on Associate Staff for ≥2 years	In the process of becoming eligible for another staff category	Members of Active or Associate Staff at another hospital	Members of Active or Associate Staff at another hospital		Long-standing service to the Hospital	Solely limit practice to providing telemedicine services	Faculty member of the Medical School		
PREROGATIVES										
Exercise clinical privileges	Y	Y	Y	Y (but not admit)	NA (no privileges and cannot admit)	NA (no privileges and cannot admit)	NA (may not admit patients)	Y	Y	Y, but only for ambulatory care
May attend meetings	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Right to vote	Y	P	P	P	P	P	N	Y	P	P
Serve as officer or department chairperson or committee chairperson	Y	N	N (unless waived)	N (unless waived)	N (unless waived and can serve as committee chairperson)	N (can serve as committee chairperson)	N	N	N	N (unless waived)

APPENDIX A

	Active	Associate	Courtesy	Consulting	Affiliate	Honorary	Telemedicine	Professor	Allied Health	Ambulatory
RESPONSIBILITIES										
Serve on committees	Y	Y	Y (if invited to serve)	Y (if invited to serve)	Y	Y	N	Y (if invited to serve)	Y (if invited to serve)	Y (if invited to serve)
Serve on the On-call Schedule	Y	Y	May be excused, but will be required if MEC determines need	N (unless required by MEC)	N	NA	NA	NA	N	N
Participate in/ cooperate with professional practice evaluation and performance improvement processes	Y	Y	Y	Y	N	NA	NA	NA	Y	Y
Accept inpatient consultations	Y	Y	N	N	N (required to accept referrals from ED for follow-up care)	NA	NA	NA	N	N (but required to accept referrals from ED for follow-up care)
Arrange for appropriate consultation or admission for established patients	Y	Y	Y	N	N	NA	NA	NA	N	N

Y = Yes
N = No
P = Partial (with respect to voting, only when appointed to a committee)
NA = Not Applicable

MEDICAL CENTER HOSPITAL

CREDENTIALS POLICY

Revised Discussion Draft
March 22, 2019

Horty, Springer & Mattern, P.C.

CREDENTIALS POLICY

TABLE OF CONTENTS

PAGE

PAGE

PAGE

PAGE

PAGE

ARTICLE 1

GENERAL

1.A. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated, and are not intended to create any rights with respect to members of the Medical Staff or Allied Health Staff.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or the Allied Health Staff members who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

1.C.2. Peer Review Protection:

All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all departments;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq. Peer review activities are not subject to an Open Records request.

1.D. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital's Bylaws.

1.E. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. A listing of the categories of allied health professionals practicing at the Hospital is included at Appendix A. Allied health professionals include licensed independent practitioners and advanced practice clinicians:

- "LICENSED INDEPENDENT PRACTITIONER" means an allied health professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Licensed independent practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges as moonlighting residents.

- "ADVANCED PRACTICE CLINICIAN" means a type of allied health professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.

- "DEPENDENT PRACTITIONER" means a type of allied health professional who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted.

- Except as otherwise expressly stated in this Policy and the Medical Staff Bylaws, the term "allied health professional" will be limited to Licensed Independent Practitioners and Advanced Practice Clinicians.

(2) "ALLIED HEALTH STAFF" means those licensed independent practitioners and advanced practice clinicians who have been appointed to the Allied Health Staff by the Board.

(3) "BALLOT" means the method that will be used for voting as outlined in the Medical Staff Electronic Voting Policy.

(4) "BOARD" means the governing body of the Hospital and the Ector County Hospital District.

(5) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, any specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, or the American Board of Foot and Ankle Surgery, upon an individual, as applicable.

(6) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(7) "CHIEF MEDICAL OFFICER" means the individual appointed by the Hospital to act as the Chief Medical Officer of the Hospital, in cooperation with the Chief of Staff.

(8) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

(9) "COMPLETED APPLICATION" means that all questions on the application form have been answered, all supporting documentation has been supplied, and all

information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(10) "CORE PRIVILEGES" means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(11) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(12) "DAYS" means regular business days, not including any nationally recognized holidays.

(13) "DENTIST" means a doctor of dental medicine or doctor of dental surgery or equivalent degree.

(14) "DISTRICT" means the Ector County Hospital District.

(15) "EX-OFFICIO" means a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

(16) "HOSPITAL ADMINISTRATION" or "ADMINISTRATOR" means the Chief Executive Officer or his or her designee.

(17) "MEDICAL EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff as set forth in the Medical Staff Bylaws.

(18) "MEDICAL STAFF" means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

(19) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, or committee chairperson.

(20) "MEDICAL STAFF YEAR" means the period from January 1 to December 31.

(21) "MEMBER" means a physician, dentist, or podiatrist who has been granted Medical Staff appointment, or an advanced practice nurse or physician assistant who has been granted Allied Health Staff appointment, by the Board to practice at the Hospital.

(22) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(23) "PATIENT CONTACTS" includes any admission, consultation, procedure, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities but excluding, in the physician's discretion, treatment of or consulting on a patient as a result of serving on the on-call schedule.

(24) "PERFORMANCE IMPROVEMENT" activities means structured processes by which members and allied health professionals can learn about and apply performance measures over a useful interval and evaluate their performance.

(25) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.

(26) "PHYSICIAN ASSISTANT" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the state board and is licensed to perform medical services delegated by the Supervising Physician and is acceptable to the Board of the Hospital.

(27) "PODIATRIST" means a doctor of podiatric medicine.

(28) "PROFESSIONAL REVIEW ACTION" has the meaning defined in the Health Care Quality Improvement Act.

(29) "PROFESSIONAL REVIEW ACTIVITY" has the meaning defined in the Health Care Quality Improvement Act.

(30) "RESTRICTION" means a professional review action based on clinical competence or professional conduct which results in the inability of an individual to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree to before privileges can be exercised).

(31) "SERVICE LINE" means members of the Medical Staff or Allied Health Staff and Hospital personnel organized to collaboratively address the medical, mental/emotional, nutritional, social, and other needs of patients suffering from a particular condition or group of conditions. In the event that any service lines are developed, until such time as the Medical Staff Bylaws, Rules and Regulations, and policies are amended to specifically address their organizational functions, they will be guided by the principles applicable to departments and will be entitled to the same confidentiality, privilege, indemnification, and immunity protections that apply to departments and their leaders.

(32) "SERVING ON THE ON-CALL SCHEDULE" means providing coverage for the Emergency Department for unassigned patients, accepting referrals from the Emergency Department for follow-up care of patients, and accepting inpatient consultations, based on the needs of the Hospital as determined by the Medical Executive Committee and the Board.

(33) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(34) "SUPERVISING PHYSICIAN" means a member of the Medical Staff who has agreed in writing to supervise or collaborate with an advanced practice clinician and to accept full responsibility for the actions of the advanced practice clinician while he or she is practicing in the Hospital.

(35) "SUPERVISION" means the supervision of (or collaboration with) an advanced practice clinician by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each advanced practice clinician is credentialed and will be consistent with any applicable written supervision or collaboration agreement.

(36) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician with clinical privileges, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

Only physicians with Doctor of Medicine or Doctor of Osteopathy degrees or equivalent (e.g., M.B.B.S. degree), dentists with Doctor of Dental Medicine or Doctor of Dental Surgery degrees or equivalent (e.g., B.D.S. degree), or podiatrists with a Doctor of Podiatric Medicine degree, and holding a license or permit to practice in the State of Texas are qualified for membership on the Medical Staff of Medical Center Hospital.[1]

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must, as applicable:

(a) have a current, unrestricted license to practice in Texas that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice in any jurisdiction revoked, terminated, restricted, involuntarily surrendered, or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration, if necessary for applicant's scope of practice;

(c) while providing services, be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) have not, within the last ten years, been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have not, within the last ten years, had medical staff or allied health staff appointment or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

[1] In every instance where the term "physician" is used, it shall include physician, dentist, and podiatrist, as applicable. In every instance where the term "medical" is used, it shall include medical/dental, as applicable.

(g) have not, within the last ten years, resigned medical staff or allied health staff appointment or relinquished privileges during an investigation, under threat of an investigation, in exchange for not conducting an investigation or after being advised of an investigation, at any health care facility, including this Hospital;

(h) not currently be under any criminal investigation, information, or indictment and have not, within the last ten years, been required to pay a civil money penalty for governmental fraud or program abuse or been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;

(i) not currently be under investigation by any federal or state agency or health care facility for reasons related to clinical competence or professional conduct;

(j) agree to serve on the on-call schedule for their specialty, based on the needs of the Hospital as determined by the Medical Executive Committee and the Board;

(k) have an appropriate coverage arrangement, as determined by the Medical Executive Committee, with other members of the Medical Staff for those times when the individual will be unavailable. Such coverage arrangement will be one in which the unavailable provider assures timely, adequate professional care of his or her patients in the Hospital with an eligible alternate provider who has current clinical privileges in the Hospital, and at least an equivalent practice and scope as the provider who will be unavailable;

(l) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;

(m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;

(n) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;

(o) demonstrate recent clinical activity in their primary area of practice during the last two years;

(p) have successfully completed[2]:

[2] The residency training requirement will be applicable only to those individuals who apply for initial appointment after the date of adoption of this Policy. Existing members will be governed by the residency training requirement in effect at the time of their initial appointment.

(1) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;

(2) a dental training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(4) for allied health professionals, have satisfied the applicable training requirements as established by the Hospital;

(q) be or have been certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, any specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, or the American Board of Foot and Ankle Surgery, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training;[3] and

(r) if seeking to practice as an advanced practice clinician, must have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of Texas law and Hospital policy.

2.A.2. Extension of Time Frame to Satisfy Board Certification Criterion:

In exceptional circumstances, the seven-year time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(a) the individual has been on the Hospital's Medical Staff for at least three consecutive years;

[3] This board certification requirement will be applicable only to those individuals who apply for initial appointment after June 11, 2013; members appointed prior to this date, and who remain on the Medical Staff in good standing, will be governed by the board certification requirement in effect at the time of their initial appointment.

(b) there have been no documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure that have risen to the level of the involvement of the Medical Executive Committee;

(c) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

(d) the appropriate department chairperson at the Hospital provides a favorable report concerning the individual's qualifications.

2.A.3. Waiver of Threshold Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.

(c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.A.4. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.5. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed or reappointed to the Medical Staff or Allied Health Staff or be granted or exercise particular clinical privileges merely because he or she:

(a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, medical staff or allied health staff appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred physician organization, or other entity.

2.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and maintenance of clinical privileges, every individual specifically agrees to the following:

(a) to provide continuous and timely care for their patients;

(b) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

(c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) to serve on the on-call schedule;

(e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;

(f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(h) to use the Hospital sufficiently to allow continuing assessment of current competence;

(i) to seek consultation whenever necessary;

(j) to complete in a timely manner all medical and other required records;

(k) to perform all services and to act in a cooperative and professional manner;

(1) to arrange for appropriate consultation or admission for an established patient who presents to the Emergency Department or has been admitted to the Hospital;

(m) to promptly pay any applicable dues, assessments, or fines;

(n) to utilize the Hospital's electronic medical record system;

(o) to satisfy continuing medical education requirements;

(p) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;

(q) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(r) to maintain a current Hospital e-mail address with the Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Staff information to the member;

(s) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

(t) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an advanced practice clinician, the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and

(u) that, if the individual is an advanced practice clinician, he or she will abide by the conditions of practice set forth in Article 8.

2.B.2. Burden of Providing Information:

(a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become

incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required may be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying, in writing, the Medical Staff Services Office, the Chief of Staff, or the Chief Executive Officer of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:

(1) any information on the application form;

(2) any threshold eligibility criteria for appointment or clinical privileges;

(3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA registration;

(4) changes in professional liability insurance coverage;

(5) the filing of a professional liability lawsuit against the practitioner;

(6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and

(8) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health).

2.C. APPLICATION

2.C.1. Information:

(a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Executive Committee. These applications existing now (and as may be revised) are incorporated by reference and made a part of this Policy.

(b) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and Chief Executive Officer will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Chief of Staff and the Chief Executive Officer to explain the misstatement or omission. The Chief of Staff and the Chief Executive Officer will review the response and determine whether appointment and privileges should be deemed to be an automatic resignation.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

(1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment or clinical privileges are granted;

(2) apply throughout the credentialing process and the term of any appointment, reappointment, or clinical privileges; and

(3) survive for all time, even if appointment, reappointment, or clinical privileges are denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if

the individual no longer maintains appointment or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, or clinical privileges or the individual's qualifications for the same, including, but not limited to:

(i) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or Medical Staff policies and rules and regulations;

(iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates to share information with one another.

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(6) Access to Information by Individuals:

(i) Upon request, applicants will be informed of the status of their applications for appointment or clinical privileges.

(ii) Except during the hearing and appeal processes, which are governed by Articles 7 and 8 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.

(iii) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Allied Health Staff, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Texas law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Allied Health Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.

(b) A completed application form with copies of all required documents must be returned to the Medical Staff Services Office within 60 days after receipt. The application must be accompanied by the application fee. In the event that the completed application form is not returned within 60 days after receipt, the applicant may be required to submit a new application.

(c) Applications may be provided to residents who are in the final six months of their training. Final action on the application form will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Medical Staff Services Office to determine that all questions have been answered. Applicants who fail to return completed applications will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(b) The Medical Staff Services Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

(c) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chairperson at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, List of Excluded Individuals/Entities will be queried, as required, and a criminal background check will be obtained.

(d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: department chairperson, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff, Chief Medical Officer, or the Chief Executive Officer.

3.A.3. Department Chairperson and Chief Medical Officer Procedure:

(a) The Medical Staff Services Office will transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. The department chairperson or division chairperson will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Services Office.

(b) The Chief Medical Officer and the Chief Nursing Officer will also review and report on the applications for all advanced practice clinicians.

3.A.4. Credentials Committee Procedure:

(a) The Medical Staff Services Office will transmit the complete application and all supporting materials, including the report from the department chairperson, and if applicable the Chief Medical Officer and the Chief Nursing Officer, to the Credentials Committee. The Credentials Committee will then make a recommendation.

(b) The Credentials Committee may use the expertise of the department chairperson(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years.

(e) If the recommendation of the Credentials Committee is delayed longer than 30 days, the chairperson of the Credentials Committee will send a letter to the

applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.A.5. Medical Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send special notice to the applicant. The Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or the Medical Executive Committee, or to another source for additional research or information; or

(3) modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable, the Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing

(d) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

Once an application is deemed complete, it will be acted on by the Credentials Committee within 90 days, unless it becomes incomplete. The Medical Executive Committee will act on a complete application within 60 days of its receipt of the recommendation of the Credentials Committee. Thereafter, the Board will take action on a complete application within 60 days of receiving the recommendation of the Medical Executive Committee. Thereafter, notice will be sent to the individual within 20 days of the Board's action.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty or service.

(d) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from initial, ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(e) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.

(f) The report of the relevant department chairperson and, when the applicant is an advanced practice clinician, the report of the Chief Medical Officer and Chief Nursing Officer, will be processed as a part of the application for privileges.

(g) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2. Requests for Limited Privileges Within a Core or Specialty:

(a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)

(b) In appropriate circumstances, the Hospital may grant limited clinical privileges within a core or specialty as requested by an individual on the application. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

(c) A request for limited clinical privileges will be reviewed by the relevant department chairperson, Credentials Committee, Medical Executive Committee, and Board.

(d) The following factors, among others, may be considered in deciding whether to grant a waiver:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(3) the expectations of members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) fairness to other Medical Staff members who serve on the on-call schedule in the relevant specialty, including the effect that the modification would have on them; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the on-call schedule and the feasibility of safely transferring patients to other facilities.

(e) No one is entitled to be granted limited clinical privileges within a core or specialty, and denial of such a request does not trigger a right to a hearing or appeal.

4.A.3. Resignation of Limited Clinical Privileges:

A request to resign limited clinical privileges, whether or not part of the core, must provide a basis for the request. All such requests will be processed in the same manner as a request for limited clinical privileges, as described above.

4.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign **all** clinical privileges should (a) specify the desired date of resignation, (b) affirm that the individual has completed all medical records, and (c) affirm that the individual will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief of Staff, the Board will act on the request.

4.A.5. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available; and

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions.

(c) After review and comment, the department chairperson will forward the report to the Credentials Committee. The Credentials Committee will review the report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital. When determining whether to offer the new procedure at the Hospital, the Credentials Committee may take into account:

(1) whether the Hospital currently has the resources, such as space, equipment, personnel, and other support services, to safely and effectively perform the new procedure; and

(2) any requested input from the relevant Hospital committee, as applicable.

(d) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may refer the matter to the New Procedures Committee, conduct additional research, consult experts, as necessary, and thereafter develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of initial focused professional practice evaluation and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(f) On an ongoing basis, the Credentials Committee, or another committee at the request of the Credentials Committee, will evaluate the criteria for the new procedure. The Credentials Committee will report to the Medical Executive Committee if it recommends a change in the criteria for the new procedure.

4.A.6. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee may conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies). In considering this issue, the Credentials Committee may refer the matter to the New Procedures Committee, or other committee for input.

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it recommends that individuals from different specialties be permitted to request clinical privileges, the Credentials Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of initial focused professional practice evaluation and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on the on-call schedule.

(e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.7. Clinical Privileges for Dentists:

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. In the event a medical issue should arise, the hospitalist service will be contacted and have agreed to respond.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before dental surgery may be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization. The dentist will be responsible for the dental surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record.

(c) Dentists may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Clinical Privileges for Podiatrists:

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient,

if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. In the event a medical issue should arise, the hospitalist service will be contacted and have agreed to respond.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization. The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record.

(c) Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.9. Physicians and Other Practitioners in Training:

(a) Physicians and other practitioners in training, including but not limited to medical students, residents, advanced practice nurses, and physician assistants in training programs ("Trainees"), will not be granted appointment to the Medical or Allied Health Staff or clinical privileges. The clinical faculty or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each Trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols. The applicable training program will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Physicians who are in a residency training program and who wish to moonlight (outside of the training program) will be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program training requirements. Failure to comply with these requirements or termination from the residency program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.10. Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.

(b) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Executive Officer in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications

and requirements set forth in this Policy, except those relating to response times, location within the geographic service area, residence, service on the on-call schedule, and coverage arrangements.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;

(ii) a current list of privileges granted to the practitioner;

(iii) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(iv) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(v) any other attestations or information required by the agreement or requested by the Hospital.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Telemedicine privileges, if granted, will be for a period of not more than two years.

(d) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges that are granted in conjunction with a contractual agreement will expire when the agreement is terminated, not renewed, or expires.

4.A.11. Initial Focused Professional Practice Evaluation:

(a) All grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to an initial focused professional practice evaluation by the department chairperson or by a physician(s) designated by the Credentials Committee.

(b) This initial focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.

(c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.

(d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.

(e) When, based upon information obtained through the initial focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the Chief Executive Officer or Chief Medical Officer, upon recommendation of the Chief of Staff, to:

(1) applicants for initial appointment whose complete application, following a favorable recommendation of the Credentials Committee, is pending review by the Medical Executive Committee and Board. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility; and

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

(ii) when necessary to prevent a lack of services in a needed specialty area;

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff or Allied Health Staff.

(b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank and the Office of Inspector General's List of Excluded Individuals/Entities.

(c) The grant of temporary clinical privileges will not exceed 120 days.

(d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 12-month period following the grant of privileges, subject to the following conditions:

(1) the individual must notify the Medical Staff Services Office at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(2) the individual must inform the Medical Staff Services Office of any change that has occurred to the information provided on the application form for locum tenens privileges.

(e) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

(f) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the Chief Executive Officer or Chief Medical Officer, at any time, after consulting with the Chief of Staff, the chairperson of the Credentials Committee or the department chairperson.

(g) The department chairperson, the Chief of Staff, or Chief Medical Officer will assign to another member of the Medical Staff responsibility for the care of patients until

they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

(h) If there are concerns regarding the grant of temporary privileges to any individual, the Chief Medical Officer will work collaboratively with the Chief of Staff, with appropriate input from the department chairperson, to determine what, if any, appropriate action should be taken.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the department chairperson or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners who will function as volunteers ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital

employee or Medical Staff or Allied Health Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records;

(b) completed all continuing medical education requirements;

(c) paid all dues, fines and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, as applicable;

(e) paid any applicable reappointment processing fee; and

(f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further.

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments and service on the on-call schedule;

(c) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) any ongoing professional practice evaluation or focused professional practice evaluations;

(e) complaints received from patients or staff that have been reviewed through the peer review process; and

(f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

(a) Appointment terms will not extend beyond two years.

(b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services Office within 30 days.

(c) Failure to return a complete application within 30 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(d) The application will be reviewed by the Medical Staff Services Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) The Medical Staff Services Office will oversee the process of gathering and verifying relevant information. The Medical Staff Services Office will also be responsible for confirming that all relevant information has been received.

5.C.2. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for

periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) If questions or concerns are being addressed at reappointment, or if the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.C.3. Potential Adverse Recommendation:

(a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

(a) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to address and resolve questions that may be raised about members of the Medical Staff and the Allied Health Staff. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) competency assessment;

(6) automatic relinquishment of appointment and clinical privileges;

(7) leaves of absence;

(8) precautionary suspension; and

(9) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee for further action.

6.A.2. Documentation:

(a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) A summary of documentation that is prepared for and maintained in the individual's confidential file may be shared with the individual; however, the identity of any person who prepared a complaint or written concern will not be shared. The individual will have an opportunity to review the summary of the documentation and respond to it. The initial documentation, along with any response that is submitted, will also be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings.

6.A.4. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, the individual may not be accompanied by a lawyer at any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and Chief Executive Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

6.A.5. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Hospital Administration, but are not mandatory.

(3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, obligations relating to serving on the on-call schedule, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

(d) communicating expectations for professionalism and behaviors that promote a culture of safety;

(e) informational letters of guidance, education, or counseling; and

(f) performance improvement plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to an initial focused professional practice evaluation to confirm their competence.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.D. MANDATORY MEETING

(1) Whenever there is a concern regarding an individual's clinical practice or professional conduct, any two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) may require the individual to attend a mandatory meeting.

(2) Special notice will be given at least seven days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation, which may include a physical, psychological, or cognitive assessment, to determine his or her ability to safely and competently practice.

(2) A request for a fitness for practice evaluation may be made of an applicant during the initial appointment or reappointment processes, of a member during an investigation, or of a member consistent with the Practitioner Health and Wellness Policy.

(3) A request for an **immediate** evaluation may also be made when any two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

(4) The Medical Staff Leaders, Hospital Administration, or committee that requests the evaluation, including but not limited to the Practitioner Health Committee, will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

(5) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

6.F. COMPETENCY ASSESSMENT

(1) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.

(2) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by any two Medical Staff Leaders, the Credentials Committee, the Medical Executive Committee, an Investigating Committee or the Professional Practice Evaluation Committee.

(3) The Medical Staff Leaders or committee that requests the assessment will: (i) identify the health care professional(s) to perform the assessment; (ii) inform the individual of the time period within which the assessment must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to discuss and report the results of the assessment to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested assessment may result in an automatic relinquishment of appointment and privileges as set forth below.

6.G. AUTOMATIC RELINQUISHMENT

(1) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

(2) Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual. The Medical Executive Committee has the discretion to determine the effective date of an automatic relinquishment to ensure continuity of patient care.

6.G.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with the rules and regulations and Delinquent Medical Records Policy, may result in automatic relinquishment of all clinical privileges. The Chief Medical Officer will determine when the automatic relinquishment goes into effect and may factor in patient care considerations.

6.G.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

6.G.3. Criminal Activity:

The occurrence of specific criminal actions may, as recommended by the Medical Executive Committee and confirmed by the Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, information, conviction, plea of guilty or plea of no contest pertaining to any felony or misdemeanor involving the following may result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

6.G.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff, the Chief Medical Officer, or the Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other authorized committee may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

6.G.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.G.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

6.G.7. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the

Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.G.8. Failure to Comply with Request for Competency Assessment:

Failure of a member to undergo a requested competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to report the results of the assessment to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.G.9. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Allied Health Staff.

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, DEA registration, or insurance coverage will be processed by the Medical Staff Services Office. If any questions or concerns are noted, the Medical Staff Services Office will refer the matter for further review in accordance with (d) below. If an automatic relinquishment occurred due to an individual's failure to complete medical records, HIM may automatically reinstate that individual once the delinquent medical records are completed.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the Chief of Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request

have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within 90 of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

6.H. LEAVES OF ABSENCE

6.H.1. Initiation:

(a) A leave of absence of up to one year must be requested in writing and submitted to the Chief of Staff or Chief Medical Officer. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.

(b) The Chief of Staff or Chief Medical Officer will determine whether a request for a leave of absence will be granted, after consulting with the relevant department chairperson. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Allied Health Staff must report to the Chief of Staff or Chief Medical Officer any time they are away from Medical Staff, Allied Health Staff, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Medical Officer or Chief of Staff may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) The Chief of Staff or the Chief Medical Officer will inform the Medical Executive Committee whenever a leave of absence is approved.

(e) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.H.2. Duties of Member on Leave:

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, and obligations relating to service on the on-call schedule).

The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.H.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the Chief of Staff, the Chief Medical Officer and the Medical Staff Health and Wellness Committee.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. Notice of the reinstatement will be forwarded to the Medical Executive Committee. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board.

(c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician, or other physician as may be requested by the Medical Staff Health and Wellness Committee, indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff or Chief Medical Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

6.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.I.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer and the Chief of Staff. The Chief Executive Officer will notify the Board. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that a suspension, restriction, or voluntary agreement to refrain from exercising privileges that is in effect for longer than 30 days must be reported to the National Practitioner Data Bank.

(f) The relevant Supervising Physician will be notified when the affected individual is a member of the Allied Health Staff.

6.I.2. Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, restriction, or voluntary agreement to refrain from exercising privileges, the Medical Executive Committee will review the reasons for the suspension.

(b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

(c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides that the suspension, restriction, or voluntary agreement to refrain from exercising privileges must be continued, it will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a precautionary suspension, the Chief of Staff or the Chief Medical Officer will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.J. INVESTIGATIONS

6.J.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the department chairperson, the chairperson of a standing committee, the Chief Medical Officer, the Chief Executive Officer, or the chairperson of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or

(4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Staff, including the inability of the member to work harmoniously with others.

(b) If the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Staff member, the matter will be referred to the Chief of Staff, the Chief Medical Officer, or the Chief Executive Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, will forward it to the Medical

Executive Committee. If the question pertains to a member of the Allied Health Staff, the Supervising Physician may also be notified.

(d) To preserve impartiality, the person to whom the matter is directed will not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the Chief of Staff or the Chief Medical Officer.

(e) No action taken pursuant to this section will constitute an investigation.

6.J.2. Initiation of Investigation:

(a) The Medical Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Executive Committee.

(b) The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital, Medical Staff, or Allied Health Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.J.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will not include any individual who:

(1) is in direct economic competition with the individual being investigated;

(2) is a relative of the individual being investigated;

(3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(4) actively participated in the matter previously.

(b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, podiatrist, advanced practice nurse, or physician assistant).

(c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the Chief Executive Officer or the Chief Medical Officer. The objections must be in writing. The Chief Executive Officer or the Chief Medical Officer will review the objection and determine whether another member should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) During the course of the investigation, the Investigating Committee may consult with legal counsel to assist it with any matters pertaining to the investigation.

(f) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(g) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 60 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are

intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(h) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

6.J.4. Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

(7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;

(8) recommend revocation of appointment or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment or clinical privileges;

(3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(b) No other recommendation or action will entitle the individual to a hearing.

(c) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

(a) a letter of guidance, counsel, warning, or reprimand;

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) participation in or being subject to a focused professional practice evaluation;

(h) denial of a request for leave of absence or for an extension of a leave;

(i) removal from the on-call schedule or any reading or rotational panel;

(j) the voluntary acceptance of a performance improvement plan option;

(k) determination that an application is incomplete;

(l) determination that an application will not be processed due to a misstatement or omission; or

(m) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or an exclusive contract or because the Hospital is not accepting applications in the specialty or service.

7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer), if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days (including adjourning and reconvening the hearing), to review and respond with additional information.

(b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party. If the witness list is amended, the other party may request a postponement if additional time is needed to prepare for the new witness.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Chief Executive Officer, after consulting with the Chief of Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff or Allied Health Staff, or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Allied Health Staff or laypersons not affiliated with the Hospital).

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(5) The Hearing Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is a relative of the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The Chief Executive Officer, after consultation with the Chief of Staff, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the Chief of Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the

hearing may contribute to the compensation paid, but is not required to do so. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members, the Presiding Officer, or the Hearing Officer.

(e) Objections:

Any objection to any member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within ten days of receipt of notice, to the Chief Executive Officer. The objection must include reasons to support it. A copy of the objection will be provided to the Chief of Staff. The Chief of Staff will be given a reasonable opportunity to comment. The Chief Executive Officer will rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements, or other confidentiality agreements as determined appropriate by Hospital legal counsel, in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Allied Health Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified, in writing, and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees, Medical Staff members or Allied Health Staff members, and confirmed their willingness to meet. Any employee, Medical Staff or Allied Health Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

(a) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(b) All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.4. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.5. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Notwithstanding the foregoing, administrative personnel may be present as requested by the Chief Executive Officer or the Chief of Staff.

7.C.7. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, that Hearing Panel member must certify that he or she read the entire transcript of the portion of the hearing from which he or she was absent.

7.C.8. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action.

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the Chief Executive Officer. The Chief Executive Officer will send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer will also provide a copy of the report to the Chief of Staff.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chairperson of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

(a) The Board will take final action at its next regularly scheduled meeting after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested. Any deliberations by the Board regarding the recommendation of the Hearing Panel may be conducted in executive session and as such shall not be subject to an open records request.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

(c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the Chief of Staff.

(e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

7.G. MEDIATION

(1) With respect to matters involving an individual's request for initial appointment, reappointment, initial clinical privileges, and/or renewed clinical privileges at the Hospital, either party may request mediation prior to final action being taken by the Board.

(2) Any request for mediation must be made in writing and must be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, within the following time frames:

(a) within ten days after receipt of a Review Panel's recommendation; or

(b) in the case of an appeal that is held before the full Board, within ten days after the adjournment of the appeal.

If mediation is not requested within these time frames, the mediation will be deemed to be waived and the Review Panel's recommendation will be forwarded to the Board for final action, or, in the case of an appeal held before the full Board, the Board will take final action.

(3) If mediation is requested, it will be conducted within a reasonable period of time. The Board will then take final action on the matter at its next regularly scheduled meeting.

ARTICLE 8

CONDITIONS OF PRACTICE APPLICABLE
TO ALLIED HEALTH PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS

8.A.1. Standards of Practice for the Utilization of Advanced Practice Clinicians in the Inpatient Setting:

(a) Advanced practice clinicians are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all advanced practice clinicians specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of advanced practice clinicians in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of advanced practice clinicians in the inpatient hospital setting:

(1) Admitting Privileges. Advanced practice clinicians are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(2) Consultations. Advanced practice clinicians may not independently provide patient consultations in lieu of the practitioner's Supervising Physician. If the advanced practice clinician sees the patient, the advanced practice clinician must discuss the patient with his or her Supervising Physician immediately. An advanced practice clinician may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).

(3) Service on the On-Call Schedule. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an advanced practice clinician prior to the Supervising Physician who is serving on the on-call schedule. An advanced practice clinician in the Emergency Department cannot make the decision, without approval from a Supervising Physician, to contact the physician serving on the on-call schedule. Advanced practice clinicians may not independently serve on the on-call schedule (formally, or informally by agreement with their Supervising Physicians) in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician)

must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an advanced practice clinician to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact an advanced practice clinician prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

(5) Daily Inpatient Rounds. An advanced practice clinician may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

8.A.2. Oversight by Supervising Physician:

(a) Advanced practice clinicians may function in the Hospital only so long as they have a Supervising Physician.

(b) Any activities permitted to be performed at the Hospital by an advanced practice clinician will be performed only under the oversight of the Supervising Physician.

(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the advanced practice clinician fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the advanced practice clinician's clinical privileges will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

(d) As a condition of clinical privileges, an advanced practice clinician and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Chief Medical Officer within three days of any such change.

8.A.3. Questions Regarding the Authority of an Advanced Practice Clinician:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an advanced practice clinician to act or issue instructions outside the presence of the Supervising Physician, such individual will

have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the advanced practice clinician. Any act or instruction of the advanced practice clinician will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.

(b) Any question regarding the conduct of an advanced practice clinician will be reported to the Chief of Staff, the chairperson of the Credentials Committee, the relevant department chairperson, the Chief Medical Officer, or the Chief Executive Officer for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

8.A.4. Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of an advanced practice clinician in their clinical practice at the Hospital must notify the Medical Staff Services Office of this fact in advance and must ensure that the individual has been appropriately credentialed before the advanced practice clinician performs services or engages in any kind of activity in the Hospital.

(b) Supervising Physicians who wish to utilize the services of advanced practice clinicians in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.

(c) The number of advanced practice clinicians acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the advanced practice clinician, to the extent that such filings are required.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the advanced practice clinician in amounts required by the Board. The insurance must cover all clinical activities of the advanced practice clinician in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital, including the specialty and medical care covered. The advanced practice clinician will act in the Hospital only while such coverage is in effect.

8.B. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS AND ADVANCED PRACTICE CLINICIANS

In the event a recommendation is made by the Medical Executive Committee or the Board pertaining to a licensed independent practitioner or an advanced practice clinician that would constitute grounds for a hearing, the process set forth in Article 7 of this Policy will be followed.

ARTICLE 9

CONFLICTS OF INTEREST

(a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) When performing a function outlined in this Policy, the Bylaws, the Medical Staff Rules and Regulations, or a related policy, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(d) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief Medical Officer or the Chief of Staff or the applicable department chairperson or committee chairperson.

(e) The Chief Medical Officer or the Chief of Staff (or the applicable department chairperson or committee chairperson) will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee.

(f) The fact that a department chairperson or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(g) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 10

AMENDMENTS AND ADOPTION

(a) The amendment process for this Policy is set forth in the Bylaws.

(b) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Medical Staff Rules and Regulations, and Hospital or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____ (Date) _____

Approved by the Board: _____ (Date) _____

APPENDIX A

ALLIED HEALTH PROFESSIONALS

The allied health professionals currently practicing at the Hospital as licensed independent practitioners:

- PhD or PsyD Psychologists
- Optometrists
- Massage therapists

The allied health professionals currently practicing at the Hospital as advanced practice clinicians:

- Advanced Practice Nurses
- Certified Registered Nurse Anesthetists
- Nurse Practitioners
- Physician Assistants

MEDICAL CENTER HOSPITAL

MEDICAL STAFF ORGANIZATION MANUAL

Revised Discussion Draft
March 22, 2019

Horty, Springer & Mattern, P.C.

TABLE OF CONTENTS

PAGE

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in this Manual are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL DEPARTMENTS AND SERVICES

2.A. DEPARTMENTS

The Medical Staff will be organized into the following departments:

Department of Ambulatory Medicine

Department of Anesthesiology

Department of Cardiology

Department of Emergency Medicine

Department of Family Practice

Department of Hospital Medicine

Department of Medicine

Department of Obstetrics/Gynecology

Department of Pathology

Department of Pediatrics

Department of Radiology

Department of Surgery

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and department chairpersons are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments, and service lines, as applicable, will be created and may be consolidated or dissolved by the Medical Executive Committee as set forth below.

(2) The following factors will be considered in determining whether a clinical department or service line should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department or service line; for departments, this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws;

(b) the level of clinical activity that will be affected is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department or service line vote in favor of the creation of such;

(d) it has been determined by Medical Staff leadership that there is a clinical and administrative need for a new department or service line; and

(e) the voting members of the Medical Staff of the proposed department or service line have offered a reasonable proposal for how the new department or service line will fulfill the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors will be considered in determining whether the dissolution of a clinical department or service line is warranted:

(a) there is no longer an adequate number of members of the Medical Staff to enable the department or service line to accomplish the functions set forth in the Bylaws and related Medical Staff policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or service line;

(c) the department or service line fails to fulfill designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as department chairperson or service line chief; or

(e) a majority of the voting members of the department or service line vote for its dissolution.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

3.B. DUTIES, MEETINGS, REPORTS, AND RECOMMENDATIONS

(1) At a minimum, each committee will perform the duties set forth below and any additional duties which may be assigned by the Medical Executive Committee.

(2) Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely written report after each meeting to the Medical Executive Committee and other committees and individuals as may be indicated in this Manual.

3.C. CANCER COMMITTEE

3.C.1. Composition:

The Cancer Committee will include at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology and pathology, the Cancer Liaison Physician, and one representative each from administration, nursing, social services, medical records, rehabilitation service, quality assurance, and the cancer registry.

3.C.2. Duties:

The Cancer Committee may perform the following duties:

(a) develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;

(b) promote a coordinated, multidisciplinary approach to patient management;

(c) establish, monitor and evaluate the cancer conference (tumor board) frequency, encourage multidisciplinary attendance, total case and prospective case

presentation, discussion of stage, including diagnostic indicators and the use of evidence-based treatment guidelines, and options for clinical trial participation on an annual basis;

(d) ensure that an active supportive care system is in place for patients, families and staff;

(e) monitor quality management and improvement through completion of quality management studies that focus on quality access to care and outcomes;

(f) promote clinical research (institutions not involved in research must provide patients with information about trials and the mechanism to access clinical trials);

(g) supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting;

(h) perform quality control of registry data;

(i) encourage data usage and regular reporting;

(j) publish the annual report upon request by the Medical Executive Committee; and

(k) uphold medical ethical standards.

3.D. CONTINUING MEDICAL EDUCATION COMMITTEE

3.D.1. Composition:

The Continuing Medical Education Committee will consist of at least three members of the Medical Staff selected to provide representation from the various clinical services on the Medical Staff.

3.D.2. Duties:

The Continuing Medical Education Committee will perform the following functions:

(a) develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff and Allied Health Staff informed of significant new developments and new skills in medicine;

(b) evaluate the effectiveness of the educational programs developed and implemented;

(c) act upon continuing education recommendations from the Medical Executive Committee, the departments, or other committees responsible for patient care monitoring functions; and

(d) maintain a permanent record of education activities and submit periodic reports to the Medical Executive Committee concerning these activities.

3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

(a) The Credentials Committee will consist of the Chief of Staff, the Vice Chief of Staff and up to four Past Chiefs of Staff who are current members of the Active Staff. The Chairperson will be the immediate Past Chief of Staff, unless otherwise appointed by the current Chief of Staff.

(b) Additional members may be appointed to the Credentials Committee if at any time the continued workability of the committee is hindered by the inability of any of the Past Chiefs of Staff to serve.

(c) Members of the Credentials Committee will be appointed for an initial two-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.

(d) The chairperson of the Credentials Committee may appoint a representative(s) from the Allied Health Staff to serve as a member(s) of the committee.

3.E.2. Duties:

The Credentials Committee will perform the following duties:

(a) review the credentials of all applicants for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview applicants, and make written reports of its findings and recommendations;

(b) review, as may be requested by the Medical Executive Committee, all information available regarding the current clinical competence of individuals currently appointed to the Medical Staff or Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;

(c) recommend the numbers and types of cases to be reviewed as part of the focused professional practice evaluation process for initial privileges;

(d) review and approve specialty-specific criteria for ongoing professional practice evaluation and specialty-specific triggers that are identified by each department;

(e) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines; and

(f) appoint an ad hoc new procedures committee on an as-needed basis to advise on requests for new procedures or refer the matter to the appropriate department chairperson for input and a recommendation.

3.F. DA VINCI COMMITTEE

3.F.1. Composition:

The Chief of Staff, in consultation with the Vice Chief of Staff and the Chief Medical Officer, will appoint at least five members of the Medical Staff with appropriate clinical privileges to serve on the Da Vinci Committee. The Chief of Staff will strive to appoint experienced members and members from the various clinical specialties that exercise privileges to use the Da Vinci robot.

3.F.2. Duties:

The Credentials Committee may request the Da Vinci Committee to perform some or all of the following duties:

(a) review the clinical privilege delineation form for privileges to use the Da Vinci robot;

(b) evaluate the competency of physicians who are requesting clinical privileges to use the Da Vinci robot through review of threshold eligibility criteria and case logs;

(c) review the clinical work of members who have been granted clinical privileges to use the Da Vinci robot;

(d) review the use and function of the Da Vinci robot; and

(e) advise the Credentials Committee on matters relating to privileges to use the Da Vinci robot, including appropriateness of granting privileges to those physicians who apply for them.

3.F.3. Meetings, Reports, and Recommendations:

The Da Vinci Committee will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Da Vinci Committee will report to the Credentials Committee.

3.G. ENDOSCOPY COMMITTEE

3.G.1. Composition:

The Chief of Staff, in consultation with the Vice Chief of Staff and the Chief Medical Officer, will appoint at least five members of the Medical Staff with endoscopy privileges

to serve on the Endoscopy Committee. The Chief of Staff will strive to appoint experienced members and members from the various clinical specialties that exercise endoscopy privileges.

3.G.2. Duties:

The Credentials Committee may request the Endoscopy Committee to perform some or all of the following duties:

(a) review the clinical privilege delineation form for endoscopy privileges;

(b) evaluate the competency of physicians who are requesting endoscopy privileges through review of threshold eligibility criteria and case logs;

(c) review the clinical work of members who have been granted endoscopy privileges; and

(d) advise the Credentials Committee on matters relating to endoscopy privileges, including appropriateness of granting endoscopy privileges to those physicians who apply for them.

3.G.3. Meetings, Reports, and Recommendations:

The Endoscopy Committee will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Endoscopy Committee will report to the Credentials Committee.

3.H. FINANCIAL CONTROL COMMITTEE

3.H.1. Composition:

The Chief of Staff, in consultation with the Vice Chief of Staff and the Chief Medical Officer, will appoint at least three members of the Medical Staff to serve on the Financial Control Committee.

3.H.2. Duties:

The Financial Control Committee will:

(a) review potential capital purchases; and

(b) evaluate the medical necessity for proposed capital purchases through consideration of factors such as the anticipated use and cost of the purchase as well as any alternative methods available.

3.H.3. Meetings, Reports, and Recommendations:

The Financial Control Committee will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Financial Control Committee will report to the Medical Executive Committee.

3.I. LEADERSHIP COUNCIL

3.I.1. Composition:

(a) The Leadership Council will consist of the Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of Staff, and the Chief Medical Officer.

(b) Other Medical Staff members or Hospital personnel may be invited to attend a particular meeting of the Leadership Council, as guests, in order to assist the Leadership Council in its review of an issue on its agenda. These individuals will be present only for the relevant agenda item. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.I.2. Duties:

The Leadership Council will perform the following functions:

(a) review and address concerns about professional conduct as outlined in the Medical Staff Code of Conduct Policy;

(b) review and assess possible health issues that may affect an individual's ability to practice safely as outlined in the Medical Staff Practitioner Health Policy;

(c) review and address issues regarding clinical practice as outlined in the Peer Review Policy;

(d) meet, as necessary, to consider and address any situation involving an individual that may require immediate action;

(e) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(f) perform any additional functions as may be requested by the Quality Monitoring Committee, the Medical Executive Committee, or the Board.

3.I.3. Meetings, Reports, and Recommendations:

The Leadership Council will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Leadership Council will report to the Quality Monitoring Committee, the Medical Executive Committee, and others as described in the policies noted above.

3.J. MEDICAL EXECUTIVE COMMITTEE

The composition, duties, and meeting and reporting requirements of the Medical Executive Committee are set forth in Article 5 of the Medical Staff Bylaws.

3.K. MEDICAL STAFF HEALTH AND WELLNESS COMMITTEE

3.K.1. Composition:

(a) The Medical Staff Health and Wellness Committee will consist of the Immediate Past Chief of Staff and at least three other members of the Medical Staff appointed for their experience in addressing health issues.

(b) Whenever the health of a member of the Medical Staff or Allied Health Staff is under review, the relevant department chairperson will also join the committee on an ad hoc basis. The Immediate Past Chief of Staff will serve as the chairperson of the Medical Staff Health and Wellness Committee.

3.K.2. Duties:

The Medical Staff Health and Wellness Committee will:

(a) assume responsibility for the supervision and management of practitioner health issues, as requested;

(b) review the performance of any individual who is referred to the committee and assess whether the individual would benefit from or require treatment, rehabilitation, or other assistance;

(c) assist in the diagnosis, treatment, and rehabilitation of practitioners who may be impaired;

(d) develop a process for referrals to the committee (including a self-referral process);

(e) maintain confidentiality of practitioners reviewed by the committee, unless limited by law, ethical considerations, or concerns about patient safety; and

(f) recommend educational programs for the Medical Staff and the Allied Health Staff on practitioner health issues, including preventive measures designed to promote well-being.

3.K.3. Meetings and Reports:

The Medical Staff Health and Wellness Committee will meet as necessary to fulfill its duties and will report to the Leadership Council. The Leadership Council will act as a liaison between the Medical Staff Health and Wellness Committee and Medical Executive Committee.

3.L. NOMINATING COMMITTEE

3.L.1. Composition:

(a) The Nominating Committee will consist of six members of the Active Medical Staff as follows:

(1) the last three past Chiefs of Staff who are members of the Active Staff; and

(2) three members of the Active Medical Staff appointed by vote of the Medical Executive Committee (if more than three members are identified as potential members of the Nominating Committee, a written ballot will be used and the three members who receive the most votes will serve on the Nominating Committee).

(b) The chairperson of the Nominating Committee will be the committee member who most recently served as Chief of Staff.

(c) In the event there are not three eligible past Chiefs of Staff, then the Medical Executive Committee will appoint other members of the Active Staff to serve on the Nominating Committee.

3.L.2. Duties and Reporting:

(a) The Nominating Committee will offer one or more nominees for the office of Vice Chief of Staff and for any at-large member of the Medical Executive Committee that will be vacant.

(b) Notice of the nominees will be provided to the Medical Staff at least 45 days prior to the election. Additional nominations may be submitted, in writing, by a petition signed by at least 15 voting members of the Medical Staff.

(c) The Nominating Committee will report on its nominates, including other nominations received, to the Chief of Staff and the Medical Staff Coordinator no later than ten days prior to the election.

3.M. PHARMACY AND THERAPEUTICS COMMITTEE

3.M.1. Composition:

(a) The Pharmacy and Therapeutics Committee will consist of at least five members of the Active Staff.

(b) A representative from the pharmacy service, a representative from the nursing service, and a representative from Hospital Administration will serve as *ex officio* members of the Pharmacy and Therapeutics Committee.

(c) From time to time, other members or representatives of other hospital departments may be appointed to serve as ad hoc members of the Pharmacy and Therapeutics Committee to assist in the review of particular issues.

3.M.2. Duties:

The Pharmacy and Therapeutics Committee will:

(a) 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;

(b) advise the Medical Staff and the Hospital's pharmaceutical department on matters pertaining to the choice of available drugs;

(c) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and

(e) perform such other duties as assigned by the Chief of Staff or the Medical Executive Committee.

3.M.3. Meetings and Reports:

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.

3.N. PHYSICIAN INFORMATION TECHNOLOGY ADVISORY COMMITTEE

3.N.1. Composition:

(a) The Chief of Staff will appoint at least five members of the Medical Staff to serve as members of the Physician Information Technology Advisory Committee. The Chief of Staff will strive to appoint representatives from the various clinical specialties on the Medical Staff.

(b) The Chief of Staff will appoint the Chairperson of the Physician Information Technology Advisory Committee.

(c) Personnel from IT will also be appointed to serve as *ex officio* members, without vote, on the committee.

3.N.2. Duties:

The Physician Information Technology Advisory Committee will:

(a) make recommendations regarding educational and training needs around the use of the electronic medical record system;

(b) make policy recommendations regarding adoption and proposed use of the electronic medical record system by members of the Medical Staff; and

(c) provide physician input to IT services on the electronic medical record system.

3.N.3. Meetings and Reports:

The Physician Information Technology Advisory Committee will meet when needed, maintain records of its activities, and report to the Medical Executive Committee.

3.O. PROFESSIONAL PRACTICE EVALUATION COMMITTEE

3.O.1. Composition:

(a) The Professional Practice Evaluation Committees will each consist of at least seven members of the Active Staff who will be: (i) broadly representative of the clinical specialties on the Medical Staff; (ii) experienced or interested in credentialing, privileging, peer review, or other Medical Staff affairs; and (iii) supportive of evidence-based medicine protocols.

(b) The Chief of Staff will appoint the chairperson of that Professional Practice Evaluation Committee, with the approval of the Medical Executive Committee. The vice chairperson of the committee will be elected by the voting members of the committee.

(c) The Chief Executive Officer, the Chief Medical Officer, the Director of Quality Resources, and the Chairperson of the Hospital Quality Council will serve on the Professional Practice Evaluation Committee, *ex officio*, without vote.

(d) Before any Professional Practice Evaluation Committee member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members will participate, as required, in periodic training on peer review, with the nature of the training to be identified by the Medical Executive Committee and the Professional Practice Evaluation Committee.

(e) If additional expertise is required, the Professional Practice Evaluation Committee may request that a physician with the necessary expertise attend the committee meetings while the matter is under consideration. The physician may assist the Professional Practice Evaluation Committee in its deliberations and the appropriate interventions. The physician will be present only for the relevant agenda items. Any such physician will attend as a guest, without vote, but will be an integral part of the peer review process and will be bound by the same confidentiality requirements as the standing members of the committee.

3.O.2. Duties:

The Professional Practice Evaluation Committees are responsible for the following:

(a) overseeing the implementation of the Professional Practice Evaluation Policy and providing training and support on the various components of the process;

(b) reviewing and approving specialty-specific criteria (as identified by each department) for focused professional practice evaluation triggered by a concern being raised;

(c) identifying those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an informational letter may be sent to the practitioner involved in the case;

(d) reviewing referred cases as outlined in the Professional Practice Evaluation Policy;

(e) developing, when appropriate, performance improvement plans for practitioners, as described in the Professional Practice Evaluation Policy;

(f) monitoring and determining that system issues that are identified as part of peer review activities (and not identified and addressed through other forums such as Root Cause Analyses) are successfully resolved;

(g) periodically reviewing the effectiveness of the Professional Practice Evaluation Policy and recommending revisions as may be necessary;

(h) reviewing any practitioner-specific reports and/or reviews performed by a department; and

(i) performing any additional functions as may be requested by the Medical Executive Committee or the Board.

3.O.3. Meetings and Reports:

The Professional Practice Evaluation Committees will meet at least ten times per year and will promptly report their findings to the Medical Executive Committee.

3.P. QUALITY MONITORING COMMITTEE

3.P.1. Composition:

(a) The Quality Monitoring Committee consists of the following:

(1) the Vice Chief of Staff;

(2) one representative from each clinical department, preferably the medical director or department chairperson; and

(3) the Medical Director of Quality Assurance/ Utilization Review.

(b) If additional expertise is required, the Quality Monitoring Committee may request that a physician with the necessary expertise attend the committee meetings while the matter is under consideration. The physician may assist the Quality Monitoring Committee in its deliberations and the appropriate interventions. The physician will be present only for the relevant agenda items. Any such physician will attend as a guest, without vote, but will be an integral part of the peer review process and will be bound by the same confidentiality requirements as the standing members of the committee.

(c) The Chief Executive Officer, Chief Medical Officer, representatives from hospital departments/services, the Director of Quality Resources, and the Chairperson of the Hospital Quality Council will serve on the Quality Monitoring Committee, *ex officio*, without vote.

(d) The Vice Chief of Staff will serve as chairperson of the committee.

3.P.2. Duties:

The Quality Monitoring Committee will foster physician leadership in performance improvement functions, and conduct and/or assess the effective performance of the following:

(a) the coordination of quality, appropriateness, and improvement activities and processes related to operative and other procedures, the use of blood and blood components, the use of medications, medical record review, autopsy results, and other measurement and review of the medical assessment and treatment of patients;

(b) activities required to maintain the hospital utilization review program;

(c) activities required to maintain the hospital infection control program;

(d) evaluation of the efficiency of clinical practice patterns, and significant departures from established patterns of clinical practice; and

(e) any other functions reasonably requested by the Medical Executive Committee or the Board.

3.Q. TRAUMA SYSTEMS COMMITTEE

3.Q.1. Composition:

(a) The Trauma Systems Committee will consist of Medical and Hospital staff from all areas of the Hospital who are involved in the care of trauma patients.

(b) The chairperson of the committee will be a member of the Active Staff.

3.Q.2. Duties:

The Trauma Systems Committee will:

(a) facilitate revision, development and approval of integrated trauma care policies and procedures;

(b) coordinate review of trauma charts, the care of trauma patients and the utilization of trauma services;

(c) routinely collect information about important aspects of patient care provided to trauma patients, periodically assess this information, and develop objective criteria for use in evaluating patient care provided to trauma patients;

(d) provide a forum for review and evaluation of performance improvement and ongoing quality of trauma care provided within the Hospital;

(e) plan and provide continuing medical education programs;

(f) address regulatory standards/requirements and facilitate compliance;

(g) provide leadership for future community trauma needs; and

(h) in accordance with American College of Surgeons guidelines and requirements, itself or through a subcommittee, conduct preliminary peer review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to trauma patients and report its findings to the Professional Practice Evaluation Committee.

3.R. UTILIZATION REVIEW COMMITTEE

3.R.1. Composition:

(a) The Chief of Staff, in consultation with the Vice Chief of Staff and the Chief Medical Officer, will appoint at least three members of the Medical Staff to the Utilization Review Committee.

(b) Administrative personnel, as appointed by the Chief Executive Officer, will also serve on the Utilization Review Committee, *ex officio*, without vote.

(c) The Medical Director of Utilization and Outcomes Management will serve as the chairperson of the Utilization Review Committee.

3.R.2. Duties:

The Utilization Review Committee will perform the following general duties as well as all others specifically defined by approved policies:

(a) monitor utilization to evaluate the appropriateness of Hospital admissions, lengths of stay, discharge practices, and use of medical and Hospital services and resources;

(b) formulate a written utilization review plan for the Hospital, to be approved by the Medical Executive Committee, the Chief Executive Officer, and the Board;

(c) evaluate the medical necessity for continued Hospital services for particular patients, where appropriate, and make recommendations on the same to the attending physician; and

(d) recommend rules and regulations that may be necessary to carry out the purpose of the committee.

ARTICLE 4

AMENDMENTS

The process for amending this Medical Staff Organization Manual is set forth in Article 8 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter contained in this Organization Manual.

Adopted by the Medical Staff on:

Date: _____

_____
Chief of Staff

Approved by the Board:

Date: _____

_____
Chairperson, Board of Directors

MEDICAL CENTER HOSPITAL

MEDICAL STAFF PRACTITIONER HEALTH AND WELLNESS POLICY

Revised Discussion Draft
February 18, 2019

Horty, Springer & Mattern, P.C.

TABLE OF CONTENTS

PAGE

MEDICAL CENTER HOSPITAL

MEDICAL STAFF

PRACTITIONER HEALTH AND WELLNESS POLICY

1. POLICY STATEMENT

A. Scope of Policy

This Policy applies to all practitioners who provide patient care services at Medical Center Hospital (the "Hospital"). For purposes of this Policy, a "practitioner" means a member of the Medical Staff or a member of the Allied Health Staff.

B. Objectives

The Hospital and its Medical Staff are committed to providing safe, quality care, which can be compromised if a practitioner is suffering from a health issue that is not appropriately addressed. The Hospital is also committed to assisting colleagues address health issues so they may practice safely and competently.

C. Definitions

The definitions set forth in the Credentials Policy apply to this Policy as well.

For the purpose of this Policy, "health issue" means any physical, mental, or emotional condition that could adversely affect an individual's ability to practice safely.

D. Delegation of Functions

When a function is to be carried out by a member of Hospital Administration, a member of the Medical Staff or Allied Health Staff, a Medical Staff Leader or a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function as defined in this Policy, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

E. Role of Medical Staff Health and Wellness Committee

Practitioner health issues will be addressed by the Medical Staff Health and Wellness Committee ("Health and Wellness Committee") as outlined in this Policy. The Health and Wellness Committee may request other practitioners to assist it if additional expertise would help it address health concerns that are identified in a particular case.

The Health and Wellness Committee will also recommend to the Medical Executive Committee educational materials that address practitioner health issues and emphasize prevention, identification, diagnosis, and treatment. This Policy and any educational materials approved by the Medical Executive Committee will be made available to each practitioner. In addition, the Medical Executive Committee will periodically include information regarding illness and impairment recognition issues in its recommendations on CME activities.

F. Health Issues Identified During Credentialing Process

A health issue that is identified during the credentialing process will be addressed pursuant to the Credentials Policy. If a determination is made that the practitioner is qualified for appointment and privileges, but has a health issue that should be monitored or treated, the matter will be referred to the Practitioner Well-Being Committee for ongoing monitoring or oversight of treatment pursuant to this Policy.

G. Referral to Medical Executive Committee

Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy if necessary to address a situation that may compromise patient care and safety.

H. Fitness for Practice Evaluation

A fitness for practice evaluation is an individualized evaluation of a practitioner's current ability to exercise clinical privileges safely and competently and to perform the essential functions of appointment and clinical privileges. A fitness for practice evaluation may include assessment of infection risk, motor skills, cognitive ability and judgment, or other issues which may adversely affect a practitioner's ability to care for patients or to interact appropriately with other caregivers. If requested by the Health and Wellness Committee, this assessment may also include recommendations as to whether any accommodation is possible and reasonable. The practitioner will be responsible for the costs associated with the evaluation or any other required assessment of health status.

I. Confidentiality

To the extent possible, and consistent with quality patient care, health issues will be handled in a confidential manner. All parties should avoid speculation, conclusions, gossip, and any discussions of the matter with anyone other than those described in this Policy.

J. Peer Review Protection

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq. and Texas laws governing peer review, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

The committees or individuals charged with making reports, findings, or recommendations pursuant to this Policy will be considered to be acting on behalf of the Hospital and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act.

2. REPORTS OF POTENTIAL HEALTH ISSUES

A. Duty to Self-Report

Practitioners who have a health issue that could adversely affect an individual's ability to practice safely are required to report it to the Chief Medical Officer, the Chief of Staff, other Medical Staff Leaders, or the practitioner's department chairperson.

B. Absence from the Medical Staff for Health Reasons

The Chief Medical Officer or the Chief of Staff will report to the Leadership Council if a practitioner requests a formal leave of absence for health reasons pursuant to the Credentials Policy. Similarly, the Chief of Staff will report to the Leadership Council if a health issue causes a practitioner to be absent from the Medical Staff or unable to exercise his or her clinical privileges for health reasons, for longer than 30 days, even if a formal leave of absence is not in effect. The foregoing reporting obligations do not apply to maternity or paternity related absences.

C. Reports of Suspected Health Issues by Others

(1) Reports

Any practitioner or Hospital employee who is concerned that a practitioner has a health issue, or who is told by a patient, family member or other individual about a potential health concern, is encouraged to report the concern to the Chief Medical Officer, the Chief of Staff, other Medical Staff Leaders, the appropriate department chairperson, or the Medical Staff Services Office.

(2) Gathering Information

The individual who received the verbal report may request that the concern be submitted in writing, factually describing what led to the concern. The identity of the individual who raised the concern will be maintained in a confidential fashion. The individual who received the report may interview the reporting individual and any other individuals who may have relevant information.

(3) Review of Reports

If the individual receiving the report believes there is enough information to warrant a review, the matter will be referred to the Leadership Council or the Health and Wellness Committee.

(4) Feedback to Reporter

The individual who reported the concern may be informed if follow-up action is taken, but the specifics of any action will not be shared in light of the confidential nature of the process.

3. REPORTS OF POTENTIAL HEALTH ISSUES THAT COULD POSE AN IMMEDIATE THREAT

A. Immediate Potential Threat

If a report suggests that a practitioner may have a health issue that has the potential to pose an immediate threat to patients or others, two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) will immediately assess the practitioner. The practitioner will be required to immediately submit to a blood, hair, or urine test or to undergo some other physical, psychological or cognitive assessment to determine his or her ability to safely and competently practice. Failure to comply with a requirement to undergo an assessment described in this section will result in automatic relinquishment consistent with Article 6 of the Credentials Policy.

B. Agreement to Refrain from Exercising Privileges

If the Chief Medical Officer or the Chief of Staff believes the practitioner may have a health issue and that immediate action is necessary to protect patients, the practitioner may be asked to voluntarily refrain from exercising his or her clinical privileges while the matter is being reviewed. Such a request may be made to the practitioner either before or after any tests or evaluations have been completed.

(1) If the practitioner agrees to voluntarily refrain from exercising his or her privileges, the practitioner's patients will be assigned to another individual with appropriate clinical privileges. Affected patients will be informed that the practitioner is unable to proceed with their care due to illness.

(2) If the practitioner will not agree to voluntarily refrain from exercising his or her privileges, the Chief Medical Officer or the Chief of Staff will consider whether a precautionary suspension or some other measure is necessary and consistent with the Credentials Policy.

(3) The Chief Medical Officer or the Chief of Staff will refer the matter to the Leadership Council or the Health and Wellness Committee for review pursuant to this Policy.

4. INITIAL ASSESSMENT OF HEALTH STATUS

A. Initial Review

The Leadership Council will act expeditiously in reviewing concerns regarding a potential health issue. As part of its review, the Leadership Council may meet with the individual who initially reported the concern, as well as any other individual who may have relevant information. If the Leadership Council determines that the concerns are credible, it will refer the matter to the Health and Wellness Committee. The Health and Wellness Committee may consult with the relevant department chairperson or involve the chairperson in the review process.

B. Meeting with Practitioner

If the Health and Wellness Committee believes that a practitioner has or might have a health issue, it will meet with the practitioner. At this meeting, the practitioner will be told that there is a concern that his or her ability to practice safely and competently may be compromised by a health issue and advised of the nature of the concern. The practitioner will be reminded that retaliation against anyone who may have reported a concern is prohibited and may be requested to review and sign the "Confidentiality and Non-Retaliation Agreement" that is attached as Appendix A.

C. Assessment of Health Status

(1) The Health and Wellness Committee may recommend to the Medical Executive Committee, that the practitioner:

(a) undergo a fitness for practice evaluation;

(b) submit to an alcohol or drug screening test (blood, hair, or urine) (including where to obtain the screening) as desired;

(c) obtain a letter from a physician acceptable to the Health and Wellness Committee confirming the practitioner's ability to safely and competently practice and authorize the physician to meet with the Health and Wellness Committee; and/or

(d) be evaluated by a physician or organization appropriate to the circumstances, and have the results of any such evaluation provided to the Health and Wellness Committee.

(2) The Health and Wellness Committee will select the health care professional(s) or organization to perform any evaluation. The practitioner will be responsible for any costs associated with the evaluation.

(3) A form authorizing the Hospital to release information to the health care professional or organization conducting the evaluation is attached as Appendix B. A form authorizing the health care professional or organization conducting the evaluation to disclose information about the practitioner to the Health and Wellness Committee is attached as Appendix C. A Fitness for Practice Evaluation Form that may be used to document the results of an evaluation is attached as Appendix D.

(4) If the Health and Wellness Committee recommends that the practitioner enter a treatment program, it will assist the practitioner in identifying an appropriate program.

D. Interim Safeguards

While the assessment of health status described above is ongoing, the Health and Wellness Committee may recommend that the practitioner voluntarily take one or more of the following actions based on the nature and severity of the potential health issue:

(1) agree to specific conditions;

(2) refrain from exercising some or all privileges;

(3) take a leave of absence; or

(4) relinquish certain clinical privileges.

E. Referral to Medical Executive Committee for Non-Compliance

A matter may be referred to the Medical Executive Committee for its review and action pursuant to the Credentials Policy if the practitioner fails to:

(1) complete an agreed-upon evaluation, treatment, or rehabilitation program;

(2) comply with any condition or requirement of reinstatement or continued practice;

(3) cooperate in the monitoring of his or her practice;

(4) provide information requested by the Health and Wellness Committee, the Chief Medical Officer, the Chief of Staff, or the practitioner's department chairperson; or

(5) meet with the Health and Wellness Committee, the Chief of Staff, the Chief Medical Officer, or the practitioner's department chairperson upon request and with reasonable notice of the date, time, and place of the meeting as outlined in the Credentials Policy.

5. REINSTATEMENT/RESUMPTION OF PRACTICE

A. Written Request for Reinstatement/Removal of Conditions

A written request from a practitioner for reinstatement of clinical privileges after a leave of absence or an agreement to refrain from exercising some or all privileges, or for the removal of conditions on clinical privileges must be submitted to the Health and Wellness Committee. The Health and Wellness Committee may also require that the practitioner submit a completed copy of the Fitness for Practice Evaluation Form attached as Appendix D. Such a request will also be addressed pursuant to the procedure outlined in the Credentials Policy.

B. Second Opinion Evaluation

Before acting on a request for reinstatement or lifting conditions, the Health and Wellness Committee may request any additional information or documentation that it believes is necessary. This may include, as necessary, requiring the practitioner to undergo a fitness for practice evaluation conducted by a practitioner chosen by the Health and Wellness Committee in order to obtain a second opinion regarding the practitioner's ability to practice safely and competently.

C. Coverage

Before acting on a request for reinstatement or removing conditions, the Health and Wellness Committee may require the practitioner to identify another practitioner who is willing to assume responsibility for the care of his or her patients in the event the practitioner is unable or unavailable to fulfill patient care responsibilities.

D. Leaves of Absence

If a practitioner was granted a leave of absence, the final decision to reinstate the practitioner's clinical privileges must be approved pursuant to the process set forth in the Credentials Policy.

6. CONDITIONS OF CONTINUED PRACTICE

By way of example and not of limitation, the Health and Wellness Committee may require the practitioner to comply with one or more of the following as a condition of reinstatement or as a condition of resuming practice:

A. Ongoing Monitoring

The practitioner's exercise of clinical privileges may be monitored. The individual to act as monitor will be appointed by the Health and Wellness Committee or the department chairperson. The nature of the monitoring will be determined by the Health and Wellness Committee, in consultation with the department chairperson.

B. Periodic Reports of Health Status

If the practitioner is continuing to receive medical treatment or to participate in a substance abuse rehabilitation or after-care program, the Health and Wellness Committee may require the practitioner to sign a release authorizing the committee to obtain periodic reports from the treating physician or the substance abuse rehabilitation/after-care program. The nature and frequency of these reports will be determined on a case-by-case basis depending on the health issue.

C. Random Alcohol or Drug Screens

A practitioner who has undergone treatment for substance abuse may be required to submit to random alcohol or drug screening tests at the request of the Health and Wellness Committee.

7. DOCUMENTATION

A. Health File

Reports of potential health issues and documentation received or created pursuant to this Policy will be included in the practitioner's confidential health file. The practitioner's health file will be maintained by the Medical Staff Services Office as a separate file, and will not be included in the credentials file.

B. Information Reviewed at Reappointment

(1) The information reviewed by those involved in the reappointment process will not routinely include all documentation in a practitioner's health file. Instead, the process set forth in this subsection will be followed.

(2) When a reappointment application is received from an individual who has a health issue that is currently being reviewed or monitored by the Health and Wellness Committee, or that has been reviewed and resolved in the past reappointment cycle, the Medical Staff Services Office will contact the Health and Wellness Committee.

(3) The Health and Wellness Committee will prepare a confidential summary health report to the Credentials Committee. The summary health report will be included in the credentials file, and will be reviewed by the Credentials Committee only after the Credentials Committee has determined that the applicant is otherwise qualified for clinical privileges, as set forth in the Credentials Policy.

(4) The Health and Wellness Committee's summary health report will state that the Health and Wellness Committee is actively monitoring, or has monitored in the past reappointment cycle, a health issue involving the practitioner. The summary health report will also include a recommendation regarding the practitioner's ability to perform the duties of membership and safely exercise clinical privileges.

(5) If the Credentials Committee, Medical Executive Committee, or Board of Directors has any questions about the practitioner's ability to safely practice, the relevant entity will discuss the issue with a member of the Health and Wellness Committee. If the relevant entity still believes additional information is necessary, members of that entity may review the practitioner's confidential health file in the Medical Staff Services Office.

8. PEER REVIEW PROTECTION AND REPORTING

A. Required Reporting; Contact with Law Enforcement Authorities or Governmental Agencies

The Hospital will file reports required by applicable law. In addition, if at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the practitioner or others, the Hospital may contact law enforcement authorities or other governmental agencies.

B. Requests for Information Concerning Practitioner with a Health Issue

All reference requests or other requests for information concerning a practitioner with a health issue will be forwarded to the Chief Executive Officer for response.

Adopted by the Medical Executive Committee on _____.

Approved by the Board of Directors on _____.

APPENDIX A

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my health status and my ability to practice safely and competently at the Hospital. As part of the review process, the Health and Wellness Committee would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Health and Wellness Committee also wants to take appropriate steps to maintain the confidentiality of the information, as well as to facilitate a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. If requested by the Health and Wellness Committee, I will maintain all the information that I review in a **confidential** manner. Specifically, I will not disclose or discuss this information except to the Health and Wellness Committee or my legal counsel. I will not discuss this information with any other individual(s) without first obtaining the express written permission of the Hospital.

2. I understand that this information is being provided to me as part of the Medical Staff's Practitioner Health and Wellness Policy. In addition to discussing these matters with the Health and Wellness Committee, I understand that I may also prepare a written response and that this response will be maintained in my confidential credentials file.

3. I understand that the Hospital and Medical Staff have a responsibility to provide a safe, non-threatening workplace for members of the Medical Staff and the Allied Health Staff and for Hospital employees. Therefore, **I will not discuss this matter with any individual who may have expressed concerns about me or provided information in this matter. I will not engage in any retaliatory conduct with respect to these individuals**. This means that I will not approach, confront, ostracize, discriminate against, or otherwise mistreat any such individual who may have provided information that led to the concern being raised about me.

4. I understand that any retaliation by me would be a very serious matter and will not be tolerated. Any such conduct by me will be grounds for immediate referral to the Medical Executive Committee for its review and for action pursuant to the Credentials Policy.

By signing this Agreement, I understand that I am **not waiving** any of the rights or privileges afforded to me under the Medical Staff Bylaws or Credentials Policy.

_____ _____

Date

[Include the following signature line only if a Medical Staff Leader(s) personally reviews the content of this agreement with the practitioner]

Approved by:

_____ _____

Appropriate Medical Staff Leader Date

APPENDIX B

CONFIDENTIAL PEER REVIEW DOCUMENT

CONSENT FOR DISCLOSURE OF INFORMATION
AND
RELEASE FROM LIABILITY

I hereby authorize Medical Center Hospital ("Hospital") to provide *[the facility or physician performing fitness for practice evaluation] (the "Facility")* <u>OR</u> *[my treating physician]* all information, written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow *[the Facility]* <u>OR</u> *[my treating physician]* to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is protected by the Texas peer review law and that the Hospital, *[the Facility]* <u>OR</u> *[my treating physician]* and others involved in the peer review process are required to maintain the confidentiality of peer review information, pursuant to Texas law.

I release from any and all liability, and agree not to sue, the Hospital, any of its officers, directors, or employees, any member of the Hospital's Medical Staff or Allied Health Staff, or any authorized representative of the Hospital, for any matter arising out of the release of information by the Hospital to *[the Facility]* <u>OR</u> *[my treating physician]*.

I also release from any and all liability, and agree not to sue, *[the Facility or any of its officers, directors, employees, or authorized representatives]* <u>OR</u> *[my treating physician]*, for any matter arising out of *[the Facility's]* <u>OR</u> *[my treating physician's]* provision of an evaluation of my health status to the Hospital.

_____ _____

Date Signature of Practitioner

APPENDIX C

CONFIDENTIAL PEER REVIEW DOCUMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ *[facility performing health assessment and/or Practitioner overseeing treatment or treatment program] (the "Facility")* <u>OR</u> *[my treating physician]* to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice, to Medical Center Hospital (the "Hospital") and its Health and Wellness Committee or Medical Executive Committee. The information to be released includes, but is not limited to, answers to the questions on the attached Fitness for Practice Evaluation Form, along with the following:

1. my current health condition;

2. whether I am *[continuing to receive medical treatment and, if so, the treatment plan]* OR *[continuing to participate in a substance abuse rehabilitation program or in an after-care program, a description of that program and whether I am in compliance with all aspects of the program]*;

3. to what extent, if any, my behavior and clinical practice need to be monitored;

4. whether I am capable of resuming clinical practice and providing continuous, competent care to patients as requested; and

5. any conditions or restrictions that are necessary for me to safely exercise my clinical privileges.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for Medical Staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

I understand that the willingness of the Facility to conduct this assessment or provide treatment does not depend on my signing this Authorization.

OR

Since the Hospital is paying for the health assessment and/or treatment and has conditioned payment for the assessment and/or treatment on receipt of a report, the Facility may refuse to conduct the assessment or provide treatment if I refuse to sign this Authorization.

I understand that my health information is protected by federal law. I also understand that, by signing this Authorization, the information will be disclosed to the parties hereby authorized to receive it and could be disclosed to other parties. However, if the information in question relates to my treatment at a federally-assisted drug or alcohol treatment facility, then federal law prohibits it from being re-disclosed. Also, the information being disclosed is protected by the Texas peer review laws and *[the Facility] OR [my treating physician]*, the Hospital, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to those state laws.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that *[the Facility] OR [my treating physician]* has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when *[the Facility] OR [my treating physician]* has knowledge of it.

This Authorization expires when my Medical Staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, *[the Facility] OR [my treating physician]* may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date	Signature of Practitioner

APPENDIX D

CONFIDENTIAL PEER REVIEW DOCUMENT

FITNESS FOR PRACTICE EVALUATION FORM

Please respond to the following questions based upon your assessment of the current health status of _____ (the "Practitioner"). If additional space is required, please attach a separate sheet.

CURRENT HEALTH STATUS	YES	NO
1. Does the Practitioner have any medical, psychiatric, or emotional conditions that could affect his/her ability to exercise safely the clinical privileges set forth on the attached list and/or to perform the duties of Medical Staff appointment, including response to emergency call? If "yes," please provide the diagnosis and prognosis: _____ _____ _____	❑	❑
2. Is the Practitioner continuing to receive medical treatment for any conditions identified in Question 1? If "yes," please describe treatment plan: _____ _____ _____	❑	❑
3. Has the Practitioner been prescribed or is the Practitioner currently taking any medication that may affect either clinical judgment or motor skills? If "yes," please specify medications and any side effects: _____ _____ _____	❑	❑
4. Is the Practitioner currently under any limitations concerning activities or work load? If "yes," please specify: _____ _____ _____	❑	❑

SUBSTANCE ABUSE/AFTER-CARE PROGRAM *(If the Practitioner is participating in a substance abuse or after-care program, please also answer the questions in this section.)*	**YES**	**NO**
1. Please specifically describe the substance abuse rehabilitation or after-care program: _____ _____		
2. Is the Practitioner in compliance with all aspects of the program? If "no," please explain: _____ _____ _____	❑	❑
CONDITIONS, RESTRICTIONS, AND ACCOMMODATIONS	**YES**	**NO**
1. Does the Practitioner's behavior and/or clinical practice need to be monitored? If "yes," please describe: _____ _____ _____	❑	❑
2. In your opinion, are any conditions or restrictions on the Practitioner's clinical privileges or other accommodations necessary to permit the Practitioner to exercise privileges safely and/or to fulfill Medical Staff responsibilities appropriately? If "yes," please describe such restrictions, conditions, or accommodations: _____ _____	❑	❑
3. In your opinion, is the Practitioner capable of resuming clinical practice and providing continuous, competent care to patients as requested? If "no," please explain: _____ _____ _____	❑	❑

_____ _____

Date Signature of Evaluating Practitioner

MEDICAL CENTER HOSPITAL

MEDICAL STAFF
CODE OF CONDUCT POLICY

Revised Discussion Draft
February 18, 2019

Horty, Springer & Mattern, P.C.

TABLE OF CONTENTS

CODE OF CONDUCT POLICY

1. POLICY STATEMENT

A. Scope of Policy

(1) This Code of Conduct Policy (the "Policy") applies to all practitioners who provide patient care services at the Medical Center Hospital (the "Hospital"). For the purposes of this Policy, "practitioner" means a member of the Medical Staff or a member of the Allied Health Staff.

(2) Issues of employee conduct will be addressed in accordance with the Hospital's Human Resources policies. If the matter involves an employed practitioner, the Chief Executive Officer, in consultation with appropriate Medical Staff Leaders and legal counsel, will determine which policies apply.

(3) The Hospital's Human Resources Office may participate in the various processes set forth in this Policy including, but not limited to, receiving and following up on reported concerns and meeting with any individual who may have reported a concern.

B. Expectations for Professional Conduct

(1) At the Hospital, we are committed to conducting ourselves in an ethical, professional, respectful way. We understand that collegiality, collaboration, effective communication and teamwork are essential for the provision of safe and competent patient care and the creation of a culture of safety. As such, all practitioners are expected to treat others with respect, courtesy, and dignity, and to conduct themselves in a professional and cooperative manner.

(2) We are also committed to treating each patient as a unique individual and will strive to see and treat the person not just the illness which afflicts him or her. We understand the importance of working with our patients and we will strive to honor their values, facilitate their informed healthcare decision-making and maintain their confidentiality.

(3) Additionally, we are committed to providing safe, competent, appropriate care to our patients that is, to the extent possible, supported by reliable evidence.

(4) Most practitioners meet or exceed expectations for professionalism. However, it is necessary to address incidents of inappropriate, unprofessional conduct to:

(a) protect patients, employees, practitioners, and others and to facilitate the orderly operation of the Medical Staff and the Hospital;

(b) maintain a culture of safety;

(c) comply with the law and provide an environment free from harassment, sexual or otherwise; and

(d) assist practitioners to resolve conduct issues in a constructive, educational, and successful manner.

C. Policy Objectives and Guidelines

(1) This Policy outlines collegial efforts and progressive steps (e.g., meetings, counseling, warnings, and behavior modification education) which can be used by Medical Staff Leaders and Hospital Administration to address concerns about inappropriate conduct by practitioners, including behavior that undermines a culture of safety. The goal of these efforts is to arrive at voluntary, responsive actions by the practitioner to resolve the concerns that have been raised in a constructive manner.

(2) These efforts are encouraged, but are not mandatory, and will be within the discretion of the Leadership Council.

(3) All collegial efforts and progressive steps are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

(4) While collegial efforts are encouraged, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee or the elimination of any particular step in this Policy.

(5) In order to promote the objectives of this Policy, discussions and meetings with a practitioner whose conduct is at issue will not involve legal counsel (unless otherwise determined by Medical Staff Leaders or the Chief Executive Officer). Meetings will not be recorded.

(6) Medical Staff Leaders and Hospital Administration will educate practitioners regarding appropriate professional behavior and encourage the prompt reporting of concerns about inappropriate conduct.

(7) By way of example, practitioners are expected to:

(a) support and adhere to Medical Staff and Hospital policies and promote cooperation, teamwork and mutual respect among all members of the Healthcare team;

(b) communicate with others in a clear and respectful manner;

(c) use conflict resolution skills in managing disagreements;

(d) address concerns about clinical judgments with Medical Staff Leaders or appropriate Hospital employees directly and privately;

(e) address dissatisfaction with policies through appropriate grievance channels;

(f) accept appropriate feedback and demonstrate a change in behavior;

(g) complete medical records in a timely manner;

(h) respond to clinical obligations in a timely manner; and

(i) comply with all applicable laws and regulations.

(8) When a function in this Policy is to be carried out by a person or a committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified individuals.

(9) When a function in this Policy is to be carried out by a person and that person is the subject of a reported concern, the responsibility for fulfilling the function will automatically be delegated to another Medical Staff Leader or member of Hospital Administration.

(10) As a general rule, any actions taken pursuant to this Policy will be documented and the documentation will be maintained in the individual's confidential file. However, Medical Staff Leaders and Hospital Administration may use their discretion to decide not to document a matter that they determine is a relatively low-level incident that has been effectively addressed and resolved.

D. Definitions

The definitions set forth in the Credentials Policy apply to this Policy.

2. CONDUCT THAT IS INAPPROPRIATE, UNPROFESSIONAL, AND MAY UNDERMINE A CULTURE OF SAFETY

To aid in both the education of practitioners and the enforcement of this Policy, conduct that is inappropriate, unprofessional, and may undermine a culture of safety is defined as a single serious event or pattern of conduct involving, but is not limited to, any of the following:

(a) threatening or abusive language directed at patients, nurses, other Hospital employees, or other practitioners (e.g., belittling, berating, or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

(b) degrading or demeaning comments regarding patients, families, nurses, practitioners, Hospital employees, or the Hospital;

(c) using profanity or similarly offensive language while in the Hospital and/or while speaking with patients, families, nurses, other practitioners, or other Hospital employees;

(d) retaliating against any individual who may report a quality or behavior concern;

(e) inappropriate physical contact with another individual that is threatening or intimidating;

(f) intimidating or menacing other individuals, physically or otherwise, including behaviors such as slamming doors or throwing papers;

(g) inappropriate medical record entries, including entries that impugn the quality of care being provided by other practitioners, the Hospital or Hospital employees;

(h) inappropriately accessing, using, disclosing, or releasing of confidential patient information;

(i) recording (audio or video) a conversation or interaction that is not consented to by others present, including patients, other members of the care team, or other practitioners;

(j) refusing to abide by requirements delineated in the Medical Staff Bylaws, Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities); or

(k) engaging in any verbal or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

(i) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

(ii) Visual/Non-Verbal: derogatory posters, cartoons, e-mails, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

(iii) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

(iv) Other: making or threatening retaliation as a result of an individual's complaint regarding harassing conduct.

(l) "Harassment" includes unwelcome and offensive conduct related to an individual's race, color, religion, gender (including pregnancy), age, disability, national origin, citizenship, or other protected characteristic. As above, these forms of unlawful harassment may be verbal, non-visual/verbal, physical, or other in nature.

See Appendix A for the Joint Commission's Sentinel Event Alert on behaviors that undermine a culture of safety.

3. REPORTING CONCERNS ABOUT CONDUCT

A. Reports of Concerns about Conduct

Any Hospital employee or practitioner who observes, or is subjected to, inappropriate conduct by a practitioner is encouraged to report the incident in a timely manner. The concern can be reported by submitting a completed Professional Conduct Reporting Form, or similar document, to the Medical Staff Services Office or the Human Resources Office. A copy of the Professional Conduct Reporting Form is included as Appendix B. Any report received by the Human Resources Office that pertains to a practitioner will be referred, in a timely fashion, to the Medical Staff Services Office. This referral is not intended to limit the ability of the Human Resource Office from taking appropriate action with respect to an employed practitioner.

B. Follow-up to Reports of Concerns about Conduct

(1) The Chief Medical Officer or the Chief of Staff will follow up with the individual who made the initial report and will:

(a) inform the individual that the matter will be reviewed in accordance with this Policy and that further information may be needed;

(b) inform the individual that retaliation will not be tolerated and that any retaliation and other incidents of inappropriate conduct should be reported immediately; and

(c) advise the individual that due to confidentiality requirements, details regarding the outcome of the review cannot be provided.

A letter that can be used for this purpose is attached as Appendix C. As an alternative to sending a letter, the content of the letter may be used as talking points to discuss with the individual who reported the concern.

(2) The Chief Medical Officer and the Chief of Staff may interview witnesses or other individuals who were involved in the incident, as necessary, in order to fully understand the circumstances.

(3) The Chief Medical Officer and the Chief of Staff will report their findings to the department chairperson.

(4) Based on the information that has been received, the Chief of Staff and the department chairperson, in consultation with the Chief Medical Officer, may recommend any of the following:

(a) no further review or action is required;

(b) a face-to-face collegial intervention should be held with the involved practitioner; or

(c) further review or action is required by the Leadership Council.

(5) If there is documentation of an action taken, it will be maintained in the confidential quality file.

4. LEADERSHIP COUNCIL PROCEDURE

A. Initial Review

Members of the Leadership Council will review the summary and all supporting documentation and may meet with the individual who submitted the report and any witnesses to the incident. Members of the Leadership Council may also consult with or include the appropriate department chairperson.

B. Obtaining Input from the Practitioner

(1) If the Leadership Council determines that further review or action is required, it will notify the practitioner and will invite the practitioner to

participate in the review process and provide his or her perspective. A letter that can be used for this purpose is attached as Appendix D.

(2) The Leadership Council will take appropriate steps to maintain the confidentiality of the information, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital.

(3) The practitioner may be requested to review and sign the "Confidentiality and Non-Retaliation Agreement" that is attached as Appendix E.

(4) The practitioner will be reminded that any retaliation against the person reporting a concern would violate this Policy and lead to more formal review by the Medical Executive Committee, as appropriate.

(5) The practitioner may be requested to provide a written explanation of what occurred. The practitioner may also be invited to meet with the Leadership Council to discuss the circumstances further.

C. Leadership Council's Determination or Recommendation

(1) Based on all of the information received, the Leadership Council may:

(a) determine that no further review or action is required;

(b) send the practitioner a letter of guidance or letter of counsel about the conduct (a sample letter that can be used for this purpose is attached as Appendix F);

(c) engage in face-to-face collegial intervention, education, and coaching efforts with the practitioner, including, when appropriate, education about administrative channels that are available for registering concerns about quality or services;

(d) require that the practitioner attend a mandatory meeting with the Leadership Council, the Medical Executive Committee or another group of Medical Staff leaders to discuss the concerns about the practitioner's conduct;

(e) send a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing (a sample letter that can be used for this purpose is attached as Appendix F);

(f) require that the practitioner complete a behavior modification course, acceptable to the Leadership Council, at the practitioner's expense;

(g) develop a personal code of conduct (a sample letter that can be used for this purpose is attached as Appendix G); or

(h) refer the matter to the Medical Executive Committee.

(2) The Leadership Council will inform the relevant department chairperson of all determinations and recommendations.

(3) Consistent with the Medical Staff Bylaws and the Credentials Policy, none of the above recommendations or actions would entitle the practitioner to a hearing or appeal, nor are any reports required to be made to the Texas Medical Board, the Texas Board of Nursing, or the National Practitioner Data Bank. Appendix H provides additional guidance regarding these and other options for conduct and their related implementation issues.

D. Practitioner's Refusal to Attend Mandatory Meeting with Leadership Council

If the practitioner fails or refuses to attend a mandatory meeting with the Leadership Council or other specified individuals when requested to do so, the practitioner's clinical privileges may be automatically relinquished until the meeting occurs, pursuant to the provisions in the Medical Staff Bylaws and the Credentials Policy.

E. Letters Placed in Practitioner's Confidential Quality File

Copies of letters sent to the practitioner as part of the efforts to address the concerns about conduct will be placed in the practitioner's confidential quality file. The practitioner will be given an opportunity to respond in writing, and any response will also be kept in the practitioner's confidential quality file.

F. Additional Reports of Inappropriate Conduct

If additional reports of inappropriate conduct are received concerning a practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined above as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

G. Determination to Address Concerns through Practitioner Health Policy

If the Leadership Council believes that there may be a legitimate, underlying health issue, that is causing the concerns that have been raised, it may address the issue pursuant to the Practitioner Health Policy.

5. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

A. Referral to the Medical Executive Committee

At any point, the Leadership Council may refer a matter to the Medical Executive Committee for review and action. The Medical Executive Committee will be fully apprised of the actions taken previously by the Leadership Council to address the concerns. When it makes such a referral, the Leadership Council may also suggest a recommended course of action. The practitioner will be notified if the Leadership Council decides to refer a matter to the Medical Executive Committee.

B. Medical Executive Committee Review

The Medical Executive Committee will review the matter and take appropriate action in accordance with the Credentials Policy.

C. Recommendation That Entitles Practitioner to a Hearing

If, at any time, the recommendation of the Medical Executive Committee would entitle the practitioner to request a hearing pursuant to the Credentials Policy, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer for further action.

6. REVIEW OF REPORTS OF SEXUAL HARASSMENT. All reports of sexual harassment will be reviewed by the Leadership Council in the same manner as set forth above. However, because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

A. Personal Meeting and Letter of Admonition and Warning

Two or more members of the Leadership Council will personally meet with the practitioner to discuss the incident. If the practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting will be followed with a letter of admonition and warning to be placed in the practitioner's confidential quality file. This letter will also set forth any additional actions or conditions imposed on the practitioner's continued practice in the Hospital.

B. Referral to the Medical Executive Committee

The matter will be immediately referred to the Medical Executive Committee if:

(1) the practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct;

(2) there are confirmed reports of retaliation or further incidents of sexual harassment, after the practitioner agreed there would be no further improper conduct; or

(3) two or more reports of sexual harassment are received pertaining to the practitioner.

The Medical Executive Committee will conduct its review in accordance with the Credentials Policy. Such referral will not preclude other action under applicable Hospital Human Resources policies.

Adopted by the Medical Executive Committee:

_____ (Date) _____

Approved by the Board:

_____ (Date) _____

The Joint Commission

Sentinel Event Alert

July 09, 2008

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) "Any behavior which impairs the health care team's ability to function well creates risk," says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. "If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk."

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with "blowing the whistle" on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are "let off the hook" for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
   - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
   - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
   - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
   - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
   - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

References

1 Rosenstein, AH and O'Daniel, M: Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians. *American Journal of Nursing*, 2005, 105,1,54-64

2 Institute for Safe Medication Practices: Survey on workplace intimidation. 2003. Available online: https://ismp.org/Survey/surveyresults/Survey0311.asp (accessed April 14, 2008)

3 Morrissey J: Encyclopedia of errors; Growing database of medication errors allows hospitals to compare their track records with facilities nationwide in a nonpunitive setting. *Modern Healthcare*, March 24, 2003, 33(12):40,42

4 Gerardi, D: Effective strategies for addressing "disruptive" behavior: Moving from avoidance to engagement. Medical Group

Management Association Webcast, 2007; and, Gerardi, D: Creating Cultures of Engagement: Effective Strategies for Addressing Conflict and "Disruptive" Behavior. Arizona Hospital Association Annual Patient Safety Forum, 2008

5 Ransom, SB and Neff, KE, et al: Enhancing physician performance. American College of Physician Executives, Tampa, Fla., 2000, chapter 4, p.45-72

6 Rosenstein, A, et al: Disruptive physician behavior contributes to nursing shortage: Study links bad behavior by doctors to nurses leaving the profession. *Physician Executive*, November/December 2002, 28(6):8-11. Available online: http://findarticles.com/p/articles/mi_m0843/is_6_28/ai_94590407 (accessed April 14, 2008)

7 Gerardi, D: The Emerging Culture of Health Care: Improving End-of-Life Care through Collaboration and Conflict Engagement Among Health Care Professionals. *Ohio State Journal on Dispute Resolution*, 2007, 23(1):105-142

8 Weber, DO: Poll results: Doctors' disruptive behavior disturbs physician leaders. *Physician Executive*, September/October 2004, 30(5):6-14

9 Leape, LL and Fromson, JA: Problem doctors: Is there a system-level solution? *Annals of Internal Medicine*, 2006, 144:107-155

10 Porto, G and Lauve, R: Disruptive clinical behavior: A persistent threat to patient safety. *Patient Safety and Quality Healthcare*, July/August 2006. Available online: http://www.psqh.com/julaug06/disruptive.html (accessed April 14, 2008)

11 Hickson, GB: A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. *Academic Medicine*, November 2007, 82(11):1040-1048

12 Rosenstein, AH: Nurse-physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing*, 2002, 102(6):26-34

13 Hickson GB, et al: Patient complaints and malpractice risk. *Journal of the American Medical Association*, 2002, 287:2951-7

14 Hickson GB, et al; Patient complaints and malpractice risk in a regional healthcare center. *Southern Medical Journal*, August 2007, 100(8):791-6

15 Stelfox HT, Ghandi TK, Orav J, Gustafson ML: The relation of patient satisfaction with complaints against physicians, risk management episodes, and malpractice lawsuits. *American Journal of Medicine*, 2005, 118(10):1126-33

16 Gerardi, D: The culture of health care: How professional and organizational cultures impact conflict management. *Georgia Law Review*, 2005, 21(4):857-890

17 Keogh, T and Martin, W: Managing unmanageable physicians. *Physician Executive*, September/October 2004, 18-22

18 ECRI Institute: Disruptive practitioner behavior report, June 2006. Available for purchase online: http://www.ecri.org/Press/Pages/Free_Report_Behavior.aspx (accessed April 14, 2008)

19 Kahn, MW: Etiquette-based medicine. *New England Journal of Medicine*, May 8, 2008, 358; 19:1988-1989

20 Marshall, P and Robson, R: Preventing and managing conflict: Vital pieces in the patient safety puzzle. *Healthcare Quarterly*, October 2005, 8:39-44

* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

-Top-

APPENDIX B

PROFESSIONAL CONDUCT REPORTING FORM

PRIVILEGED AND CONFIDENTIAL
PURSUANT TO TEXAS PEER REVIEW STATUTE

For Employees, Medical Staff Members, and Allied Health Staff Members

Instructions: This form may be used to report an incident involving conduct that you are concerned is inappropriate, unprofessional or that otherwise jeopardizes our culture of safety. Attach additional sheets if necessary. Please provide the following information as **specifically** and as **objectively** as possible and submit the completed form to the Medical Staff Services Office or to Human Resources.

DATE, TIME, AND LOCATION OF INCIDENT		
Date of incident:	Time of incident:	a.m. p.m.
Location of incident:		
Range of dates if your concerns are not limited to one particular event: _____/_____/20_____ to _____/_____/20_____		

PRACTITIONER INFORMATION			
Name of practitioner about whose conduct is at issue: _____			
PATIENT INFORMATION			
Was a patient involved in the event?	**Yes** ❑	**No** ❑	Medical Record # _____
Patient's Last Name: _____			Patient's First Name: _____

DESCRIPTION OF INCIDENT
Describe what happened as specifically and objectively as possible:

OTHER INDIVIDUALS INVOLVED/WITNESSES
Name(s) of other practitioner(s) or Hospital employee(s) who witnessed this event: _____ _____ _____ _____
Name(s) of any other person(s) who witnessed this event (e.g., visitors; family members): _____ _____ _____ _____

EFFECT OF CONDUCT
How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? _____ _____ _____

RESPONSE TO CONDUCT	Yes	No
Are you aware of any attempts that were made to address this behavior with the practitioner when it occurred?	❑	❑
If yes, please explain and indicate by whom: _____ _____ _____		

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

APPENDIX C

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS CONCERN ABOUT CONDUCT*

PRIVILEGED AND CONFIDENTIAL
PURSUANT TO TEXAS PEER REVIEW STATUTE

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at Medical Center Hospital.

Your concern will be reviewed in accordance with the Medical Staff Code of Conduct Policy and we may need to contact you for additional information. Because your report may involve confidential matters under Texas law, we may not be able to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

As part of our culture of safety and quality care, retaliation against any individual who reports a concern is not tolerated. Therefore, if you believe that you have been subjected to any retaliation as a result of raising your concern, please report that immediately to me or the Chief of Staff.

Once again, thank you for bringing your concern to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

Chief Medical Officer

*** As an alternative to sending a letter, the content of this letter may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.**

APPENDIX D

COVER LETTER TO PRACTITIONER PROVIDING INFORMATION ABOUT REPORTED CONCERNS

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Information Related to Behavioral Concerns

Dear _____:

As you know from our conversation, concerns have been raised about your professional conduct at Medical Center Hospital (the "Hospital"). As part of the review process, the Leadership Council would like you to be fully aware of the relevant issues and have an opportunity to respond to them. Accordingly, enclosed is information that summarizes the concerns that have been raised.

The Leadership Council would appreciate your perspective on these issues and any other information that you believe would be helpful to our review. Please provide your written response to me by _____ ***[date]***, so that it may be considered by the Leadership Council at its next meeting. *Optional: Specifically, please respond to the following questions: _____ [list specific questions, if any]*.

Your input into these issues is essential as we attempt to achieve our goal of having a timely, fair, and constructive review process. ***Please recognize that if you do not respond to this request for written input prior to the date set forth above, a process will commence that could result in the automatic relinquishment of your clinical privileges until the information is provided.*** We trust this will not occur and look forward to your participation in the review.

The Leadership Council would also like the opportunity to meet with you to discuss this matter further. Please plan on being in attendance at the Leadership Council meeting on _____ __, 20__ at _____ a.m./p.m. in the _____ Room. If for some reason you are unable to attend this meeting, please let us know by no later than _____ __, 20__ at _____ a.m./p.m.

Finally, the Leadership Council has an obligation to ensure that all peer review information such as this is maintained in a confidential manner. The Leadership Council also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, as a courtesy, we wanted to remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Code of Conduct Policy:

(1) Like the Leadership Council, you must maintain all information related to this review in a strictly confidential manner, as required by Texas law. Specifically, you may not disclose this information to, or discuss it with, anyone ***except*** the following individuals without first obtaining the written permission of the Hospital: (i) the Leadership Council, or (ii) any legal counsel who may be advising you.

(2) You may not retaliate against anyone who you believe may have raised a concern about you, provided information regarding this matter, or otherwise been involved in the review process. ***This means that you may not, under any circumstances, discuss this matter with any such individual***, because even well-intentioned conversations can be perceived as intimidating. ***Nor may you engage in any other retaliatory or abusive conduct*** such as confronting, ostracizing, or discriminating against such individual.

Please recognize that any retaliation by you, as described in the previous paragraph, is a very serious matter and will be grounds for referral for an independent review under the Medical Staff Code of Conduct Policy.

Thank you for your attention to this matter.

Sincerely,

Chief of Staff

Chief Medical Officer

cc: Confidential File

APPENDIX E

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

PRIVILEGED AND CONFIDENTIAL
PURSUANT TO TEXAS PEER REVIEW STATUTE

Concerns have been raised about my professional conduct at the Hospital. As part of the review process, the Leadership Council would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Leadership Council also wants to take appropriate steps to maintain the confidentiality of the information, as well as to facilitate a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all the information that I review in a **confidential** manner. Specifically, I will not disclose or discuss this information except to the Leadership Council or my legal counsel. I will not discuss this information with any other individual(s) without first obtaining the express written permission of the Hospital.

2. I understand that this information is being provided to me as part of the Medical Staff's Code of Conduct Policy. In addition to discussing these matters with the Leadership Council, I understand that I may also prepare a written response and that this response will be maintained in my confidential quality file.

3. I understand that the Hospital and Medical Staff have a responsibility to provide a safe, non-threatening workplace for members of the Medical Staff and the Allied Health Staff and for employees. Therefore, **I will not discuss this matter with any individual who may have expressed concerns about me or provided information in this matter. I will not engage in any retaliatory conduct with respect to these individuals**. This means that I will not approach, confront, ostracize, discriminate against, or otherwise mistreat any such individual who may have provided information that led to the concern being raised about me.

4. I understand that any retaliation by me would be a very serious matter and will not be tolerated. Any such conduct by me will be grounds for immediate referral to the Medical Executive Committee for its review and for action pursuant to the Credentials Policy.

By signing this Agreement, I understand that I am **not waiving** any of the rights or privileges afforded to me under the Medical Staff Bylaws or Credentials Policy.

I also understand that I am permitted to raise any question or concern that I may have regarding the care being provided by a nurse or other Hospital employee, another member of the Medical Staff or Allied Health Staff, or the Hospital itself. **However, I understand that I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.** These mechanisms are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff Leaders and Hospital Administration to fully review the matter and take action to address the issue, as may be necessary.

_____ _____

Date

[Include the following signature line only if a Medical Staff Leader(s) personally reviews the content of this agreement with the practitioner]

Approved by:

_____ _____

Appropriate Medical Staff Leader Date

APPENDIX F

FOLLOW-UP LETTER TO COLLEGIAL INTERVENTION

CONFIDENTIAL PEER REVIEW DOCUMENT

[Date]

[Name of Practitioner]
[Address]

Re: Follow-Up to Meeting

Dear _____:

Thank you for meeting today with the Leadership Council. These meetings can be difficult for all of us and we very much appreciate your cooperation and your professionalism.

The purpose of this letter is to briefly follow up on our discussion regarding *[list issues discussed, e.g., "concerns that have been raised regarding your interactions with other Medical Staff members and Hospital employees" or "your pattern of failing to follow the protocols relating to diabetes care"]*.

*[**Optional paragraph where more supportive approach is appropriate:** We first want to reiterate that we value your significant contributions to the Hospital. Our meeting was intended to be helpful and constructive. Its purpose was to collegially discuss our concerns, and have you work with us to modify your conduct/practice so that the issues can be successfully resolved.]*

*[**Optional paragraph where firmer approach is necessary:** As you know, the purpose of our meeting was to inform you of the Medical Staff leadership's serious concerns regarding _____. The Medical Staff leadership believes that these issues, which have developed into a pattern over time, have now escalated to a more serious level.]*

Insert paragraphs regarding the following, as applicable.

- *Summarize discussion of issues;*
- *Note the practitioner's history of similar incidents, if applicable;*
- *Citation/quote of relevant bylaws or policy provisions, if applicable;*
- *Reiterate any action/changes in practice that may have been agreed to by practitioner during the meeting;*

- *Outline the consequences of failing to meet expectations (appropriate to include if there is a pattern or concerns; required if the matter under review involves sexual harassment); and*
- *Reiterate how future conduct/practice will be monitored, if applicable.*

*[**Optional paragraph to address retaliation:** As we hope you understand, it is our responsibility to provide a safe, non-threatening workplace for Hospital employees and other Medical Staff members. Therefore, please avoid any action that could be perceived as retaliatory or threatening to anyone who you believe may have been involved in this matter. Specifically, it is essential that you not attempt to discuss this matter with any individual who you believe may have reported a concern, provided information, or participated in the review. Regardless of your intent, such conversations could be viewed as retaliatory by such individuals. Accordingly, any further discussions or additional information that you may have about the matters we discussed during our meeting must be directed to the Medical Staff leadership.]*

*[**Optional paragraph to counsel practitioner to improve behavior:** Teamwork and open communications are essential to quality care. Accordingly, as a leader of the health care team, you must set the example by striving to maintain a professional demeanor at all times. This is not simply a question of avoiding hurt feelings. Instead, professionalism and respectful interactions are necessary to promote quality care. The Joint Commission, the courts, and articles throughout the medical literature all recognize that the best hospital care is provided by teams that work together in a collegial manner. The expectations for conduct in the Hospital are reflected in the Medical Staff Code of Conduct Policy, a copy of which is enclosed for your convenience.]*

We hope this letter is helpful to you. No response from you is required at this time.

Thank you again for your cooperation. Please let me know if we can provide any further assistance to you in addressing this matter.

Sincerely,

_____ _____

Chief of Staff Chief Medical Officer

cc: Confidential File

APPENDIX G

SAMPLE PERSONAL CODE OF CONDUCT LETTER

CONFIDENTIAL & PRIVILEGED
PEER REVIEW

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Personal Code of Conduct

Dear Dr. [Name]:

As you are aware, there have been several incidents over the past several months in which you have engaged in inappropriate, unprofessional behavior at Medical Center Hospital. Specifically, you recently [describe incidents]. These incidents were reviewed by the Leadership Council which determined that your conduct violated the Medical Staff Code of Conduct Policy.

The Leadership Committee is concerned that the nature and the number of issues that have been raised about you conduct support that your practice could have an adverse effect on patient care and patient safety. In order to help you improve and to foster our culture of safety, the Leadership Council developed the following Personal Code of Conduct ("PCC"):

1. You agree to treat others at the Hospital, including nurses, staff, members of the Medical Staff and Allied Health Staff, Medical Staff Services personnel, and members of Administration, with respect, dignity and courtesy.

2. You agree not to yell or engage in other angry or hostile behavior at the Hospital.

3. You agree not to demean, belittle or berate others at the Hospital, including members of the Medical Staff and Allied Health Staff, Medical Staff Services personnel, and members of Administration.

4. You agree to refrain from non-constructive criticism which intimidates, undermines confidence, or implies stupidity or incompetence.

5. You agree to address dissatisfaction with policies through appropriate administrative channels.

After you have had an opportunity to review this letter, please let us know if you have any additional questions or need any further clarifications regarding the elements of the PCC. Your agreement to voluntarily abide by and participate in this PCC is not considered a restriction of your privileges. Furthermore, the implementation of a PCC is not an adverse professional review action and will not be reported to the National Practitioner Data Bank or to the Texas Board of Medicine *or Texas Board of Nursing*.

To demonstrate your commitment to work with us and your willingness to participate in the PCC, please sign and return a copy of this letter within three business days to one of us. If you decide not to participate in the PCC as outlined in this letter, the Leadership Council will refer this matter to the Medical Executive Committee for its review and action pursuant to the Credentials Policy, which may include the commencement of an investigation.

Consistent with the Medical Staff Code of Conduct Policy, a copy of this letter will be placed in your confidential file. You may write a response if you wish and your response, along with this letter, will be maintained in your confidential file. If you have any questions or wish to discuss this matter further, please feel free to contact one of us.

Sincerely,

Chief of Staff Chief Medical Officer

cc: Confidential File

I understand and agree to abide by the Personal Code of Conduct outlined in this letter. I further understand that if I fail to abide by the Personal Code of Conduct, the matter will be referred to the Medical Executive Committee consistent with the Credentials Policy.

_____ _____

Date [Name]

APPENDIX H

OPTIONS FOR CONDUCT AND IMPLEMENTATION ISSUES CHECKLIST

PRIVILEGED AND CONFIDENTIAL PURSUANT TO TEXAS PEER REVIEW STATUTE

OPTION	*IMPLEMENTATION ISSUES*
Meeting with Leadership Council, Medical Executive Committee, or Designated Group	***Who Should Attend Meeting with Practitioner?*** ❑ Leadership Council ❑ Medical Executive Committee ❑ Other designated group (may include Board Chairperson or other Board members), including: _____ ***May Practitioner Bring Representative (Not Legal Counsel) to the Meeting?*** ❑ Yes ❑ No Is pre-meeting to plan intervention necessary? ❑ Yes ❑ No If yes, where and when: _____ _____ ***Scheduling Meeting with Practitioner*** ❑ Date of meeting: _____ ❑ Time of meeting: _____ ❑ Location of meeting: _____ ***Notice of Meeting*** ❑ Notice of meeting sent ❑ Letter to practitioner states that meeting is part of the peer review process, therefore ❑ No attorneys allowed ❑ No audio or video recording ❑ Should notice state that failure to appear will result in automatic relinquishment of clinical privileges? ❑ Yes ❑ No ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Documentation*** If not already provided, will documentation of reports regarding concern be shared before meeting? ❑ Yes ❑ No If yes, has practitioner signed an agreement not to retaliate? ❑ Yes ❑ No ***Follow-Up*** Monitor for additional incidents ❑ Through reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at designated intervals): _____

OPTION	IMPLEMENTATION ISSUES
Letters of Warning or Reprimand	***Content of Letter of Warning or Reprimand*** ❑ Practitioner informed that he/she may provide response for inclusion in file ❑ Copy included in practitioner's confidential quality file ***Review/Signature*** Letter reviewed and approved by: ❑ Chief of Staff ❑ Leadership Council ❑ Medical Executive Committee ❑ Other: _____ Who signs/sends the letter? ❑ Chief of Staff ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Requirement*** ❑ Acceptable programs include: _____ _____ Chief of Staff approval required before practitioner enrolls: ❑ Program approved: _____ ❑ Date of approval: _____ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Leadership Council or Medical Executive Committee to provide information to the behavior modification course (if necessary) and course to provide report to Leadership Council or Medical Executive Committee _____ _____ Practitioner must submit ❑ Documentation of successful completion signed by course director ❑ Other: _____ _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused review (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)***	***Content of Personal Code of Conduct*** ❑ Practitioner informed that he/she may provide response for inclusion in confidential quality file. ❑ Copy of personal code of conduct included in practitioner's confidential quality file. ❑ Is practitioner required to agree in writing to abide by the personal code of conduct? ❑ Yes ❑ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ❑ Does the personal code of conduct describe consequences of a confirmed violation? ❑ Yes ❑ No ***Consequence of first violation (e.g., final warning):*** _____ ***Consequence of second violation (e.g., short-term suspension):*** ***Consequence of third violation (e.g., recommendation for disciplinary action):*** ***Review/Signature*** Letter outlining the personal code of conduct reviewed and approved by: ❑ Chief of Staff ❑ Leadership Council ❑ Medical Executive Committee ❑ Other Individuals: _____ Letter outlining the personal code of conduct signed: ❑ Chief of Staff ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Short-Term Suspension That Does Not Trigger a Hearing or Reporting (e.g., suspension of clinical privileges for 30 days or less) ***(for use by Medical Executive Committee only)***	***Date/Duration of Suspension*** ❑ Suspension begins on: _____ Date ❑ Suspension ends on: _____ Date ***Patient Care Arrangements*** ❑ If suspension begins immediately, what arrangements are made for patients currently admitted? _____ ❑ What arrangements are made for on-call responsibilities? _____ ***Contents of Notice of Suspension*** ❑ Practitioner informed that he/she may provide response for inclusion in confidential quality file. ❑ Copy of notice included in practitioner's confidential quality file. ***Review/Signature*** Notice of suspension reviewed and approved by: ❑ Chief of Staff ❑ Medical Executive Committee ❑ Other Individuals: _____ Notice of suspension signed by: ❑ Chief of Staff ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused review (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	*IMPLEMENTATION ISSUES*
"Other" ***Examples:*** • ***Chaperone;*** • ***CME;*** • ***Grand rounds on teamwork or creating culture of safety;*** • ***Letter of apology (review and approval of letter are imperative before it is sent).***	

ECTOR COUNTY HOSPITAL DISTRICT
Investment Portfolio
Charles Brown, Hilltop Securities Independent Network Inc.
March 31, 2019

All prices and values reflected in this report are captured from the Hilltop Securities statements dated 03/29/2019.

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

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2019

Yield Summary

SECTOR	PAR VALUE	Weighted Avg Yield	Market Value	Gain/Loss
US AGENCY	$ 10,000,000.00	1.73%	$ 9,880,700.00	$ (119,300.00)
SHORT-TERM INVESTMENTS	$ 47,444,267.49	2.31%	$ 47,425,159.80	$ (19,107.69)
TOTAL	**$ 57,444,267.49**	**2.210%**	**$ 57,305,859.80**	**$ (138,407.69)**

	3/29/2019	3/29/2018
13 WEEK TREASURY BILL	2.33%	1.67%
5 YEAR TREASURY BILL	2.24%	2.56%
10 YEAR TREASURY NOTE	2.41%	2.74%
30 YEAR TREASURY NOTE	2.82%	2.97%

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2019

Maturity Distribution **1-5 Years**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	YIELD (%)	PAR VALUE	BOOK VALUE	MARKET VALUE	ANNUAL INCOME	GAIN (LOSS)
3136G35L0	DP4-FNMA	6/30/2021	1.730%	1.730%	$ 2,000,000.00	$ 2,000,000.00	$ 1,976,140.00	$ 34,600.00	$ (23,860.00)
3136G3SL0	FND-FNMA	6/30/2021	1.730%	1.730%	$ 8,000,000.00	$ 8,000,000.00	$ 7,904,560.00	$ 138,400.00	$ (95,440.00)
					$10,000,000.00	$ 10,000,000.00	$ 9,880,700.00	$ 173,000.00	$ (119,300.00)

Weighted Avg Life	**2.24**
Weighted Avg Yield	**1.73%**

$10,000,000.00	**$ 10,000,000.00**	**$ 9,880,700.00**	**$ 173,000.00**	**$ (119,300.00)**

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2019

Safekeeping

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Dispro 4 (339788818)					
3136G3SL0	DP4-FNMA	6/30/2021	1.73%	$ 2,000,000.00	$ 1,976,140.00
CR10226T3	DP4-CDARS	4/11/2019	2.38%	$ 1,000,000.00	$ 1,000,000.00
CR02326T1	DP4-CDARS	8/22/2019	2.52%	$ 1,500,000.00	$ 1,499,700.00
CR02226T4	DP4-CDARS	8/15/2019	2.52%	$ 238,000.00	$ 237,309.80
Money Market			1.51%	$ 525,116.47	$ 525,116.47
TOTAL				**$ 5,263,116.47**	**$ 5,238,266.27**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Funded Depreciation (339814498)					
3136G3SL0	FND Dep-FNMA	6/30/2021	1.73%	$ 8,000,000.00	$ 7,904,560.00
CR10226T3	FND-Dep CDARS	4/11/2019	2.41%	$ 8,000,000.00	$ 8,000,000.00
CR03226T1	FND-CDARS	8/15/2019	2.52%	$ 8,000,000.00	$ 7,998,008.00
CR02226T4	FND-CDARS	8/15/2019	2.52%	$ 10,000,000.00	$ 10,000,000.00
Money Market	FND-Dep Dreyfus		1.51%	$ 6,830,438.51	$ 6,830,438.51
TOTAL				**$ 40,830,438.51**	**$ 40,733,006.51**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Funded Workers Comp (339818296)					
CR02326T1	FWC-CDARS	8/22/2019	2.52%	$ 1,000,000.00	$ 999,800.00
CR0226T4	FWC-CDARS	8/15/2019	2.52%	$ 1,221,000.00	$ 1,217,489.10
Money Market	FWC-Dreyfus		1.51%	$ 12,529.78	$ 12,529.78
TOTAL				**$ 2,233,529.78**	**$ 2,229,818.88**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Professional Liability (339767185)					
CR10226T3	Prof Liab-CDARS	4/11/2019	2.41%	$ 2,000,000.00	$ 2,000,000.00
CR02226T4	Prof Liab-CDARS	8/15/2019	2.52%	$ 1,000,000.00	$ 997,100.00
Money Market	Prof Liab-Dreyfus		1.51%	$ 5,757.00	$ 5,757.00
TOTAL				**$ 3,005,757.00**	**$ 3,002,857.00**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Designated Funds (339801057)					
CR02226T4	DES-CDARS	8/15/2019	2.52%	$ 1,148,000.00	$ 1,144,670.80
CR02326T1	DES-CDARS	8/22/2019	2.52%	$ 2,000,000.00	$ 1,999,600.00
Money Market	DES-Dreyfus		1.51%	$ 24,589.91	$ 24,589.91
TOTAL				**$ 3,172,589.91**	**$ 3,168,860.71**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location General Operating (339809022)					
CR02326T1	GEN Op-CDARS	8/22/2019	2.52%	$ 1,000,000.00	$ 999,800.00
CR02226T4	GEN Op-CDARS	8/15/2019	2.52%	$ 1,926,000.00	$ 1,920,414.61
Money Market	GEN Op-Dreyfus		1.51%	$ 12,835.82	$ 12,835.82
TOTAL				**$ 2,938,835.82**	**$ 2,933,050.43**

GRAND TOTAL	**$ 57,444,267.49**	**$ 57,305,859.80**

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2019

Short Term Invesments

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	YIELD (%)	ORIGINAL FACE	PAR VALUE	BOOK VALUE	MARKET VALUE	ANNUAL INCOME	GAIN (LOSS)
CR10226T3	DP4-CDARS	4/11/2019	2.38%	2.38%	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 23,800.00	$0.00
CR10226T3	Prof Liab - CDARS	4/11/2019	2.41%	2.41%	$ 2,000,000.00	$ 2,000,000.00	$ 2,000,000.00	$ 2,000,000.00	$ 48,200.00	$0.00
CR10226T3	FND Dep-CDARS	4/11/2019	2.41%	2.41%	$ 8,000,000.00	$ 8,000,000.00	$ 8,000,000.00	$ 8,000,000.00	$ 192,800.00	$0.00
CR02226T4	FND Dep-CDARS	8/15/2019	2.52%	2.52%	$ 10,000,000.00	$ 10,000,000.00	$ 10,000,000.00	$ 10,000,000.00	$ 252,000.00	$0.00
CR02226T4	DP4-CDARS	8/15/2019	2.52%	2.52%	$ 238,000.00	$ 238,000.00	$ 238,000.00	$ 237,309.80	$ 5,997.60	($690.20)
CR02226T4	FWC-CDARS	8/15/2019	2.52%	2.52%	$ 1,221,000.00	$ 1,221,000.00	$ 1,221,000.00	$ 1,217,489.10	$ 30,769.20	($3,510.90)
CR02226T4	Prof Liab - CDARS	8/15/2019	2.52%	2.52%	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 997,100.00	$ 25,200.00	($2,900.00)
CR02226T4	DES-CDARS	8/15/2019	2.52%	2.52%	$ 1,148,000.00	$ 1,148,000.00	$ 1,148,000.00	$ 1,144,670.80	$ 28,929.60	($3,329.20)
CR02226T4	GEN Op-CDARS	8/15/2019	2.52%	2.52%	$ 1,926,000.00	$ 1,926,000.00	$ 1,926,000.00	$ 1,920,414.61	$ 48,535.20	($5,585.39)
CR02326T1	FND Dep-CDARS	8/15/2019	2.52%	2.52%	$ 8,000,000.00	$ 8,000,000.00	$ 8,000,000.00	$ 7,998,008.00	$ 201,600.00	($1,992.00)
CR02326T1	GEN Op-CDARS	8/15/2019	2.52%	2.52%	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 999,800.00	$ 25,200.00	($200.00)
CR02326T1	FWC-CDARS	8/22/2019	2.52%	2.52%	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 999,800.00	$ 25,200.00	($200.00)
CR02326T1	DES-CDARS	8/22/2019	2.52%	2.52%	$ 2,000,000.00	$ 2,000,000.00	$ 2,000,000.00	$ 1,999,600.00	$ 50,400.00	($400.00)
CR02326T1	DP4-CDARS	8/22/2019	2.52%	2.52%	$ 1,500,000.00	$ 1,500,000.00	$ 1,500,000.00	$ 1,499,700.00	$ 37,800.00	($300.00)
Weighted Avg Life		0.282			**$ 40,033,000.00**	**$ 40,033,000.00**	**$ 40,033,000.00**	**$ 40,013,892.31**	**$ 996,431.60**	**($19,107.69)**
Weighted Avg Yield		2.460%								

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	YIELD (%)	ORIGINAL FACE	PAR VALUE	BOOK VALUE	MARKET VALUE	ANNUAL INCOME
Money Market	DP4-Dreyfus		1.51%	1.51%	$ 525,116.47	$ 525,116.47	$ 525,116.47	$ 525,116.47	$ 7,929.26
Money Market	FND-Dep Dreyfus		1.51%	1.51%	$ 6,830,438.51	$ 6,830,438.51	$ 6,830,438.51	$ 6,830,438.51	$ 103,139.62
Money Market	FWC-Dreyfus		1.51%	1.51%	$ 12,529.78	$ 12,529.78	$ 12,529.78	$ 12,529.78	$ 189.20
Money Market	Prof Liab-Dreyfus		1.51%	1.51%	$ 5,757.00	$ 5,757.00	$ 5,757.00	$ 5,757.00	$ 86.93
Money Market	DES-Dreyfus		1.51%	1.51%	$ 24,589.91	$ 24,589.91	$ 24,589.91	$ 24,589.91	$ 371.31
Money Market	GEN-Op Dreyfus		1.51%	1.51%	$ 12,835.82	$ 12,835.82	$ 12,835.82	$ 12,835.82	$ 193.82
Weighted Avg Life		0.00			**$ 7,411,267.49**	**$ 7,411,267.49**	**7,411,267.49**	**7,411,267.49**	**$111,910.14**
Weighted Avg Yield		1.51%							

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2019

Outstanding Bonded Debt

2010-B Build America Bonds

Amount	MAT/Call		
$1,753,000	9/15/2019		
$1,820,000	9/15/2020		
$10,333,000	9/15/2025	CALL	9/15/2020
$29,058,000	9/15/2035	CALL	9/15/2020

Medical Center Hospital
A Member of Medical Center Health System

MEMORANDUM

TO: Ricky D. Napper, President and Chief Executive Officer

FROM: Robert Abernethy, Chief Financial Officer

RE: **Quarterly Investment Report – Second Quarter 2019**

DATE: May 7, 2019

The Investment Report of Ector County Hospital District for the second quarter ended March 31, 2019 will be presented at the Finance Committee meeting May 7, 2019. This report was prepared in order to provide the Hospital President and Chief Financial Officer and Board of Directors information as required under the Public Funds Investment Act. Investments purchased during the second quarter of fiscal 2019 met the requirements of the Investment Policy and the Public Funds Investment Act.

To the best of my knowledge, as of March 30, 2019 the investment portfolio is in compliance with the Public Funds Investment Act and with the District's Investment Policy.

Robert Abernethy
Investment Officer

Medical Center Health System
Your One Source for Health

DATE: April 30, 2019

TO: Board of Directors
Ector County Hospital District

FROM: Robert Abernethy
Senior Vice President / Chief Financial Officer

Subject: Financial Report for the month ended March 31, 2019

Attached are the Financial Statements for the month ended March 31, 2019 and a high-level summary of the month's activity.

As previously discussed, the Medicaid Supplemental funding that that has been paid to ProCare for Uncompensated Care (UC) ceased being paid by Permian Basin Clinical Servicing Partnership in October 2018. For the month of March, $958,470 of funding was not received and contributed to the significant loss that was incurred in March. Additionally, we have recognized $4,375,000 as a receivable from the partnership which has not been paid, even though ECHD had made the Inter-Governmental Transfer (IGT) and should have received those payments. We are pursuing legal remedies in order to recover the payments that are due ECHD. However, we will begin reserving for that receivable in April and will continue that through July depending on the progress of the legal remedies that are being pursued. We will keep the Board informed as that situation develops.

Also, we are restructuring the UC funding through the 1115 Waiver program and will no longer partner with other organizations, but will reassign ProCare contracts to ECHD and IGT for the District only. This will reduce the risk of the partner nonpayment reoccurring.

Operating Results - Hospital Operations:
For the month ended March, the change in net position was a loss of $2,743,156 comparing unfavorably to the budget loss of $901,878. Inpatient (I/P) revenue was above budget by $5,976,000 or 11.6% driven primarily by increased average daily census (ADC) with associated tests and procedures and increased surgeries. Outpatient (O/P) revenue was above budget by $1,655,305 or 4.3% due to increased observation days and other outpatient volumes. Net patient revenue was $1,127,619 or

5.7% above the budget of $19,677,735. Net operating revenue was $1,004,207 or 3.8%, above budget due to increased net patient revenue.

Operating expenses for the month were over budget by $1,919,654 due primarily to unfavorable salaries, physician fees, purchased services, supplies, repairs and maintenance, and other expenses. Unfavorable salaries and wages expenses were caused by increased use of employed staff and a decrease in contract labor usage. Actual FTEs per EEOB were 4.7 vs. budgeted 4.9. Physician fees unfavorable variance was caused by $125,950 in call pay to ProCare physicians that was previously paid by the Permian Basin Clinical Servicing Partnership. Purchased services unfavorable variances include $306,744 in additional collection fees, $257,118 in additional contract medical record coding, and $288,617 service contract for biomedical engineering that was previously paid under repairs and maintenance. Supplies unfavorable variance was due to $111,871 increased spine and other implants used in surgery and $61,885 supplies used in vascular surgeries. The major favorable variance for the month was in benefits due to decreased pension accrual (GASB 68) based on TCDRS investment performance.

Operating Results - ProCare (501a) Operations:
For the month of March the net loss from operations before capital contributions was $2,465,268 compared to a budgeted loss of $1,061,721. Net operating revenue was below budget by $958,470 due primarily to unpaid Medicaid Supplemental Payments from the Permian Basin Clinical Servicing Partnership during the month. Total operating costs were over budget by $318,489 due to increased contract CRNA usage of $215,254, contract radiologist usage of $79,270, and $78,832 in locum expense for Dr. Wu. Salaries were over budget by $98,092 due to $147,669 in the 4% unbudgeted payroll increase in January.

Operating Results - Family Health Center Operations:
For the month of March the net gain/loss from operations by location:

- Clements: $57,346 loss compared to a budgeted loss of $107,214. Net revenue was favorable by $58,063 due to increased volume. Operating costs were $8,195 unfavorable to budget due to increased drug costs associated with the increased volume.
- West University: $83,485 loss compared to a budgeted loss of $84,215. Net revenue was unfavorable by $71,761 due to decreased volumes. Operating costs were favorable by $72,491 driven by decreased physician allocation from ProCare.

Blended Operating Results - Ector County Hospital District:
The Change in Net Position for the month of March was a deficit of $2,743,156 comparing unfavorably to a budgeted deficit of $901,878. The Change in Net Position year to date is a surplus of $1,604,221 comparing favorably to a budgeted deficit of $6,009,892.

Volume:
Total admissions for the month were 1,189 or 7.9% above budget and 6.8% above last year. Year to date admissions were 7,035 or 3.7% above budget and 2.7% above last year. Patient days for the month were 5,873 or 8.0% above budget and 7.8% above last year. Year to date patient days were 34,068 or 2.7% above budget and 0.8% above

last year. Due to the preceding, total average length of stay (ALOS) was 4.94 for the month and 4.84 year to date. Observation days were above budget by 21.3% and above prior year by 43.2%.

Emergency room visits for the month were 4,487 resulting in a decrease compared to budget of 1.3% and an increase compared to last year of 9.2%. Year to date emergency room visits were 27,772 or 4.6% above budget and 4.7% above prior year. Total O/P occasions of service for the month were 6.4% above budget for the month and 6.0% above last year. Year to date OP occasions of service were 11.6% above budget and 8.5% above last year.

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
MARCH 2019

	CURRENT MONTH					YEAR-TO-DATE				
		BUDGET		PRIOR YEAR			BUDGET		PRIOR YEAR	
	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%
Hospital InPatient Admissions										
Acute / Adult	1,165	1,080	7.9%	1,091	6.8%	6,856	6,608	3.8%	6,677	2.7%
Neonatal ICU (NICU)	24	34	-29.9%	33	-27.3%	179	179	0.3%	172	4.1%
Total Admissions	1,189	1,114	6.7%	1,124	5.8%	7,035	6,787	3.7%	6,849	2.7%
Patient Days										
Adult & Pediatric	4,477	4,151	7.9%	4,218	6.1%	25,723	25,424	1.2%	26,007	-1.1%
ICU	463	384	20.6%	387	19.6%	2,557	2,286	11.9%	2,550	0.3%
CCU	476	403	18.1%	376	26.6%	2,573	2,401	7.2%	2,446	5.2%
NICU	457	500	-8.6%	467	-2.1%	3,215	3,072	4.7%	2,809	14.5%
Total Patient Days	5,873	5,438	8.0%	5,448	7.8%	34,068	33,183	2.7%	33,812	0.8%
Observation (Obs) Days	782	645	21.3%	546	43.2%	4,635	3,846	20.5%	4,061	14.1%
Nursery Days	246	238	3.4%	234	5.1%	1,517	1,428	6.2%	1,473	3.0%
Total Occupied Beds / Bassinets	6,901	6,321	9.2%	6,228	10.8%	40,220	38,457	4.6%	39,346	2.2%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.65	4.57	1.7%	4.57	1.8%	4.50	4.56	-1.2%	4.64	-3.1%
NICU	19.04	14.60	30.5%	14.15	34.6%	17.96	17.21	4.4%	16.33	10.0%
Total ALOS	4.94	4.88	1.2%	4.85	1.9%	4.84	4.89	-1.0%	4.94	-1.9%
Acute / Adult & Pediatric w/o OB	5.44			5.36	1.5%	5.33			5.49	-2.8%
Average Daily Census	189.5	175.4	8.0%	175.7	7.8%	187.2	182.3	2.7%	185.8	0.8%
Hospital Case Mix Index (CMI)	1.6194	1.5166	6.8%	1.5218	6.4%	1.5843	1.5166	4.5%	1.5166	4.5%
Medicare										
Admissions	460	432	6.5%	429	7.2%	2,711	2,615	3.7%	2,773	-2.2%
Patient Days	2,485	2,300	8.0%	2,167	14.7%	13,844	13,444	3.0%	14,390	-3.8%
Average Length of Stay	5.40	5.32	1.5%	5.05	6.9%	5.11	5.14	-0.7%	5.19	-1.6%
Case Mix Index	1.8086			1.6145	12.0%	1.7342			1.6438	5.5%
Medicaid										
Admissions	135	126	7.1%	137	-1.5%	906	876	3.4%	823	10.1%
Patient Days	735	681	7.9%	760	-3.3%	4,948	4,832	2.4%	4,310	14.8%
Average Length of Stay	5.44	5.40	0.7%	5.55	-1.9%	5.46	5.52	-1.0%	5.24	4.3%
Case Mix Index	1.3044			1.1928	9.4%	1.2213			1.1827	3.3%
Commercial										
Admissions	330	309	6.8%	312	5.8%	1,961	1,891	3.7%	1,738	12.8%
Patient Days	1,391	1,288	8.0%	1,364	2.0%	8,356	8,153	2.5%	7,810	7.0%
Average Length of Stay	4.22	4.17	1.1%	4.37	-3.6%	4.26	4.31	-1.2%	4.49	-5.2%
Case Mix Index	1.5587			1.5131	3.0%	1.5519			1.5257	1.7%
Self Pay										
Admissions	249	233	6.9%	214	16.4%	1,334	1,286	3.7%	1,360	-1.9%
Patient Days	1,178	1,091	8.0%	990	19.0%	6,283	6,130	2.5%	6,558	-4.2%
Average Length of Stay	4.73	4.68	1.0%	4.63	2.3%	4.71	4.77	-1.2%	4.82	-2.3%
Case Mix Index	1.4424			1.4960	-3.6%	1.4873			1.3948	6.6%
All Other										
Admissions	15	14	7.1%	32	-53.1%	123	119	3.4%	155	-20.6%
Patient Days	84	78	7.7%	167	-49.7%	637	624	2.1%	744	-14.4%
Average Length of Stay	5.60	5.57	0.5%	5.22	7.3%	5.18	5.24	-1.2%	4.80	7.9%
Case Mix Index	2.3928			1.8035	32.7%	2.1327			1.8170	17.4%
Radiology										
InPatient	4,620	4,562	1.3%	4,877	-5.3%	27,099	27,163	-0.2%	27,518	-1.5%
OutPatient	7,596	7,549	0.6%	7,727	-1.7%	46,073	44,938	2.5%	43,126	6.8%
Cath Lab										
InPatient	492	569	-13.5%	498	-1.2%	3,307	3,384	-2.3%	3,379	-2.1%
OutPatient	535	582	-8.1%	570	-6.1%	3,606	3,464	4.1%	3,440	4.8%
Laboratory										
InPatient	75,218	69,961	7.5%	70,206	7.1%	432,214	416,489	3.8%	420,132	2.9%
OutPatient	59,623	55,258	7.9%	55,337	7.7%	352,111	329,027	7.0%	329,136	7.0%
Other										
Deliveries	147	161	-8.7%	161	-8.7%	945	966	-2.2%	964	-2.0%
Surgical Cases										
InPatient	320	302	6.0%	238	34.5%	1,765	1,801	-2.0%	1,668	5.8%
OutPatient	486	628	-22.6%	621	-21.7%	3,249	3,741	-13.2%	3,552	-8.5%
Total Surgical Cases	806	930	-13.3%	859	-6.2%	5,014	5,542	-9.5%	5,220	-3.9%
GI Procedures (Endo)										
InPatient	177	106	67.0%	106	67.0%	898	631	42.3%	604	48.7%
OutPatient	311	282	10.3%	240	29.6%	1,398	1,681	-16.8%	1,589	-12.0%
Total GI Procedures	488	388	25.8%	346	41.0%	2,296	2,312	-0.7%	2,193	4.7%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
MARCH 2019

	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	4,487	4,545	-1.3%	4,108	9.2%	27,772	26,562	4.6%	26,528	4.7%
Observation Days	782	645	21.3%	546	43.2%	4,635	3,846	20.5%	4,061	14.1%
Other O/P Occasions of Service	18,674	17,312	7.9%	17,926	4.2%	115,947	102,539	13.1%	106,176	9.2%
Total O/P Occasions of Svc.	23,943	22,502	6.4%	22,580	6.0%	148,354	132,947	11.6%	136,765	8.5%
Hospital Operations										
Manhours Paid	279,259	279,164	0.0%	278,614	0.2%	1,613,601	1,672,772	-3.5%	1,655,925	-2.6%
FTE's	1,576.5	1,575.9	0.0%	1,572.8	0.2%	1,551.5	1,608.4	-3.5%	1,592.2	-2.6%
Adjusted Patient Days	10,465	10,010	4.6%	10,074	3.9%	62,666	60,891	2.9%	61,391	2.1%
Hours / Adjusted Patient Day	26.68	27.89	-4.3%	27.66	-3.5%	25.75	27.47	-6.3%	26.97	-4.5%
Occupancy - Actual Beds	54.3%	50.3%	8.0%	50.4%	7.8%	53.6%	52.2%	2.7%	53.2%	0.8%
FTE's / Adjusted Occupied Bed	4.7	4.9	-4.3%	4.8	-3.5%	4.5	4.8	-6.3%	4.7	-4.5%
InPatient Rehab Unit										
Admissions	45	36	23.5%	30	50.0%	269	222	21.1%	183	47.0%
Patient Days	590	542	8.9%	479	23.2%	3,262	3,252	0.3%	2,407	35.5%
Average Length of Stay	13.1	14.9	-11.9%	16.0	-17.9%	12.1	14.6	-17.1%	13.2	-7.8%
Manhours Paid	9,040	8,415	7.4%	7,638	18.4%	48,628	50,213	-3.2%	37,049	31.3%
FTE's	51.0	47.5	7.4%	43.1	18.4%	46.8	48.3	-3.2%	35.6	31.3%
Center for Primary Care - Clements										
Total Medical Visits	1,145	853	34.2%	903	26.8%	7,204	5,462	31.9%	5,784	24.6%
Manhours Paid	3,806	3,887	-2.1%	4,350	-12.5%	23,117	22,818	1.3%	7,208	220.7%
FTE's	21.5	21.9	-2.1%	24.6	-12.5%	22.2	21.9	1.3%	6.9	220.7%
Center for Primary Care - West University										
Total Medical Visits	293	649	-54.9%	629	-53.4%	3,018	4,092	-26.2%	3,966	-23.9%
Total Optometry	-	231	-100.0%	229	-100.0%	1,115	1,563	-28.7%	1,551	-28.1%
Manhours Paid	1,595	2,474	-35.5%	2,912	-45.2%	9,525	14,523	-34.4%	3,762	153.2%
FTE's	9.0	14.0	-35.5%	16.4	-45.2%	9.2	14.0	-34.4%	3.6	153.2%
Total ECHD Operations										
Total Admissions	1,234	1,150	7.3%	1,154	6.9%	7,304	7,009	4.2%	7,032	3.9%
Total Patient Days	6,463	5,980	8.1%	5,927	9.0%	37,330	36,435	2.5%	36,219	3.1%
Total Patient and Obs Days	7,245	6,625	9.4%	6,473	11.9%	41,965	40,281	4.2%	40,280	4.2%
Total FTE's	1,658.0	1,659.3	-0.1%	1,656.9	0.1%	1,629.7	1,692.6	-3.7%	1,638.4	-0.5%
FTE's / Adjusted Occupied Bed	4.5	4.7	-4.5%	4.7	-4.8%	4.3	4.7	-7.5%	4.5	-4.7%
Total Adjusted Patient Days	11,517	11,007	4.6%	10,960	5.1%	68,672	65,940	4.1%	65,779	4.4%
Hours / Adjusted Patient Day	25.50	26.70	-4.5%	26.78	-4.8%	24.68	26.70	-7.5%	25.90	-4.7%
Outpatient Factor	1.7819	1.8407	-3.2%	1.8492	-3.6%	1.8394	1.8353	0.2%	1.8161	1.3%
Blended O/P Factor	1.9868	2.0966	-5.2%	2.0705	-4.0%	2.0466	2.0841	-1.8%	2.0693	-1.1%
Total Adjusted Admissions	2,199	2,118	3.8%	2,134	3.0%	13,446	12,864	4.5%	12,771	5.3%
Hours / Adjusted Admisssion	133.57	138.81	-3.8%	137.54	-2.9%	126.05	136.85	-7.9%	133.42	-5.5%
FTE's - Hospital Contract	43.4	49.1	-11.7%	53.9	-19.5%	46.8	50.4	-7.2%	61.7	-24.2%
FTE's - Mgmt Services	53.9	50.1	7.5%	3.7	1369.0%	65.0	50.1	29.8%	36.7	77.0%
Total FTE's (including Contract)	1,755.3	1,758.6	-0.2%	1,714.5	2.4%	1,741.5	1,793.2	-2.9%	1,736.9	0.3%
Total FTE'S per Adjusted Occupied Bed (including Contract)	4.7	5.0	-4.6%	4.8	-2.6%	4.6	4.9	-6.7%	4.8	-4.0%
ProCare FTEs	216.5	241.1	-10.2%	223.9	-3.3%	216.2	241.1	-10.3%	234.9	-8.0%
Total System FTEs	1,971.8	1,999.7	-1.4%	1,938.4	1.7%	1,957.7	2,034.3	-3.8%	1,971.8	-0.7%
Urgent Care Visits										
JBS Clinic	1,051	1,122	-6.3%	1,005	4.6%	6,405	6,588	-2.8%	7,080	-9.5%
West University	609	733	-16.9%	603	1.0%	4,123	4,303	-4.2%	4,815	-14.4%
42nd Street	631	838	-24.7%	710	-11.1%	4,511	4,920	-8.3%	4,842	-6.8%
Total Urgent Care Visits	2,291	2,693	-14.9%	2,318	-1.2%	15,039	15,811	-4.9%	16,737	-10.1%
Wal-Mart Clinic Visits										
East Clinic	441	820	-46.2%	418	5.5%	3,072	3,204	-4.1%	3,041	1.0%
West Clinic	337	584	-42.3%	208	62.0%	2,323	2,351	-1.2%	2,410	-3.6%
Total Wal-Mart Visits	778	1,404	-44.6%	626	24.3%	5,395	5,555	-2.9%	5,451	-1.0%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
MARCH 2019

	HOSPITAL	PRO CARE	ECTOR COUNTY HOSPITAL DISTRICT
ASSETS			
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 18,874,233	$ 5,000	$ 18,879,233
Investments	49,837,789	-	49,837,789
Patient Accounts Receivable - Gross	209,137,135	39,424,868	248,562,003
Less: 3rd Party Allowances	(99,338,332)	(7,630,921)	(106,969,253)
Bad Debt Allowance	(70,574,284)	(26,570,153)	(97,144,438)
Net Patient Accounts Receivable	39,224,518	5,223,794	44,448,313
Taxes Receivable	9,750,259	-	9,750,259
Accounts Receivable - Other	14,027,705	4,518,030	18,545,735
Inventories	6,670,025	304,656	6,974,682
Prepaid Expenses	3,996,496	199,125	4,195,620
Total Current Assets	142,381,026	10,250,605	152,631,631
CAPITAL ASSETS:			
Property and Equipment	463,222,037	467,364	463,689,401
Construction in Progress	299,780	-	299,780
	463,521,817	467,364	463,989,181
Less: Accumulated Depreciation and Amortization	(282,160,576)	(288,303)	(282,448,879)
Total Capital Assets	181,361,241	179,061	181,540,302
INTANGIBLE ASSETS / GOODWILL - NET	10,347	128,610	138,958
RESTRICTED ASSETS:			
Restricted Assets Held by Trustee	3,707,241	-	3,707,241
Restricted Assets Held in Endowment	6,255,412	-	6,255,412
Restricted TPC, LLC	382,641	-	382,641
Restricted MCH West Texas Services	2,185,854	-	2,185,854
Pension, Deferred Outflows of Resources	6,725,511	-	6,725,511
Assets whose use is Limited	-	25,467	25,467
TOTAL ASSETS	$ 343,009,273	$ 10,583,743	$ 353,593,017
LIABILITIES AND FUND BALANCE			
CURRENT LIABILITIES:			
Current Maturities of Long-Term Debt	$ 4,773,979	$ -	$ 4,773,979
Self-Insurance Liability - Current Portion	3,493,156	-	3,493,156
Accounts Payable	16,897,386	2,497,479	19,394,865
A/R Credit Balances	4,592,954	-	4,592,954
Accrued Interest	(886,454)	-	(886,454)
Accrued Salaries and Wages	3,497,761	6,292,463	9,790,223
Accrued Compensated Absences	3,951,433	-	3,951,433
Due to Third Party Payors	927,469	-	927,469
Deferred Revenue	7,717,303	446,340	8,163,642
Total Current Liabilities	44,964,986	9,236,281	54,201,267
ACCRUED POST RETIREMENT BENEFITS	49,349,123	-	49,349,123
SELF-INSURANCE LIABILITIES - Less Current Portion	2,409,871	-	2,409,871
LONG-TERM DEBT - Less Current Maturities	43,333,489	-	43,333,489
Total Liabilities	140,057,469	9,236,281	149,293,750
FUND BALANCE	202,951,804	1,347,462	204,299,266
TOTAL LIABILITIES AND FUND BALANCE	$ 343,009,273	$ 10,583,743	$ 353,593,017

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
MARCH 2019

	CURRENT YEAR	PRIOR FISCAL YEAR END HOSPITAL AUDITED	PRIOR FISCAL YEAR END PRO CARE AUDITED	CURRENT YEAR CHANGE
ASSETS				
CURRENT ASSETS:				
Cash and Cash Equivalents	$ 18,879,233	$ 35,063,275	$ 5,200	$ (16,189,242)
Investments	49,837,789	20,681,168	-	29,156,621
Patient Accounts Receivable - Gross	248,562,003	233,801,086	50,818,982	(36,058,064)
Less: 3rd Party Allowances	(106,969,253)	(96,357,975)	(14,361,289)	3,750,011
Bad Debt Allowance	(97,144,438)	(106,436,913)	(30,938,698)	40,231,173
Net Patient Accounts Receivable	44,448,313	31,006,197	5,518,995	7,923,121
Taxes Receivable	9,750,259	9,874,752	-	(124,492)
Accounts Receivable - Other	18,545,735	20,607,851	1,919,795	(3,981,912)
Inventories	6,974,682	6,668,788	207,786	98,108
Prepaid Expenses	4,195,620	3,915,303	361,509	(81,191)
Total Current Assets	152,631,631	127,817,334	8,013,284	16,801,012
CAPITAL ASSETS:				
Property and Equipment	463,689,401	461,430,074	520,697	1,738,630
Construction in Progress	299,780	194,727	-	105,053
	463,989,181	461,624,800	520,697	1,843,684
Less: Accumulated Depreciation and Amortization	(282,448,879)	(273,018,611)	(325,258)	(9,105,010)
Total Capital Assets	181,540,302	188,606,190	195,439	(7,261,326)
INTANGIBLE ASSETS / GOODWILL - NET	138,958	28,354	190,863	(80,260)
RESTRICTED ASSETS:				
Restricted Assets Held by Trustee	3,707,241	4,731,764	-	(1,024,523)
Restricted Assets Held in Endowment	6,255,412	6,105,800	-	149,612
Restricted MCH West Texas Services	2,185,854	2,121,628	-	64,226
Pension, Deferred Outflows of Resources	6,725,511	6,725,511	-	-
Assets whose use is Limited	25,467	-	61,843	(36,375)
TOTAL ASSETS	$ 353,593,017	$ 336,519,221	$ 8,461,429	$ 8,612,366
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES:				
Current Maturities of Long-Term Debt	$ 4,773,979	$ 4,773,979	$ -	$ -
Self-Insurance Liability - Current Portion	3,493,156	3,493,156	-	-
Accounts Payable	19,394,865	16,840,141	2,485,674	69,050
A/R Credit Balances	4,592,954	4,449,515	-	143,438
Accrued Interest	(886,454)	42,618	-	(929,072)
Accrued Salaries and Wages	9,790,223	6,378,073	6,008,586	(2,596,435)
Accrued Compensated Absences	3,951,433	3,936,690	-	14,743
Due to Third Party Payors	927,469	335,256	-	592,213
Deferred Revenue	8,163,642	353,553	-	7,810,089
Total Current Liabilities	54,201,267.29	40,602,981.94	8,494,259	5,104,026
ACCRUED POST RETIREMENT BENEFITS	49,349,123	45,849,123	-	3,500,000
SELF-INSURANCE LIABILITIES - Less Current Portion	2,409,871	2,409,871	-	-
LONG-TERM DEBT - Less Current Maturities	43,333,489	44,929,369	-	(1,595,880)
Total Liabilities	149,293,750	133,791,345	8,494,259	7,008,146
FUND BALANCE	204,299,266	202,727,876	(32,831)	1,604,221
TOTAL LIABILITIES AND FUND BALANCE	$ 353,593,017	$ 336,519,221	$ 8,461,429	$ 8,612,367

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
MARCH 2019

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Inpatient Revenue	$ 57,313,437	$ 51,337,437	11.6%	$ 50,577,648	13.3%	$ 326,550,953	$ 306,879,012	6.4%	$ 303,720,246	7.5%
Outpatient Revenue	56,559,690	56,299,184	0.5%	54,144,210	4.5%	341,783,123	332,677,418	2.7%	324,779,246	5.2%
TOTAL PATIENT REVENUE	$ 113,873,127	$ 107,636,621	5.8%	$ 104,721,859	8.7%	$ 668,334,076	$ 639,556,430	4.5%	$ 628,499,492	6.3%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 69,946,220	$ 68,070,314	2.8%	$ 71,541,354	-2.2%	$ 418,298,988	$ 405,056,163	3.3%	$ 415,401,628	0.7%
Policy Adjustments	1,078,606	1,818,002	-40.7%	611,717	76.3%	15,565,607	10,534,097	47.8%	12,403,734	25.5%
Uninsured Discount	12,283,558	8,016,665	53.2%	15,222,965	-19.3%	56,241,615	48,188,259	16.7%	43,292,730	29.9%
Indigent	(56,610)	1,749,382	-103.2%	308,506	-118.3%	104,258	10,108,624	-99.0%	2,914,800	-96.4%
Provision for Bad Debts	8,119,034	6,383,925	27.2%	(2,987,175)	-371.8%	34,248,409	37,331,863	-8.3%	31,977,572	7.1%
TOTAL REVENUE DEDUCTIONS	$ 91,370,808	$ 86,038,288	6.2%	$ 84,697,368	7.9%	$ 524,458,876	$ 511,219,006	2.6%	$ 505,990,464	3.6%
	80.24%	79.93%		80.88%		78.47%	79.93%		80.51%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 429,208	$ 1,156,242	-62.9%	$ 1,156,242	-62.9%	$ 4,756,171	6,937,452	-31.4%	$ 6,937,454	-31.4%
DSRIP	971,658	971,658	0.0%	1,000,000	-2.8%	5,829,948	5,829,948	0.0%	5,773,262	1.0%
Medicaid Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	132,051	-100.0%
TOTAL OTHER PATIENT REVENUE	$ 1,400,866	$ 2,127,900	-34.2%	$ 2,156,242	-35.0%	$ 10,586,119	$ 12,767,400	-17.1%	$ 12,842,767	-17.6%
NET PATIENT REVENUE	$ 23,903,185	$ 23,726,233	0.7%	$ 22,180,733	7.8%	$ 154,461,319	$ 141,104,824	9.5%	$ 135,351,796	14.1%
OTHER REVENUE										
Tax Revenue	$ 5,797,268	$ 5,919,754	-2.1%	$ 6,059,933	-4.3%	$ 35,944,376	$ 34,729,051	3.5%	$ 32,400,797	10.9%
Other Revenue	928,257	936,987	-0.9%	822,699	12.8%	5,082,595	5,178,410	-1.9%	4,732,541	7.4%
TOTAL OTHER REVENUE	$ 6,725,525	$ 6,856,741	-1.9%	$ 6,882,632	-2.3%	$ 41,026,971	$ 39,907,461	2.8%	$ 37,133,338	10.5%
NET OPERATING REVENUE	$ 30,628,711	$ 30,582,974	0.1%	$ 29,063,366	5.4%	$ 195,488,290	$ 181,012,285	8.0%	$ 172,485,134	13.3%
OPERATING EXPENSES										
Salaries and Wages	$ 13,808,471	$ 12,807,134	7.8%	$ 13,011,213	6.1%	$ 79,025,079	$ 76,239,530	3.7%	$ 77,017,677	2.6%
Benefits	3,081,123	3,301,166	-6.7%	4,140,880	-25.6%	18,029,093	19,605,713	-8.0%	22,155,612	-18.6%
Temporary Labor	1,111,674	886,553	25.4%	963,104	15.4%	6,321,649	5,176,965	22.1%	5,774,896	9.5%
Physician Fees	1,348,372	1,124,473	19.9%	976,579	38.1%	6,904,417	7,017,922	-1.6%	7,224,754	-4.4%
Texas Tech Support	1,002,621	1,001,417	0.1%	1,000,000	0.3%	5,962,280	6,008,502	-0.8%	5,026,866	18.6%
Purchased Services	4,562,475	3,735,842	22.1%	2,540,361	79.6%	27,173,692	22,967,938	18.3%	13,040,265	108.4%
Supplies	5,055,504	4,954,388	2.0%	4,550,796	11.1%	29,778,150	28,900,750	3.0%	28,287,059	5.3%
Utilities	317,710	400,294	-20.6%	364,167	-12.8%	1,922,169	2,081,099	-7.6%	2,048,656	-6.2%
Repairs and Maintenance	762,487	635,901	19.9%	437,698	74.2%	4,991,653	3,611,429	38.2%	5,376,104	-7.2%
Leases and Rent	128,461	142,648	-9.9%	77,042	66.7%	739,759	632,450	17.0%	780,803	-5.3%
Insurance	146,353	135,201	8.2%	133,238	9.8%	778,993	810,206	-3.9%	784,019	-0.6%
Interest Expense	259,550	264,238	-1.8%	274,267	-5.4%	1,553,489	1,557,024	-0.2%	1,649,847	-5.8%
ECHDA	326,585	253,230	29.0%	50,061	552.4%	1,803,492	1,487,620	21.2%	1,061,042	70.0%
Other Expense	318,900	223,718	42.5%	159,375	100.1%	1,068,779	1,206,522	-11.4%	1,084,606	-1.5%
TOTAL OPERATING EXPENSES	$ 32,230,287	$ 29,866,203	7.9%	$ 28,678,780	12.4%	$ 186,052,695	$ 177,303,670	4.9%	$ 171,312,207	8.6%
Depreciation/Amortization	$ 1,396,629	$ 1,718,696	-18.7%	$ 1,694,539	-17.6%	$ 9,477,679	$ 10,306,388	-8.0%	$ 10,336,160	-8.3%
(Gain) Loss on Sale of Assets	-	-	0.0%	(1,500)	-100.0%	7,935	-	0.0%	(1,952)	-506.6%
TOTAL OPERATING COSTS	$ 33,626,916	$ 31,584,899	6.5%	$ 30,371,819	10.7%	$ 195,538,308	$ 187,610,058	4.2%	$ 181,646,415	7.6%
NET GAIN (LOSS) FROM OPERATIONS	**$ (2,998,205)**	**$ (1,001,925)**	**-199.2%**	**$ (1,308,453)**	**-129.1%**	**$ (50,019)**	**$ (6,597,773)**	**-99.2%**	**$ (9,161,281)**	**-99.5%**
Operating Margin	-9.79%	-3.28%	198.8%	-4.50%	117.4%	-0.03%	-3.64%	-99.3%	-5.31%	-99.5%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 114,587	$ 24,485	368.0%	$ 18,854	507.8%	$ 707,672	$ 133,723	429.2%	$ 154,239	358.8%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	
Donations	-	-		-		300,260	786	38101.0%	923	32447.8%
Build America Bonds Subsidy	82,117	82,117	0.0%	84,413	-2.7%	490,407	492,702	-0.5%	506,751	-3.2%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (2,801,501)	$ (895,323)	212.9%	$ (1,205,186)	132.5%	$ 1,448,321	$ (5,970,562)	-124.3%	$ (8,499,368)	-117.0%
Unrealized Gain/(Loss) on Investments	$ 61,517	$ (12,484)	0.0%	$ (47,251)	-230.2%	$ 91,674	$ (74,904)	0.0%	$ (99,874)	-191.8%
Investment in Subsidiaries	(3,172)	5,929	-153.5%	22,190	-114.3%	64,226	35,574	80.5%	38,252	67.9%
CHANGE IN NET POSITION	**$ (2,743,156)**	**$ (901,878)**	**-204.2%**	**$ (1,230,247)**	**-123.0%**	**$ 1,604,221**	**$ (6,009,892)**	**126.7%**	**$ (8,560,990)**	**118.7%**

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
MARCH 2019

	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 Routine Revenue	$ 57,313,437	$ 51,337,216	11.6%	$ 50,577,648	13.3%	$ 326,550,953	$ 306,877,730	6.4%	$ 303,716,870	7.5%
Outpatient Revenue	44,815,450	43,160,145	3.8%	42,950,295	4.3%	274,121,707	256,337,653	6.9%	247,879,695	10.6%
TOTAL PATIENT REVENUE	$ 102,128,886	$ 94,497,582	8.1%	$ 93,527,943	9.2%	$ 600,672,660	$ 563,216,665	6.7%	$ 551,599,941	8.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 63,022,555	$ 61,226,292	2.9%	$ 66,810,261	-5.7%	$ 384,211,562	$ 365,538,805	5.1%	$ 374,498,130	2.6%
Policy Adjustments	473,476	1,601,759	-70.4%	388,002	22.0%	4,253,629	9,265,778	-54.1%	10,835,623	-60.7%
Uninsured Discount	11,633,517	7,898,898	47.3%	15,146,870	-23.2%	53,202,012	47,507,928	12.0%	42,768,213	24.4%
Indigent Care	(38,337)	1,669,102	-102.3%	238,948	-116.0%	50,122	9,640,979	-99.5%	2,502,380	-98.0%
Provision for Bad Debts	7,633,186	3,676,696	107.6%	(5,858,624)	-230.3%	34,805,652	21,448,935	62.3%	17,544,623	98.4%
TOTAL REVENUE DEDUCTIONS	$ 82,724,398	$ 76,072,747	8.7%	$ 76,725,456	7.8%	$ 476,522,977	$ 453,402,425	5.1%	$ 448,148,970	6.3%
	81.00%	80.50%		82.03%		79.33%	80.50%		81.25%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 429,208	$ 281,242	52.6%	$ 281,242	52.6%	$ 381,171	$ 1,687,452	-77.4%	$ 1,687,454	-77.4%
DSRIP	971,658	971,658	0.0%	1,000,000	-2.8%	5,829,948	5,829,948	0.0%	5,773,262	1.0%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	132,051	-100.0%
TOTAL OTHER PATIENT REVENUE	$ 1,400,866	$ 1,252,900	11.8%	$ 1,281,242	9.3%	$ 6,211,119	$ 7,517,400	-17.4%	$ 7,592,767	-18.2%
NET PATIENT REVENUE	$ 20,805,354	$ 19,677,735	5.7%	$ 18,083,730	15.1%	$ 130,360,802	$ 117,331,640	11.1%	$ 111,043,739	17.4%
OTHER REVENUE										
Tax Revenue	$ 5,797,268	$ 5,919,754	-2.1%	$ 6,059,933	-4.3%	$ 35,944,376	$ 34,729,051	3.5%	$ 32,400,797	10.9%
Other Revenue	793,303	794,229	-0.1%	694,755	14.2%	4,133,201	4,357,415	-5.1%	3,913,632	5.6%
TOTAL OTHER REVENUE	$ 6,590,571	$ 6,713,983	-1.8%	$ 6,754,689	-2.4%	$ 40,077,577	$ 39,086,466	2.5%	$ 36,314,429	10.4%
NET OPERATING REVENUE	$ 27,395,925	$ 26,391,718	3.8%	$ 24,838,418	10.3%	$ 170,438,379	$ 156,418,106	9.0%	$ 147,358,167	15.7%
OPERATING EXPENSE										
Salaries and Wages	$ 9,969,084	$ 9,065,839	10.0%	$ 9,203,175	8.3%	$ 56,443,451	$ 54,283,084	4.0%	$ 53,522,969	5.5%
Benefits	2,691,790	2,896,219	-7.1%	3,731,201	-27.9%	15,564,143	17,197,852	-9.5%	19,469,724	-20.1%
Temporary Labor	475,284	568,652	-16.4%	674,467	-29.5%	3,087,238	3,427,449	-9.9%	4,305,240	-28.3%
Physician Fees	1,169,226	1,043,359	12.1%	834,315	40.1%	5,944,680	6,401,485	-7.1%	6,256,485	-5.0%
Texas Tech Support	1,002,621	1,001,417	0.1%	1,000,000	0.3%	5,962,280	6,008,502	-0.8%	5,026,866	18.6%
Purchased Services	4,329,534	3,505,508	23.5%	2,412,656	79.5%	25,824,363	21,673,111	19.2%	13,202,463	95.6%
Supplies	4,928,417	4,800,540	2.7%	4,431,671	11.2%	28,890,272	28,001,811	3.2%	27,399,775	5.4%
Utilities	314,500	396,128	-20.6%	360,875	-12.9%	1,900,031	2,056,158	-7.6%	2,027,865	-6.3%
Repairs and Maintenance	762,326	634,861	20.1%	436,136	74.8%	4,989,858	3,605,189	38.4%	5,370,046	-7.1%
Leases and Rentals	(45,819)	(29,931)	53.1%	(113,396)	-59.6%	(305,899)	(402,252)	-24.0%	(385,305)	-20.6%
Insurance	97,778	87,358	11.9%	84,446	15.8%	487,291	524,148	-7.0%	499,280	-2.4%
Interest Expense	259,550	264,238	-1.8%	274,267	-5.4%	1,553,489	1,557,024	-0.2%	1,649,847	-5.8%
ECHDA	326,585	253,230	29.0%	50,061	552.4%	1,803,492	1,487,620	21.2%	1,061,042	70.0%
Other Expense	270,931	144,735	87.2%	83,284	225.3%	699,904	800,228	-12.5%	683,135	2.5%
TOTAL OPERATING EXPENSES	$ 26,551,807	$ 24,632,153	7.8%	$ 23,463,160	13.2%	$ 152,844,593	$ 146,621,409	4.2%	$ 140,089,434	9.1%
Depreciation/Amortization	$ 1,377,056	$ 1,699,769	-19.0%	$ 1,673,810	-17.7%	$ 9,357,874	$ 10,189,819	-8.2%	$ 10,196,994	-8.2%
(Gain)/Loss on Disposal of Assets	-	-	0.0%	(1,500)	-100.0%	7,935	-	100.0%	(1,952)	-506.6%
TOTAL OPERATING COSTS	$ 27,928,862	$ 26,331,922	6.1%	$ 25,135,471	11.1%	$ 162,210,402	$ 156,811,228	3.4%	$ 150,284,477	7.9%
NET GAIN (LOSS) FROM OPERATIONS	**$ (532,937)**	**$ 59,796**	**-991.3%**	**$ (297,053)**	**-79.4%**	**$ 8,227,978**	**$ (393,122)**	**-2193.0%**	**$ (2,926,309)**	**-381.2%**
Operating Margin	-1.95%	0.23%	-958.6%	-1.20%	62.7%	4.83%	-0.25%	-2020.8%	-1.99%	-343.1%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 114,587	$ 24,485	368.0%	$ 18,854	507.8%	$ 707,672	$ 133,723	429.2%	$ 154,239	358.8%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	0.0%
Donations	-	-	0.0%	-	0.0%	300,260	786	38101.0%	923	32447.8%
Build America Bonds Subsidy	82,117	82,117	0.0%	84,413	-2.7%	490,407	492,702	-0.5%	506,751	-3.2%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	$ (336,234)	$ 166,398	-302.1%	$ (193,785)	73.5%	$ 9,726,317	$ 234,089	4055.0%	$ (2,264,396)	-529.5%
Procare Capital Contribution	(2,465,268)	(1,061,721)	132.2%	(1,397,355)	76.4%	(8,277,996)	(6,204,651)	33.4%	(6,689,283)	23.8%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (2,801,501)	$ (895,323)	212.9%	$ (1,591,140)	76.1%	$ 1,448,321	$ (5,970,562)	-124.3%	$ (8,953,680)	-116.2%
Unrealized Gain/(Loss) on Investments	$ 61,517	$ (12,484)	-592.8%	$ (47,251)	-230.2%	$ 91,674	$ (74,904)	-222.4%	$ (99,874)	-191.8%
Investment in Subsidiaries	(3,172)	5,929	-153.5%	22,190	-114.3%	64,226	35,574	80.5%	38,252	67.9%
CHANGE IN NET POSITION	**$ (2,743,156)**	**$ (901,878)**	**-204.2%**	**$ (1,616,201)**	**-69.7%**	**$ 1,604,221**	**$ (6,009,892)**	**126.7%**	**$ (9,015,301)**	**117.8%**

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
MARCH 2019

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 11,744,241	$ 13,139,039	-10.6%	$ 11,193,915	4.9%	$ 67,661,416	$ 76,339,765	-11.4%	$ 76,899,551	-12.0%
TOTAL PATIENT REVENUE	$ 11,744,241	$ 13,139,039	-10.6%	$ 11,193,915	4.9%	$ 67,661,416	$ 76,339,765	-11.4%	$ 76,899,551	-12.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 6,923,665	$ 6,844,022	1.2%	$ 4,731,093	46.3%	$ 34,087,426	$ 39,517,358	-13.7%	$ 40,903,498	-16.7%
Policy Adjustments	605,130	216,243	179.8%	223,715	170.5%	11,311,978	1,268,319	791.9%	1,568,110	621.4%
Uninsured Discount	650,040	117,767	452.0%	76,096	754.2%	3,039,603	680,331	346.8%	524,517	479.5%
Indigent	(18,274)	80,280	-122.8%	69,558	-126.3%	54,136	467,645	-88.4%	412,419	-86.9%
Provision for Bad Debts	485,848	2,707,229	-82.1%	2,871,449	-83.1%	(557,243)	15,882,928	-103.5%	14,432,950	-103.9%
TOTAL REVENUE DEDUCTIONS	$ 8,646,410	$ 9,965,541	-13.2%	$ 7,971,911	8.5%	$ 47,935,900	$ 57,816,581	-17.1%	$ 57,841,494	-17.1%
	73.62%	75.85%		71.22%		70.85%	75.74%		75.22%	
Medicaid Supplemental Payments	$ -	$ 875,000	-100.0%	$ 875,000	-100.0%	4,375,000	5,250,000	-16.7%	$ 5,250,000	-16.7%
NET PATIENT REVENUE	$ 3,097,831	$ 4,048,498	-23.5%	$ 4,097,004	-24.4%	$ 24,100,516	$ 23,773,184	1.4%	$ 24,308,057	-0.9%
OTHER REVENUE										
Other Income	$ 134,954	$ 142,758	-5.5%	$ 127,944	5.5%	$ 949,394	$ 820,995	15.6%	$ 818,910	15.9%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,232,786	$ 4,191,256	-22.9%	$ 4,224,948	-23.5%	$ 25,049,910	$ 24,594,179	1.9%	$ 25,126,966	-0.3%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 3,839,387	$ 3,741,295	2.6%	$ 3,808,038	0.8%	$ 22,581,628	$ 21,956,446	2.8%	$ 23,494,708	-3.9%
Benefits	389,333	404,947	-3.9%	409,679	-5.0%	2,464,950	2,407,861	2.4%	2,685,888	-8.2%
Temporary Labor	636,390	317,901	100.2%	288,637	120.5%	3,234,412	1,749,516	84.9%	1,469,656	120.1%
Physician Fees	179,147	81,114	120.9%	142,263	25.9%	959,737	616,437	55.7%	968,269	-0.9%
Purchased Services	232,941	230,334	1.1%	127,705	82.4%	1,349,329	1,294,827	4.2%	(162,198)	-931.9%
Supplies	127,087	153,848	-17.4%	119,124	6.7%	887,878	898,939	-1.2%	887,284	0.1%
Utilities	3,210	4,166	-22.9%	3,292	-2.5%	22,138	24,941	-11.2%	20,791	6.5%
Repairs and Maintenance	161	1,040	-84.5%	1,562	-89.7%	1,795	6,240	-71.2%	6,058	-70.4%
Leases and Rentals	174,280	172,579	1.0%	190,438	-8.5%	1,045,659	1,034,702	1.1%	1,166,108	-10.3%
Insurance	48,575	47,843	1.5%	48,792	-0.4%	291,702	286,058	2.0%	284,739	2.4%
Other Expense	47,969	78,983	-39.3%	76,090	-37.0%	368,875	406,294	-9.2%	401,471	-8.1%
TOTAL OPERATING EXPENSES	$ 5,678,481	$ 5,234,050	8.5%	$ 5,215,620	8.9%	$ 33,208,102	$ 30,682,261	8.2%	$ 31,222,772	6.4%
Depreciation/Amortization	$ 19,573	$ 18,927	3.4%	$ 20,729	-5.6%	$ 119,805	$ 116,569	2.8%	$ 139,166	-13.9%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 5,698,053	$ 5,252,977	8.5%	$ 5,236,349	8.8%	$ 33,327,907	$ 30,798,830	8.2%	$ 31,361,938	6.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (2,465,268)**	**$ (1,061,721)**	**-132.2%**	**$ (1,011,401)**	**143.7%**	**$ (8,277,997)**	**$ (6,204,651)**	**-33.4%**	**$ (6,234,972)**	**-32.8%**
Operating Margin	-76.26%	-25.33%	201.0%	-23.94%	218.6%	-33.05%	-25.23%	31.0%	-24.81%	33.2%
MCH Contribution	$ 2,465,268	$ 1,061,721	132.2%	$ 522,355	372.0%	$ 8,277,997	$ 6,204,651	33.4%	$ 6,689,283	23.8%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ (489,046)**	**-100.0%**	**$ -**	**$ -**	**0.0%**	**$ 454,311**	**-100.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	9,809	11,109	-11.70%	9,378	4.60%	59,942	60,362	-0.70%	60,258	-0.52%
Total Hospital Visits	5,864	5,142	14.04%	4,959	18.25%	31,969	30,130	6.10%	29,822	7.20%
Total Procedures	11,973	12,080	-0.89%	10,362	15.55%	72,227	71,102	1.58%	70,891	1.88%
Total Surgeries	863	797	8.28%	750	15.07%	5,210	4,529	15.04%	4,985	4.51%
Total Provider FTE's	84.4	83.0	1.67%	85.2	-0.94%	84.5	85.8	-1.49%	86.3	-2.09%
Total Staff FTE's	121.4	146.1	-16.90%	127.5	-4.78%	119.5	143.3	-16.62%	127.6	-6.35%
Total Administrative FTE's	10.7	12.0	-10.83%	11.2	-4.46%	12.2	12.0	1.67%	21.0	-41.90%
Total FTE's	216.5	241.1	-10.20%	223.9	-3.31%	216.2	241.1	-10.33%	234.9	-7.96%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE CLEMENTS - OPERATIONS SUMMARY
MARCH 2019

	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	$ 412,459	$ 367,974	12.1%	$ 339,950	21.3%	$ 2,673,932	$ 2,160,107	23.8%	$ 2,182,300	22.5%
TOTAL PATIENT REVENUE	$ 412,459	$ 367,974	12.1%	$ 339,950	21.3%	$ 2,673,932	$ 2,160,107	23.8%	$ 2,182,300	22.5%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ (5,817)	$ 73,801	-107.9%	$ (131,017)	-95.6%	$ 196,717	$ 426,280	-53.9%	$ 792,233	-75.2%
Self Pay Adjustments	(1,181)	17,033	-106.9%	(46,913)	-97.5%	37,042	98,383	-62.3%	181,246	-79.6%
Bad Debts	225,602	128,080	76.1%	446,151	-49.4%	1,001,419	739,798	35.4%	778,572	28.6%
TOTAL REVENUE DEDUCTIONS	$ 218,603	$ 218,914	-0.1%	$ 268,221	-18.5%	$ 1,235,178	$ 1,264,461	-2.3%	$ 1,752,051	-29.5%
	53.0%	59.5%		78.9%		46.2%	58.5%		80.3%	
NET PATIENT REVENUE	$ 193,856	$ 149,060	30.1%	$ 71,729	170.3%	$ 1,438,754	$ 895,646	60.6%	$ 430,249	234.4%
OTHER REVENUE										
FHC Other Revenue	$ 14,591	$ 1,324	0.0%	$ -	0.0%	$ 81,410	$ 7,944	0.0%	$ 10,595	668.4%
TOTAL OTHER REVENUE	$ 14,591	$ 1,324	1002.0%	$ -	0.0%	$ 81,410	$ 7,944	924.8%	$ 10,595	668.4%
NET OPERATING REVENUE	$ 208,447	$ 150,384	38.6%	$ 71,729	190.6%	$ 1,520,164	$ 903,590	68.2%	$ 440,844	244.8%
OPERATING EXPENSE										
Salaries and Wages	$ 88,418	$ 83,983	5.3%	$ 94,698	-6.6%	$ 517,991	$ 493,004	5.1%	$ 232,788	122.5%
Benefits	23,874	26,830	-11.0%	38,393	-37.8%	142,835	156,192	-8.6%	84,680	68.7%
Physician Services	112,259	122,968	-8.7%	74,145	51.4%	598,342	956,096	-37.4%	947,647	-36.9%
Cost of Drugs Sold	25,894	6,031	329.4%	5,779	348.1%	49,873	35,404	40.9%	28,824	73.0%
Supplies	6,792	3,172	114.1%	3,074	121.0%	30,208	18,763	61.0%	22,446	34.6%
Utilities	602	3,722	-83.8%	5,898	-89.8%	16,209	22,241	-27.1%	25,109	-35.4%
Repairs and Maintenance	575	3,974	-85.5%	1,942	-70.4%	4,736	23,844	-80.1%	31,233	-84.8%
Leases and Rentals	378	380	-0.7%	355	6.4%	2,553	2,280	12.0%	2,329	9.6%
Other Expense	1,880	1,416	32.8%	1,728	8.8%	10,278	8,782	17.0%	7,089	45.0%
TOTAL OPERATING EXPENSES	$ 260,672	$ 252,476	3.2%	$ 226,012	15.3%	$ 1,373,025	$ 1,716,606	-20.0%	$ 1,382,145	-0.7%
Depreciation/Amortization	$ 5,121	$ 5,122	0.0%	$ 5,150	-0.6%	$ 30,726	$ 30,732	0.0%	$ 31,072	-1.1%
TOTAL OPERATING COSTS	$ 265,793	$ 257,598	3.2%	$ 231,162	15.0%	$ 1,403,751	$ 1,747,338	-19.7%	$ 1,413,217	-0.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (57,346)**	**$ (107,214)**	**-46.5%**	**$ (159,433)**	**-64.0%**	**$ 116,413**	**$ (843,748)**	**-113.8%**	**$ (972,373)**	**-112.0%**
Operating Margin	-27.51%	-71.29%	-61.4%	-222.27%	-87.6%	7.66%	-93.38%	-108.2%	-220.57%	-103.5%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	1,145	853	34.2%	903	26.8%	7,204	5,462	31.9%	5,784	24.6%
Dental Visits	-	-	0.0%	-	0.0%	-	-	0.0%	350	-100.0%
Total Visits	1,145	853	34.2%	903	26.8%	7,204	5,462	31.9%	6,134	17.4%
Average Revenue per Office Visit	360.23	431.39	-16.5%	376.47	-4.3%	371.17	395.48	-6.1%	355.77	4.3%
Hospital FTE's (Salaries and Wages)	21.5	21.9	-2.1%	24.6	-12.5%	22.2	21.9	1.3%	6.9	220.7%
Clinic FTE's - (Physician Services)	-	-	0.0%	(5.9)	-100.0%	-	-	0.0%	14.3	-100.0%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE WEST UNIVERSITY - OPERATIONS SUMMARY
MARCH 2019

	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	$ 103,968	$ 333,402	-68.8%	$ 346,083	-70.0%	$ 1,350,097	$ 1,957,194	-31.0%	$ 2,006,461	-32.7%
TOTAL PATIENT REVENUE	$ 103,968	$ 333,402	-68.8%	$ 346,083	-70.0%	$ 1,350,097	$ 1,957,194	-31.0%	$ 2,006,461	-32.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ (41,201)	$ 57,152	-172.1%	$ (39,743)	3.7%	$ (125,487)	$ 330,114	-138.0%	$ 637,937	-119.7%
Self Pay Adjustments	(9,744)	9,478	-202.8%	(6,108)	59.5%	(35,935)	54,745	-165.6%	91,630	-139.2%
Bad Debts	117,485	157,583	-25.4%	346,943	-66.1%	975,896	910,209	7.2%	1,018,865	-4.2%
TOTAL REVENUE DEDUCTIONS	$ 66,540	$ 224,213	-70.3%	$ 301,092	-77.9%	$ 814,474	$ 1,295,068	-37.1%	$ 1,748,433	-53.4%
	64.00%	67.25%		87.00%		60.33%	66.17%		87.14%	
NET PATIENT REVENUE	$ 37,428	$ 109,189	-65.7%	$ 44,991	-16.8%	$ 535,623	$ 662,126	-19.1%	$ 258,028	107.6%
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	$ 37,428	$ 109,189	-65.7%	$ 44,991	-16.8%	$ 535,623	$ 662,126	-19.1%	$ 258,028	107.6%
OPERATING EXPENSE										
Salaries and Wages	$ 33,435	$ 44,841	-25.4%	$ 52,570	-36.4%	$ 191,437	$ 263,233	-27.3%	$ 69,673	174.8%
Benefits	9,028	14,325	-37.0%	21,313	-57.6%	52,788	83,397	-36.7%	25,344	108.3%
Physician Services	27,539	81,922	-66.4%	66,819	-58.8%	275,577	612,397	-55.0%	597,621	-53.9%
Cost of Drugs Sold	(1,952)	3,147	-162.0%	4,666	-141.8%	11,245	18,474	-39.1%	19,309	-41.8%
Supplies	10,365	5,970	73.6%	4,151	149.7%	40,525	35,128	15.4%	28,395	42.7%
Utilities	2,381	2,594	-8.2%	2,348	1.4%	14,844	15,275	-2.8%	15,590	-4.8%
Repairs and Maintenance	-	477	-100.0%	2,498	-100.0%	-	2,862	-100.0%	3,814	-100.0%
Other Expense	-	10	-100.0%	-	0.0%	-	60	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 80,796	$ 153,286	-47.3%	$ 154,364	-47.7%	$ 586,415	$ 1,030,826	-43.1%	$ 759,745	-22.8%
Depreciation/Amortization	$ 40,117	$ 40,118	0.0%	$ 40,154	-0.1%	$ 240,703	$ 240,708	0.0%	$ 240,584	0.0%
TOTAL OPERATING COSTS	$ 120,913	$ 193,404	-37.5%	$ 194,518	-37.8%	$ 827,118	$ 1,271,534	-35.0%	$ 1,000,329	-17.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (83,485)**	**$ (84,215)**	**-0.9%**	**$ (149,527)**	**-44.2%**	**$ (291,496)**	**$ (609,408)**	**-52.2%**	**$ (742,301)**	**-60.7%**
Operating Margin	-223.06%	-77.13%	189.2%	-332.35%	-32.9%	-54.42%	-92.04%	-40.9%	-287.68%	-81.1%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	293	649	-54.9%	629	-53.4%	3,018	4,092	-26.2%	3,966	-23.9%
Optometry Visits	-	231	-100.0%	229	-100.0%	1,115	1,563	-28.7%	1,551	-28.1%
Total Visits	293	880	-66.7%	858	-65.9%	4,133	5,655	-26.9%	5,517	-25.1%
Average Revenue per Office Visit	354.84	378.87	-6.3%	403.36	-12.0%	326.66	346.11	-5.6%	363.69	-10.2%
Hospital FTE's (Salaries and Wages)	9.0	14.0	-35.5%	16.4	-45.2%	9.2	14.0	-34.4%	3.6	153.2%
Clinic FTE's - (Physician Services)	-	-	0.0%	(2.2)	-100.0%	-	-	0.0%	11.4	-100.0%

ECTOR COUNTY HOSPITAL DISTRICT
MARCH 2019

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	$ 39,470,418	38.6%	$ 35,554,670	38.1%	$ 236,561,740	39.3%	$ 211,211,404	38.3%
Medicaid	10,444,025	10.2%	9,007,909	9.6%	62,490,365	10.4%	51,521,753	9.3%
Commercial	29,221,101	28.6%	28,472,104	30.4%	171,788,902	28.6%	157,259,327	28.5%
Self Pay	19,056,200	18.7%	15,985,124	17.1%	106,670,749	17.8%	105,894,817	19.2%
Other	3,937,142	3.9%	4,508,136	4.8%	23,160,903	3.9%	25,712,641	4.7%
TOTAL	**$ 102,128,886**	**100.0%**	**$ 93,527,943**	**100.0%**	**$ 600,672,660**	**100.0%**	**$ 551,599,941**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 9,249,508	45.0%	$ 7,880,603	40.9%	$ 45,703,201	39.3%	$ 41,155,786	38.6%
Medicaid	2,103,627	10.3%	1,327,891	6.9%	13,179,606	11.3%	8,679,466	8.1%
Commercial	6,877,422	33.5%	7,784,517	40.4%	44,876,649	38.5%	39,324,561	36.8%
Self Pay	1,693,498	8.3%	1,516,636	7.9%	8,331,786	7.2%	7,815,153	7.3%
Other	589,661	2.9%	751,118	3.9%	4,360,986	3.7%	9,797,585	9.2%
TOTAL	**$ 20,513,716**	**100.0%**	**$ 19,260,763**	**100.0%**	**$ 116,452,226**	**100.0%**	**$ 106,772,551**	**100.0%**
TOTAL NET REVENUE	19,404,488		16,802,487		124,149,683		103,450,972	
% OF GROSS REVENUE	19.0%		18.0%		20.7%		18.8%	
VARIANCE	1,109,228		2,458,276		(7,697,457)		3,321,580	
% VARIANCE TO CASH COLLECTIONS	5.7%		14.6%		-6.2%		3.2%	

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
MARCH 2019

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	$ 59,267	14.4%	$ 23,651	7.0%	$ 376,053	14.1%	$ 209,472	9.6%
Medicaid	178,897	43.4%	147,758	43.4%	1,145,803	42.9%	820,008	37.6%
PHC	-	0.0%	-	0.0%	-	0.0%	26,649	1.2%
Commercial	79,310	19.2%	67,725	19.9%	519,387	19.4%	440,339	20.2%
Self Pay	94,141	22.8%	100,244	29.5%	626,309	23.4%	681,963	31.2%
Other	844	0.2%	572	0.2%	6,380	0.2%	3,870	0.2%
TOTAL	**$ 412,459**	**100.0%**	**$ 339,950**	**100.0%**	**$ 2,673,932**	**100.0%**	**$ 2,182,300**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 6,166	5.7%	$ 2,250	2.2%	$ 39,271	6.9%	$ 16,111	4.5%
Medicaid	53,979	49.7%	33,913	33.7%	254,719	44.9%	103,260	28.9%
PHC	-	0.0%	-	0.0%	-	0.0%	5,631	1.6%
Commercial	32,023	29.5%	46,103	45.8%	159,653	28.2%	123,014	34.5%
Self Pay	16,455	15.1%	18,257	18.1%	113,058	19.9%	108,452	30.4%
Other	-	0.0%	199	0.2%	305	0.1%	512	0.1%
TOTAL	**$ 108,624**	**100.0%**	**$ 100,721**	**100.0%**	**$ 567,006**	**100.0%**	**$ 356,981**	**100.0%**
TOTAL NET REVENUE	193,856		71,729		1,438,754		430,249	
% OF GROSS REVENUE	47.0%		21.1%		53.8%		19.7%	
VARIANCE	(85,233)		28,992		(871,748)		(73,268)	
% VARIANCE TO CASH COLLECTIONS	-44.0%		40.4%		-60.6%		-17.0%	

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
MARCH 2019

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	$ 23,431	22.5%	$ 45,622	13.2%	$ 224,602	16.6%	$ 245,362	12.2%
Medicaid	23,494	22.6%	$ 154,633	44.7%	534,760	39.7%	921,848	45.9%
PHC	-	0.0%	$ 10,004	2.9%	-	0.0%	58,382	2.9%
Commercial	16,254	15.6%	$ 62,676	18.1%	263,919	19.5%	383,543	19.1%
Self Pay	40,788	39.3%	$ 71,900	20.8%	326,521	24.2%	392,426	19.6%
Other	-	0.0%	$ 1,249	0.4%	294	0.0%	4,899	0.2%
TOTAL	**$ 103,968**	**100.0%**	**$ 346,083**	**100.0%**	**$ 1,350,097**	**100.0%**	**$ 2,006,461**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 8,501	24.8%	$ 1,142	2.6%	$ 55,404	17.4%	$ 9,239	5.1%
Medicaid	9,016	26.3%	12,870	29.4%	127,909	40.1%	48,465	26.9%
PHC	-	0.0%	-	0.0%	-	0.0%	3,496	1.9%
Commercial	12,090	35.2%	15,158	34.6%	92,905	29.2%	50,792	28.2%
Self Pay	4,695	13.7%	14,532	33.2%	42,528	13.3%	67,704	37.6%
Other	16	0.0%	118	0.3%	16	0.0%	578	0.3%
TOTAL	**$ 34,317**	**100.0%**	**$ 43,820**	**100.0%**	**$ 318,763**	**100.0%**	**$ 180,275**	**100.0%**
TOTAL NET REVENUE	37,428		44,991		535,623		258,028	
% OF GROSS REVENUE	36.0%		13.0%		39.7%		12.9%	
VARIANCE	(3,111)		(1,171)		(216,860)		(77,753)	
% VARIANCE TO CASH COLLECTIONS	-8.3%		-2.6%		-40.5%		-30.1%	

ECTOR COUNTY HOSPITAL DISTRICT
SCHEDULE OF CASH AND INVESTMENTS - HOSPITAL ONLY
MARCH 2019

Cash and Cash Equivalents	Frost	Hilltop	Total
Operating	$ 11,051,611	$ -	$ 11,051,611
Payroll	-	-	-
Worker's Comp Claims	-	-	-
Group Medical	-	-	-
Flex Benefits	(24,749)	-	(24,749)
Mission Fitness	427,091	-	427,091
Petty Cash	9,012	-	9,012
Dispro	-	525,116	525,116
Debt Service	-	-	-
Tobacco Settlement	-	-	-
General Liability	-	12,836	12,836
Professional Liability	-	5,757	5,757
Funded Worker's Compensation	-	12,530	12,530
Funded Depreciation	-	6,830,439	6,830,439
Designated Funds	-	24,590	24,590
Total Cash and Cash Equivalents	$ 11,462,965	$ 7,411,268	**$ 18,874,233**

Investments	Other	Hilltop	Total
Dispro	$ -	$ 4,738,000	$ 4,738,000
Funded Depreciation	-	34,000,000	34,000,000
Funded Worker's Compensation	-	2,221,000	2,221,000
General Liability	-	2,926,000	2,926,000
Professional Liability	-	3,000,000	3,000,000
Designated Funds	39,216	3,148,000	3,187,216
Allowance for Change in Market Values		(234,427)	(234,427)
Total Investments	$ 39,216	$ 49,798,573	**$ 49,837,789**
Total Unrestricted Cash and Investments			**$ 68,712,022**

Restricted Assets	Reserves	Prosperity	Total
Assets Held By Trustee - Bond Reserves	$ 2,812,074	$ -	$ 2,812,074
Assets Held By Trustee - Debt Payment Reserves	895,167	-	895,167
Assets Held In Endowment-Board Designated	-	6,255,412	6,255,412
Restricted TPC, LLC-Equity Stake	382,641	-	382,641
Restricted MCH West Texas Services-Equity Stake	2,185,854	-	2,185,854
Total Restricted Assets	$ 6,275,736	$ 6,255,412	**$ 12,531,148**
Total Cash & Investments			**$ 81,243,170**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
MARCH 2019

	Hospital	Procare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:			
Excess of Revenue over Expenses	$ 1,604,221	$ -	$ 1,604,221
Noncash Expenses:			
Depreciation and Amortization	9,159,972	25,297	9,185,269
Unrealized Gain/Loss on Investments	91,674	-	91,674
Accretion (Bonds)	-	-	-
Changes in Assets and Liabilities			
Patient Receivables, Net	(8,218,321)	295,200	(7,923,121)
Taxes Receivable/Deferred	7,488,241	446,340	7,934,581
Inventories, Prepaids and Other	6,497,716	(2,532,721)	3,964,995
Accounts Payable	200,683	11,805	212,488
Accrued Expenses	(3,794,641)	320,253	(3,474,388)
Due to Third Party Payors	592,213	-	592,213
Accrued Post Retirement Benefit Costs	3,500,000	-	3,500,000
Net Cash Provided by Operating Activities	$ 17,121,758	$ (1,433,826)	$ 15,687,932
Cash Flows from Investing Activities:			
Investments	$ (29,248,295)	$ -	$ (29,248,295)
Acquisition of Property and Equipment	(1,897,017)	53,333	(1,843,684)
Cerner Project Costs	-	-	-
Net Cash used by Investing Activities	$ (31,145,311)	$ 53,333	$ (31,091,978)
Cash Flows from Financing Activities:			
Intercompany Activities	(1,380,293)	1,380,293	-
Net Repayment of Long-term Debt/Bond Issuance	$ (1,595,880)	$ -	$ (1,595,880)
Net Cash used by Financing Activities	$ (2,976,173)	$ 1,380,293	$ (1,595,880)
Net Increase (Decrease) in Cash	$ (16,999,726)	$ (200)	$ (16,999,926)
Beginning Cash & Cash Equivalents @ 9/30/2018	$ 48,405,107	$ 5,200	$ 48,410,307
Ending Cash & Cash Equivalents @ 3/31/2019	$ 31,405,381	$ 5,000	$ 31,410,381
Balance Sheet			
Cash and Cash Equivalents	$ 18,874,233	$ 5,000	$ 18,879,233
Restricted Assets	12,531,148	-	12,531,148
Ending Cash & Cash Equivalents @ 3/31/2019	$ 31,405,382	$ 5,000	$ 31,410,381

ECTOR COUNTY HOSPITAL DISTRICT
TAX COLLECTIONS
FISCAL 2019

	ACTUAL COLLECTIONS	BUDGETED COLLECTIONS	VARIANCE	PRIOR YEAR COLLECTIONS	VARIANCE
AD VALOREM					
OCTOBER	$ 347,199	$ 1,324,858	$ (977,659)	$ 276,462	$ 70,737
NOVEMBER	863,534	1,324,858	(461,324)	584,006	279,527
DECEMBER	3,052,335	1,324,858	1,727,477	1,135,578	1,916,757
JANUARY	4,374,472	1,324,858	3,049,614	5,479,301	(1,104,829)
FEBRUARY	5,039,715	1,324,858	3,714,857	3,286,610	1,753,105
MARCH	1,683,658	1,324,858	358,800	3,496,754	(1,813,096)
TOTAL	$ 15,360,911	$ 7,949,148	$ 7,411,763	$ 14,258,711	$ 1,102,200
SALES					
OCTOBER	$ 4,584,041	$ 4,248,207	$ 335,834	$ 3,753,619	$ 830,423
NOVEMBER	4,601,483	4,563,509	37,974	3,777,148	824,335
DECEMBER	4,814,865	4,336,372	478,493	3,829,080	985,785
JANUARY	4,940,411	4,504,342	436,069	3,865,539	1,074,872
FEBRUARY	4,702,958	4,532,577	170,381	4,197,093	505,865
MARCH	4,472,410	4,594,896	(122,486)	4,263,080	209,330
TOTAL	$ 28,116,168	$ 26,779,903	$ 1,336,265	$ 23,685,558	$ 4,430,610
TAX REVENUE	**$ 43,477,079**	**$ 34,729,051**	**$ 8,748,028**	**$ 37,944,269**	**$ 5,532,811**

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAID SUPPLEMENTAL PAYMENTS
FISCAL YEAR 2019

CASH ACTIVITY	TAX (IGT) ASSESSED	GOVERNMENT PAYOUT	BURDEN ALLEVIATION	NET INFLOW
DSH				
1st Qtr	$ (2,108,131)	$ 5,042,169		$ 2,934,038
2nd Qtr	(948,218)	2,267,921		1,319,703
3rd Qtr	-	-		-
4th Qtr	-	-		-
DSH TOTAL	$ (3,056,349)	$ 7,310,091		$ 4,253,742
UC				
1st Qtr	$ (894,033)	$ 2,073,361		1,179,328
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
UC TOTAL	$ (894,033)	$ 2,073,361		$ 1,179,328
Regional UPL (Community Benefit)				
1st Qtr	$ (4,805,375)	$ -		$ (4,805,375)
2nd Qtr	(1,202,741)	-		(1,202,741)
3rd Qtr	-	-		-
4th Qtr	-	-		-
REGIONAL UPL TOTAL	$ (6,008,116)	$ -		$ (6,008,116)
DSRIP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	(7,632,806)	18,330,182		10,697,375
3rd Qtr	-	-		-
4th Qtr	-	-		-
DSRIP UPL TOTAL	$ (7,632,806)	$ 18,330,182		$ 10,697,375
UHRIP				
1st Qtr	$ (1,801,944)	$ -		$ (1,801,944)
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
UHRIP TOTAL	$ (1,801,944)	$ -		$ (1,801,944)
GME				
1st Qtr	$ -	$ -		$ -
2nd Qtr	(106,315)	254,281		147,966
3rd Qtr	-	-		-
4th Qtr	-	-		-
UHRIP TOTAL	$ (106,315)	$ 254,281		$ 147,966
MCH Cash Activity	**$ (19,499,564)**	**$ 27,967,915**		**$ 8,468,351**
ProCare Cash Activity			$ 4,375,000	**$ 4,375,000**
Blended Cash Activity	**$ (19,499,564)**	**$ 27,967,915**	**$ 4,375,000**	**$ 12,843,351**

INCOME STATEMENT ACTIVITY:	MCH	PROCARE	BLENDED
FY 2019 Accrued / (Deferred) Adjustments:			
DSH Accrual	$ 1,962,594	$ -	$ 1,962,594
Uncompensated Care Accrual	4,466,658	-	4,466,658
Regional UPL Accrual	(4,741,800)	-	(4,741,800)
URIP	(1,454,248)	-	(1,454,248)
GME	147,966	-	147,966
Regional UPL Benefit	-	4,375,000	4,375,000
Medicaid Supplemental Payments	381,171	4,375,000	4,756,171
DSRIP Accrual	5,829,948	-	5,829,948
Total Adjustments	**$ 6,211,119**	**$ 4,375,000**	**$ 10,586,119**

ECTOR COUNTY HOSPITAL DISTRICT
CONSTRUCTION IN PROGRESS - HOSPITAL ONLY
AS OF MARCH 31, 2019

ITEM	CIP BALANCE AS OF 2/28/2019	MARCH "+" ADDITIONS	MARCH "-" ADDITIONS	MARCH TRANSFERS	CIP BALANCE AS OF 3/31/2019	ADD: AMOUNTS CAPITALIZED	PROJECT TOTAL	BUDGETED AMOUNT	UNDER/(OVER) APRVD/BUDGET
RENOVATIONS									
ISOLATION ROOM RENOVATIONS	2,801	-	-	-	2,801	-	2,801	25,000	22,200
CAFETERIA RENOVATION	73,751	-	(9,365)	-	64,386	-	64,386	150,000	85,614
RADIOLOGY SCHEDULING OFFICE RENOVATION	7,343	285	-	-	7,628	-	7,628	25,000	17,372
PROCARE ADMIN RENOVATION	19,193	2,369	-	-	21,562	-	21,562	45,000	23,438
ER RENOVATION	18,797	13,069	-	-	31,866	-	31,866	125,000	93,134
NURSING EDUCATION	-	855	-	-	855	-	855	125,000	124,145
DIETARY FLOOR	-	-	-	-	-	-	-	150,000	150,000
SUB-TOTAL	$ 121,884	$ 16,579	$ (9,365)	$ -	$ 129,097	$ -	$ 129,097	$ 645,000	$ 515,903
MINOR BUILDING IMPROVEMENT									
ICU LOGISTICS MANAGEMENT SPACE	30,286	1,684	-	-	31,970	-	31,970	45,000	13,030
FURNITURE UPDATE: PHASE 3	-	-	-	-	-	-	-	45,000	45,000
CASA ORTIZ ROOF	-	600	-	-	600	-	600	35,000	34,400
ONE DOCTOR PLACE/TRAUMA	-	7,699	-	-	7,699	-	7,699	45,000	37,301
OUTDOOR COMMON AREA IMPROVEMENTS	-	-	-	-	-	-	-	45,000	45,000
9C TELEMETRY UPGRADE	-	-	-	-	-	-	-	45,000	45,000
SUB-TOTAL	$ 30,286	$ 9,983	$ -	$ -	$ 40,269	$ -	$ 40,269	$ 260,000	$ 219,731
EQUIPMENT & SOFTWARE PROJECTS - CIP INCOMPLETE									
VARIOUS CAPITAL EXPENDITURE PROJECTS	$ 154,505	$ 59,865	$ (83,957)	$ -	$ 130,414	$ -	$ 130,414	$ 1,100,000	$ 969,586
SUB-TOTAL	$ 154,505	$ 59,865	$ (83,957)	$ -	$ 130,414	$ -	$ 130,414	$ 1,100,000	$ 969,586
TOTAL CONSTRUCTION IN PROGRESS	**$ 306,675**	**$ 86,426**	**$ (93,322)**	**$ -**	**$ 299,780**	**$ -**	**$ 299,780**	**$ 2,005,000**	**$ 1,705,220**

ECTOR COUNTY HOSPITAL DISTRICT
CAPITAL PROJECT & EQUIPMENT EXPENDITURES
MARCH 2019

DEPT	ITEM	CLASS	BOOKED AMOUNT
	TRANSFERRED FROM CONSTRUCTION IN PROGRESS/RENOVATION PROJECTS		
	None		
	TOTAL PROJECT TRANSFERS		**$ -**
	EQUIPMENT PURCHASES		
	None		$ -
	TOTAL EQUIPMENT PURCHASES		**$ -**
	TOTAL TRANSFERS FROM CIP/EQUIPMENT PURCHASES		**$ -**

ECTOR COUNTY HOSPITAL DISTRICT
FISCAL 2019 CAPITAL EQUIPMENT
CONTINGENCY FUND
MARCH 2019

MONTH/ YEAR	DESCRIPTION	DEPT NUMBER	BUDGETED AMOUNT	P.O AMOUNT	ACTUAL AMOUNT	TO/(FROM) CONTINGENCY
	Available funds from budget		**$ 600,000**	**$ -**	**$ -**	**$ 600,000**
Oct-18	Birthing Bed	6700	-		33,000	(33,000)
Nov-18	SmartPump	6620	-	-	8,207	(8,207)
Nov-18	Endoscope	6790	-	-	17,664	(17,664)
Jan-19	Infusion Pump	6700			41,860	(41,860)
Jan-19	Laryngoscope	7370			29,475	(29,475)
Jan-19	Laparoscope	6620			10,000	(10,000)
Feb-19	CO2 Endoscopic Insufflator	6600			4,995	(4,995)
			$ 600,000	**$ -**	**$ 145,202**	**$ 454,798**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF ACCOUNTS RECEIVABLE - OTHER
MARCH 2019

	CURRENT YEAR	PRIOR YEAR HOSPITAL AUDITED	PRIOR YEAR PRO CARE AUDITED	CURRENT YEAR CHANGE
AR DISPRO/UPL	$ (2,291,148)	$ -	$ -	$ (2,291,148)
AR UNCOMPENSATED CARE	4,057,579	770,249	-	3,287,330
AR DSRIP	3,605,284	8,472,711	-	(4,867,427)
AR NURSING HOME UPL	-	-	-	-
AR UHRIP	2,680,086	2,332,390	-	347,697
AR GME	-	-	-	-
AR BAB REVENUE	82,117	84,413	-	(2,296)
AR PHYSICIAN GUARANTEES	572,941	568,942	-	3,999
AR ACCRUED INTEREST	283,628	46,923	-	236,705
AR OTHER:	6,103,201	5,923,220	1,919,795	(1,739,814)
Procare On-Call Fees	25,500	-	51,000	(25,500)
Procare A/R - FHC	-	-	-	-
Other Misc A/R	6,077,701	5,923,220	1,868,795	(1,714,314)
AR DUE FROM THIRD PARTY PAYOR	2,642,427	1,599,384	-	1,043,042
TOTAL ACCOUNTS RECEIVABLE - OTHER	$ 18,545,735	$ 20,607,851	$ 1,919,795	$ (3,981,912)

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF HOSPITAL TEMPORARY LABOR FTE'S
MARCH 2019

	CURRENT MONTH					YEAR TO DATE				
TEMPORARY LABOR DEPARTMENT	**ACTUAL**	**BUDGET**	**BUDGET VAR**	**PRIOR YR**	**PRIOR YR VAR**	**ACTUAL**	**BUDGET**	**BUDGET VAR**	**PRIOR YR**	**PRIOR YR VAR**
IT OPERATIONS	1.1	-	0.0%	-	0.0%	1.1	-	0.0%	-	0.0%
INPATIENT REHAB	-	1.8	-100.0%	1.7	-100.0%	0.7	1.8	-62.9%	1.7	-60.4%
9 CENTRAL	2.0	0.8	147.3%	0.1	2826.9%	1.7	0.9	102.2%	0.0	14554.5%
CARDIOPULMONARY	-	0.7	-100.0%	3.6	-100.0%	0.4	0.7	-49.9%	1.5	-74.5%
LABOR AND DELIVERY	0.1	0.8	-88.0%	0.5	-81.9%	0.0	0.8	-98.0%	1.6	-99.0%
NEO-NATAL INTENSIVE CARE	-	0.6	-100.0%	0.0	-100.0%	0.0	0.6	-96.3%	1.1	-97.9%
4 EAST	0.5	0.8	-35.4%	1.0	-47.1%	0.1	0.9	-89.3%	1.1	-91.6%
TRAUMA SERVICE	1.1	-	0.0%	1.1	5.5%	0.5	-	0.0%	1.0	-47.9%
OPERATING ROOM	-	0.8	-100.0%	0.2	-100.0%	-	0.8	-100.0%	1.3	-100.0%
INTENSIVE CARE UNIT 2	-	0.3	-100.0%	0.1	-100.0%	0.3	0.3	-3.9%	1.1	-69.3%
PM&R - OCCUPATIONAL	-	0.6	-100.0%	0.8	-100.0%	0.5	0.6	-23.4%	0.8	-37.9%
INTENSIVE CARE UNIT 4 (CCU)	-	0.3	-100.0%	0.8	-100.0%	0.4	0.3	46.8%	0.6	-34.3%
STERILE PROCESSING	3.7	0.5	625.7%	0.7	398.8%	4.5	0.5	754.9%	0.5	720.3%
PATIENT ACCOUNTING	-	0.3	-100.0%	-	0.0%	0.3	0.3	-6.1%	-	0.0%
EMERGENCY DEPARTMENT	-	0.3	-100.0%	-	0.0%	-	0.3	-100.0%	0.4	-100.0%
PHARMACY DRUGS/I.V. SOLUTIONS	-	-	0.0%	-	0.0%	-	-	0.0%	0.4	-100.0%
PM&R - PHYSICAL	-	0.2	-100.0%	-	0.0%	-	0.2	-100.0%	0.3	-100.0%
FINANCIAL ACCOUNTING	1.8	-	0.0%	-	0.0%	1.1	-	0.0%	-	0.0%
5 WEST	-	0.1	-100.0%	0.5	-100.0%	-	0.1	-100.0%	0.1	-100.0%
CARDIOPULMONARY - NICU	-	0.1	-100.0%	-	0.0%	-	0.1	-100.0%	0.2	-100.0%
ENGINEERING	-	-	0.0%	-	0.0%	-	-	0.0%	0.2	-100.0%
4 CENTRAL	-	0.0	-100.0%	-	0.0%	0.0	0.0	-47.9%	-	0.0%
8 CENTRAL	-	0.0	-100.0%	-	0.0%	-	0.0	-100.0%	-	0.0%
6 Central	-	0.0	-100.0%	-	0.0%	0.0	0.0	109.7%	0.0	-5.1%
7 CENTRAL	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
PERFORMANCE IMPROVEMENT (QA)	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
CHW - SPORTS MEDICINE	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
6 West	-	0.0	-100.0%	-	0.0%	-	0.0	-100.0%	-	0.0%
HUMAN RESOURCES	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
5 CENTRAL	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
OP SURGERY	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
IMAGING - NUCLEAR MEDICINE	1.1	-	0.0%	-	0.0%	0.5	-	0.0%	-	0.0%
IMAGING - ULTRASOUND	1.1	-	0.0%	-	0.0%	0.9	-	0.0%	-	0.0%
CERNER	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
FOOD SERVICE	-	-	0.0%	-	0.0%	0.5	-	0.0%	-	0.0%
INPATIENT REHAB - THERAPY	0.3	-	0.0%	-	0.0%	0.7	-	0.0%	-	0.0%
IMAGING - DIAGNOSTICS	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
RECOVERY ROOM	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
LABORATORY - CHEMISTRY	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
LABORATORY - MICROBIOLOGY	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
LABORATORY - TRANFUSION SERVICES	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
PM&R - SPEECH	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
MEDICAL STAFF	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
SUBTOTAL	**12.9**	**9.3**	**38.7%**	**11.1**	**15.9%**	**14.3**	**9.5**	**50.9%**	**13.8**	**3.4%**
TRANSITION LABOR										
INTENSIVE CARE UNIT 4 (CCU)	3.0	6.1	-50.0%	7.2	-57.8%	3.7	6.2	-39.3%	10.4	-63.9%
7 CENTRAL	3.1	5.3	-40.9%	5.0	-37.3%	3.6	5.5	-34.5%	5.6	-36.1%
NEO-NATAL INTENSIVE CARE	5.2	3.7	41.6%	4.3	21.3%	5.8	3.9	50.1%	3.6	63.1%
INTENSIVE CARE UNIT 2	2.2	2.3	-6.7%	3.8	-42.8%	1.9	2.4	-20.1%	3.4	-44.5%
8 CENTRAL	1.5	3.3	-54.4%	3.4	-55.2%	2.7	3.5	-23.7%	3.8	-30.1%
INPATIENT REHAB	1.3	3.7	-64.7%	2.9	-55.5%	1.5	3.8	-59.5%	2.9	-47.1%
6 Central	1.3	2.7	-52.4%	2.1	-39.2%	0.9	2.8	-68.4%	3.0	-70.5%
4 EAST	2.4	2.6	-7.9%	3.1	-22.3%	2.0	2.7	-24.1%	2.8	-28.5%
LABORATORY - CHEMISTRY	5.4	2.2	145.2%	2.4	127.5%	4.3	2.2	92.1%	2.1	100.6%
OPERATING ROOM	1.8	2.1	-16.0%	2.1	-16.1%	1.9	2.1	-8.6%	2.1	-6.5%
EMERGENCY DEPARTMENT	-	0.6	-100.0%	1.2	-100.0%	0.5	0.6	-17.7%	1.9	-72.8%
5 CENTRAL	-	1.1	-100.0%	2.1	-100.0%	0.5	1.1	-55.8%	1.7	-71.2%
LABORATORY - HEMATOLOGY	1.0	1.2	-18.8%	1.2	-17.7%	1.1	1.2	-15.6%	1.2	-11.2%
OP SURGERY	-	1.0	-100.0%	1.0	-100.0%	-	1.0	-100.0%	1.0	-100.0%
PM&R - OCCUPATIONAL	0.9	0.5	72.7%	0.6	52.3%	1.0	0.5	98.5%	0.4	177.4%
CHW - SPORTS MEDICINE	-	0.3	-100.0%	0.0	-100.0%	-	0.3	-100.0%	0.6	-100.0%
4 CENTRAL	0.1	0.4	-80.8%	0.2	-64.7%	0.0	0.4	-93.9%	0.5	-95.2%
PM&R - PHYSICAL	-	0.3	-100.0%	-	0.0%	-	0.4	-100.0%	0.5	-100.0%
INPATIENT REHAB - THERAPY	1.0	-	0.0%	-	0.0%	0.9	-	0.0%	-	0.0%
9 CENTRAL	0.1	0.3	-54.8%	0.1	6.2%	0.1	0.3	-63.8%	0.4	-66.9%
LABOR AND DELIVERY	0.2	0.1	240.9%	0.1	50.0%	0.0	0.1	-24.6%	0.1	-33.2%
6 West	0.1	0.1	9.1%	0.1	0.0%	0.0	0.1	-64.0%	0.1	-72.5%
5 WEST	-	0.0	-100.0%	-	0.0%	-	0.0	-100.0%	0.0	-100.0%
CERNER	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TRAUMA SERVICE	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
SUBTOTAL	**30.5**	**39.8**	**-23.4%**	**42.8**	**-28.7%**	**32.5**	**41.0**	**-20.6%**	**47.9**	**-32.1%**
GRAND TOTAL	**43.4**	**49.1**	**-11.7%**	**53.9**	**-19.5%**	**46.8**	**50.4**	**-7.2%**	**61.7**	**-24.2%**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF TEMPORARY LABOR, TRANSITION LABOR & PURCHASED SERVICES - HOSPITAL ONLY
MARCH 2019

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR
SP TEMPORARY LABOR	$ 37,220	$ 4,953	$ 32,267	651.5%	$ 6,238	496.7%	$ 304,935	$ 29,487	$ 275,448	934.1%	$ 33,019	823.5%
TELECOM TEMPORARY LABOR	20,416	-	20,416	100.0%	-	100.0%	86,678	-	86,678	100.0%	-	100.0%
US TEMPORARY LABOR	16,785	-	16,785	100.0%	-	100.0%	85,211	-	85,211	100.0%	-	100.0%
IMCU9 TEMPORARY LABOR	22,864	8,903	13,961	156.8%	919	2388.6%	115,096	54,449	60,647	111.4%	919	12427.5%
REHAB TEMPORARY LABOR	5	15,684	(15,679)	-100.0%	19,413	-100.0%	61,281	94,104	(32,823)	-34.9%	81,337	-24.7%
ALL OTHER	57,274	74,494	(17,220)	-23.1%	125,490	-54.4%	339,178	446,300	(107,122)	-24.0%	880,182	-61.5%
TOTAL TEMPORARY LABOR	$ 154,563	$ 104,034	$ 50,529	48.6%	$ 152,060	1.6%	$ 992,379	$ 624,340	$ 368,039	58.9%	$ 995,457	-0.3%
NICU TRANSITION LABOR	$ 58,262	$ 40,920	$ 17,342	42.4%	$ 50,227	16.0%	$ 394,311	$ 251,446	$ 142,865	56.8%	$ 232,203	69.8%
CHEM TRANSITION LABOR	43,576	18,598	24,978	134.3%	20,040	117.4%	195,177	110,702	84,475	76.3%	106,204	83.8%
OT TRANSITION LABOR	10,437	5,497	4,940	89.9%	7,770	34.3%	72,407	32,659	39,748	121.7%	23,426	209.1%
ICU2 TRANSITION LABOR	23,307	27,695	(4,388)	-15.8%	46,459	-49.8%	136,520	165,010	(28,490)	-17.3%	235,629	-42.1%
4E TRANSITION LABOR	25,228	28,099	(2,871)	-10.2%	34,365	-26.6%	133,045	170,459	(37,414)	-21.9%	179,954	-26.1%
8C TRANSITION LABOR	25,940	41,258	(15,318)	-37.1%	40,617	-36.1%	196,146	253,006	(56,860)	-22.5%	276,699	-29.1%
7C TRANSITION LABOR	32,187	56,040	(23,853)	-42.6%	53,903	-40.3%	225,436	342,049	(116,613)	-34.1%	350,924	-35.8%
6C TRANSITION LABOR	12,886	31,031	(18,145)	-58.5%	23,832	-45.9%	55,957	189,818	(133,861)	-70.5%	198,248	-71.8%
REHAB TRANSITION LABOR	15,340	50,241	(34,901)	-69.5%	41,906	-63.4%	109,969	301,446	(191,477)	-63.5%	238,277	-53.8%
ICU4 TRANSITION LABOR	29,005	76,086	(47,081)	-61.9%	92,241	-68.6%	220,491	452,984	(232,493)	-51.3%	767,796	-71.3%
ALL OTHER	44,555	89,153	(44,598)	-50.0%	111,048	-59.9%	355,399	533,530	(178,131)	-33.4%	700,424	-49.3%
TOTAL TRANSITION LABOR	$ 320,721	$ 464,618	$ (143,897)	-31.0%	$ 522,407	-38.6%	$ 2,094,858	$ 2,803,109	$ (708,251)	-25.3%	$ 3,309,784	-36.7%
GRAND TOTAL TEMPORARY LABOR	$ 475,284	$ 568,652	$ (93,368)	-16.4%	$ 674,467	-29.5%	$ 3,087,238	$ 3,427,449	$ (340,211)	-9.9%	$ 4,305,240	-28.3%
HIM CODING SERVICES	$ 342,383	$ 85,265	$ 257,118	301.6%	$ 122,534	179.4%	$ 3,027,956	$ 611,085	$ 2,416,871	395.5%	$ 462,120	555.2%
PT ACCTS COLLECTION FEES	462,073	155,329	306,744	197.5%	110,112	319.6%	2,546,652	946,111	1,600,541	169.2%	566,141	349.8%
CE OTHER PURCH SVCS	352,119	63,502	288,617	454.5%	63,750	452.3%	1,027,973	381,012	646,961	169.8%	378,417	171.7%
ADM CONSULTANT FEES	101,233	40,119	61,114	152.3%	28,208	258.9%	823,490	240,714	582,776	242.1%	184,368	346.7%
PA ELIGIBILITY FEES	116,515	27,617	88,898	321.9%	(39,091)	-398.1%	279,103	136,833	142,270	104.0%	125,722	122.0%
DIALYSIS SERVICES	157,267	126,456	30,811	24.4%	122,634	28.2%	888,166	752,739	135,427	18.0%	781,154	13.7%
IT INFORMATION SOLUTIONS SVCS	16,161	-	16,161	100.0%	15,450	4.6%	119,867	-	119,867	100.0%	207,848	-42.3%
FIN ACCT COST REPORT/CONSULTANT FEES	82,256	5,482	76,774	1400.5%	7,332	1021.8%	144,523	36,189	108,334	299.4%	97,312	48.5%
COMM REL ADVERTISMENT PURCH SVCS	41,155	18,866	22,289	118.1%	4,245	869.5%	224,030	144,642	79,388	54.9%	157,099	42.6%
ADMIN OTHER FEES	107,930	14,038	93,892	668.8%	20,155	435.5%	160,524	84,228	76,296	90.6%	86,489	85.6%
HR RECRUITING FEES	9,502	5,810	3,692	63.5%	80,524	-88.2%	158,157	83,068	75,089	90.4%	156,017	1.4%
DIET OTHER PURCH SVCS	12,070	4,440	7,630	171.9%	5,316	127.0%	62,845	26,640	36,205	135.9%	22,949	173.8%
INFECTION CONTROL OTHER PURCH SVCS	9,418	3,974	5,444	137.0%	-	100.0%	56,507	24,241	32,266	133.1%	-	100.0%
REHAB OTHER PURCH SVCS	10,052	7,320	2,732	37.3%	5,950	68.9%	75,401	43,920	31,481	71.7%	34,662	117.5%
TS OTHER PURCH SVCS	6,947	5,684	1,263	22.2%	5,119	35.7%	55,410	25,228	30,182	119.6%	19,367	186.1%
ADM CONTRACT STRYKER	29,417	25,979	3,438	13.2%	16,669	76.5%	185,201	158,239	26,962	17.0%	168,634	9.8%
COMM REL WELLNESS WORKS	21,960	21,954	6	0.0%	21,530	2.0%	155,444	131,724	23,720	18.0%	130,022	19.6%
OR FEES (PERFUSION SERVICES)	23,523	10,601	12,922	121.9%	19,223	22.4%	154,765	132,034	22,731	17.2%	158,626	-2.4%
ADM APPRAISAL DIST FEE	-	13,679	(13,679)	-100.0%	-	100.0%	101,461	82,074	19,387	23.6%	50,717	100.1%
CL OTHER PURCH SVCS	15,766	12,938	2,828	21.9%	12,222	29.0%	94,755	80,009	14,746	18.4%	72,782	30.2%
340B CONTRACT PURCH SVC	7,379	7,338	41	0.6%	9,418	-21.7%	58,332	44,028	14,304	32.5%	14,421	304.5%
ECHD POLICE DEPT OTHER PURCH SVCS	17,990	15,725	2,265	14.4%	2,817	538.6%	108,604	94,350	14,254	15.1%	89,859	20.9%
4E OTHER PURCH SVCS	7,452	51,505	(44,053)	-85.5%	5,524	34.9%	71,916	97,569	(25,653)	-26.3%	61,073	17.8%
UC-WEST CLINIC - PURCH SVCS-OTHER	27,797	43,250	(15,453)	-35.7%	49,732	-44.1%	186,789	226,786	(39,997)	-17.6%	199,606	-6.4%
ADMIN LEGAL FEES	(210,912)	40,878	(251,790)	-616.0%	39,993	-627.4%	203,533	245,268	(41,735)	-17.0%	150,764	35.0%
MED ASSETS CONTRACT	23,517	23,946	(429)	-1.8%	65,467	-64.1%	82,961	133,177	(50,216)	-37.7%	143,502	-42.2%
FA AUDIT FEES - INTERNAL	3,600	47,657	(44,057)	-92.4%	49,280	-92.7%	62,240	113,925	(51,685)	-45.4%	94,520	-34.2%
PI FEES (TRANSITION NURSE PROGRAM)	76,165	57,336	18,829	32.8%	14,725	417.2%	290,999	344,016	(53,017)	-15.4%	196,435	48.1%
PHARMACY SERVICES	24,639	35,617	(10,978)	-30.8%	54,430	-54.7%	166,713	211,149	(44,436)	-21.0%	136,911	21.8%
HISTOLOGY SERVICES	27,858	68,799	(40,941)	-59.5%	30,869	-9.8%	189,490	246,261	(56,771)	-23.1%	237,161	-20.1%
MISSION FITNESS CONTRACT PURCH SVC	(12,260)	59,236	(71,496)	-120.7%	61,961	-119.8%	293,817	351,844	(58,027)	-16.5%	338,083	-13.1%
PRO OTHER PURCH SVCS	8,783	23,982	(15,199)	-63.4%	17,723	-50.4%	60,660	143,437	(82,777)	-57.7%	122,053	-50.3%
COMM REL MEDIA PLACEMENT	7,272	47,500	(40,229)	-84.7%	17,027	-57.3%	149,772	274,038	(124,266)	-45.3%	220,822	-32.2%
SP OTHER PURCH SVCS	-	34,301	(34,301)	-100.0%	-	100.0%	61,858	201,381	(139,523)	-69.3%	7,000	783.7%
UC-CPC 42ND STREET PURCH SVCS-OTHER	34,327	68,606	(34,279)	-50.0%	63,046	-45.6%	223,636	375,881	(152,245)	-40.5%	367,892	-39.2%
PA E-SCAN DATA SYSTEM	156,306	121,506	34,800	28.6%	155,983	0.2%	550,301	729,036	(178,735)	-24.5%	490,380	12.2%
ECHDA OTHER PURCH SVCS	21,816	142,208	(120,392)	-84.7%	2,010	985.4%	607,053	853,248	(246,195)	-28.9%	6,326	9496.2%
PRIMARY CARE WEST OTHER PURCH SVCS	27,539	81,922	(54,383)	-66.4%	66,819	-58.8%	275,577	612,397	(336,820)	-55.0%	597,621	-53.9%
FHC OTHER PURCH SVCS	111,559	120,968	(9,409)	-7.8%	73,345	52.1%	593,542	944,096	(350,554)	-37.1%	940,522	-36.9%
ALL OTHERS	2,050,961	1,764,175	286,786	16.3%	1,010,604	102.9%	11,244,343	11,310,494	(66,151)	-0.6%	4,927,069	128.2%
TOTAL PURCHASED SERVICES	$ 4,329,534	$ 3,505,508	$ 824,026	23.5%	$ 2,412,656	79.5%	$ 25,824,363	$ 21,673,111	$ 4,151,252	19.2%	$ 13,202,463	95.6%

Ector County Hospital District
Debt Service Coverage Calculation
MARCH 2019

Average Annual Debt Service Requirements of 110%:

	FYTD			Annualized
	ProCare	ECHD	Consolidated	Consolidated
Change in net position	-	1,604,221	1,604,221	3,208,442
Deficiency of revenues over expenses	-	1,604,221	1,604,221	3,208,442
Depreciation/amortization	119,805	9,357,874	9,477,679	18,955,358
GASB 68	-	3,500,000	3,500,000	7,000,000
Interest expense	-	1,553,489	1,553,489	3,106,979
(Gain) or loss on fixed assets	-	-	-	-
Unusual / infrequent / extraordinary items	-	-	-	-
Unrealized (gains) / losses on investments	-	(91,674)	(91,674)	(183,347)
Consolidated net revenues	119,805	15,923,911	16,043,716	32,087,432

Note: Average annual debt service requirements is defined to mean the greater of the following 2 calculations:

1.) Average annual debt service of future maturities

	Bonds	BAB Subsidy	Total	110%
2019	3,704,003.09	1,050,540.12	4,754,543.21	5,229,997.53
2020	3,703,513.46	1,014,199.56	4,717,713.02	5,189,484.33
2021	3,703,965.62	975,673.80	4,679,639.42	5,147,603.37
2022	3,703,363.82	930,657.44	4,634,021.26	5,097,423.38
2023	3,704,094.49	883,666.27	4,587,760.76	5,046,536.84
2024	3,703,936.71	834,581.31	4,538,518.02	4,992,369.83
2025	3,703,757.92	783,331.19	4,487,089.11	4,935,798.02
2026	3,703,381.35	729,820.73	4,433,202.08	4,876,522.29
2027	3,702,861.24	670,848.36	4,373,709.60	4,811,080.56
2028	3,703,256.93	609,138.35	4,312,395.28	4,743,634.81
2029	3,702,288.56	544,540.00	4,246,828.56	4,671,511.42
2030	3,701,769.56	476,952.84	4,178,722.40	4,596,594.64
2031	3,701,420.06	406,226.18	4,107,646.24	4,518,410.86
2032	3,701,960.19	332,209.33	4,034,169.52	4,437,586.47
2033	3,701,063.45	254,726.47	3,955,789.92	4,351,368.91
2034	3,700,496.62	173,652.02	3,874,148.64	4,261,563.50
2035	3,700,933.18	88,810.18	3,789,743.36	4,168,717.70
	3,702,709.78	632,916.13	4,335,625.91	

OR

2.) Next Year Debt Service - sum of principal and interest due in the next fiscal year:

	Bonds	
Debt Service	4,754,543	*higher of the two*

	Current FYTD		
Covenant Computation	**337.4%**	(needs to be 110% or higher)	**674.9%**

Liquidity Requirement

Cash on Hand Requirement

2019	60
2020	80
2021+	100

	MARCH 2019
Consolidated operating costs	195,538,308
Less depreciation and amortization	(9,477,679)
Less other non cash expenses:	
GASB 68 - from above	(3,500,000.00)
GASB 75 - from above	-
Adjusted expenses	182,560,629
Expenses per day	**1,003,080**
Unrestricted cash and cash equivalents	18,879,233
Internally designated noncurrent cash and investments	49,837,789
Assets held in endowment, board designated	6,255,412
Total cash for calculation	**74,972,434**
Days cash on hand	**74.74**

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED RATIO ANALYSIS
MARCH 31, 2019

		YTD MARCH 2019	2017 S&P Comparison**	YTD September 2018	YTD September 2017	YTD September 2016
Statement of Operations:						
Salaries & Benefits/Net Pt Rev (%)	↑	46.6	56.4	41.1	69.1	68.6
Bad Debt Exp/Total Operating Revenue (%)	↑	36.2	N/A	18.4	34.6	34.1
Maximum Debt Service Coverage (x)	↓	24.2	2.5	34.3	7.1	7.9
Maximum Debt Service/Total Operating Rev	↑	1.2	N/A	1.1	1.7	1.8
Interest Coverage (x) [1]						
EBITDA Margin (%) [1]	↓	23.3	8.0	30.8	51.7	7.2
Operating Margin (%)	↓	9.3	-0.3	24.6	-0.7	0.7
Profit Margin (%)	↓	17.7	1.4	25.2	47.4	-1.2
Balance Sheet:						
Average Age Net Fixed Assets (years)	↑	14.9	12.4	13.8	12.7	11.7
Cushion Ratio (x)	↑	19.8	13.3	15.0	11.3	22.4
Days' Cash on Hand	↑	74.7	159.1	63.7	58.9	120.2
Days in Accounts Receivable	↓	52.4	46.8	57.5	53.6	54.6
Cash Flow/Total Liabilities (%)	↓	59.3	9.9	89.8	160.9	10.9
Unrestricted Cash/Long-Term Debt (%)	↑	173.0	131.3	129.4	177.7	193.1
Long-Term Debt/Capitilization (%)	↓	18.4	34.3	19.2	18.0	18.6
Payment Period (days)	↓	60.9	N/A	65.5	57.9	51.0
Other Ratios:						
Inventory Turnover [2]	↑	8.2	17.0	7.8	12.0	12.1

****National medians based on Standard and Poors *U.S. Not-For Profit Health Care Stand-Alone Ratios***

Note 1: EBITDA - Earnings before interest, taxes, depreciation, and amortization
Note 2: Inventory Turnover - this ratio is not reported by Standard & Poor's, Moodys or Fitch. The median of 17 was obtained by contacting several like size facilities within the VHA-SW group resulting in a range of 15 to 18.

Financial Presentation

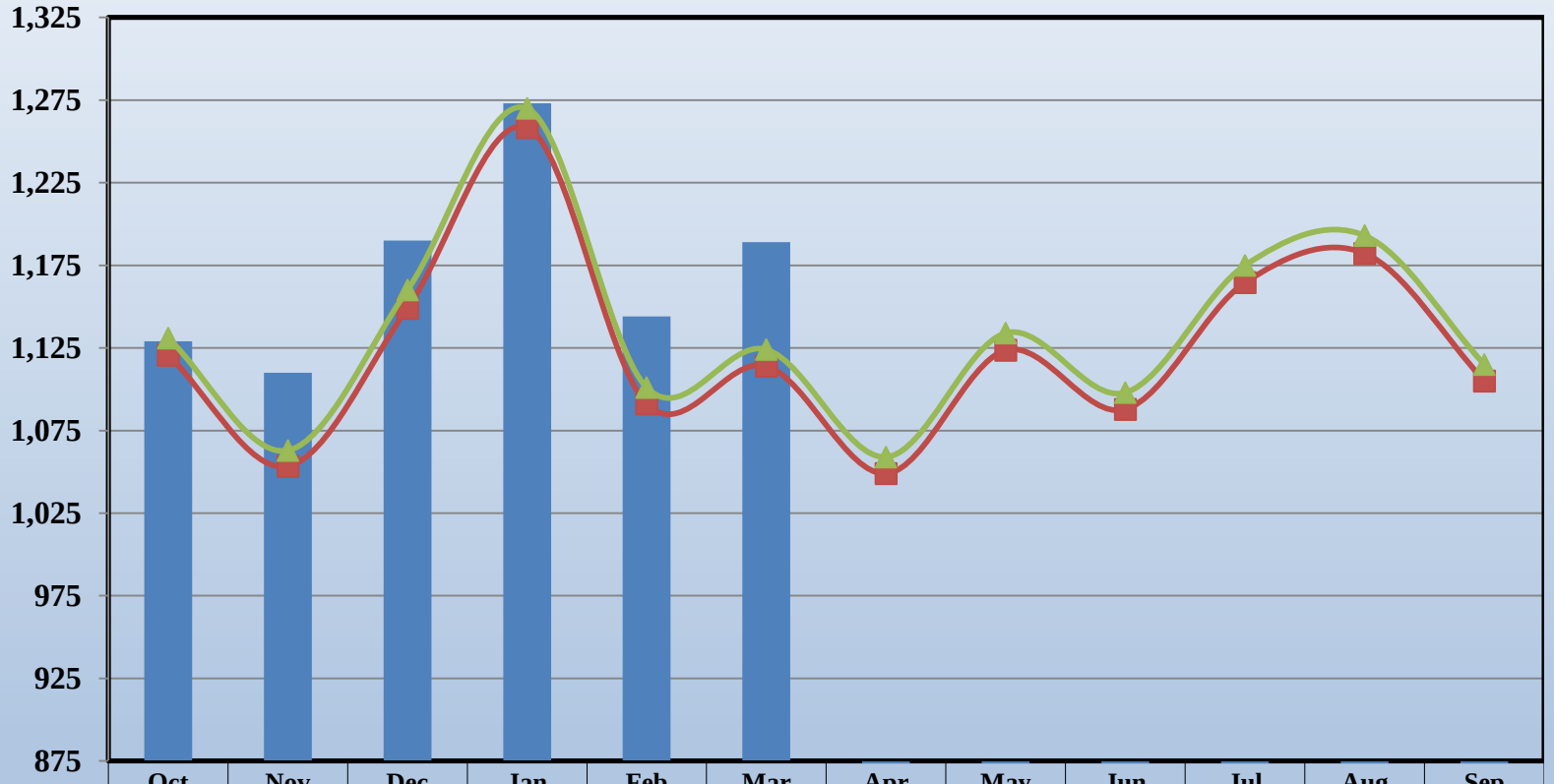
For the Month Ended

March 31, 2019


Volume
mch

Admissions

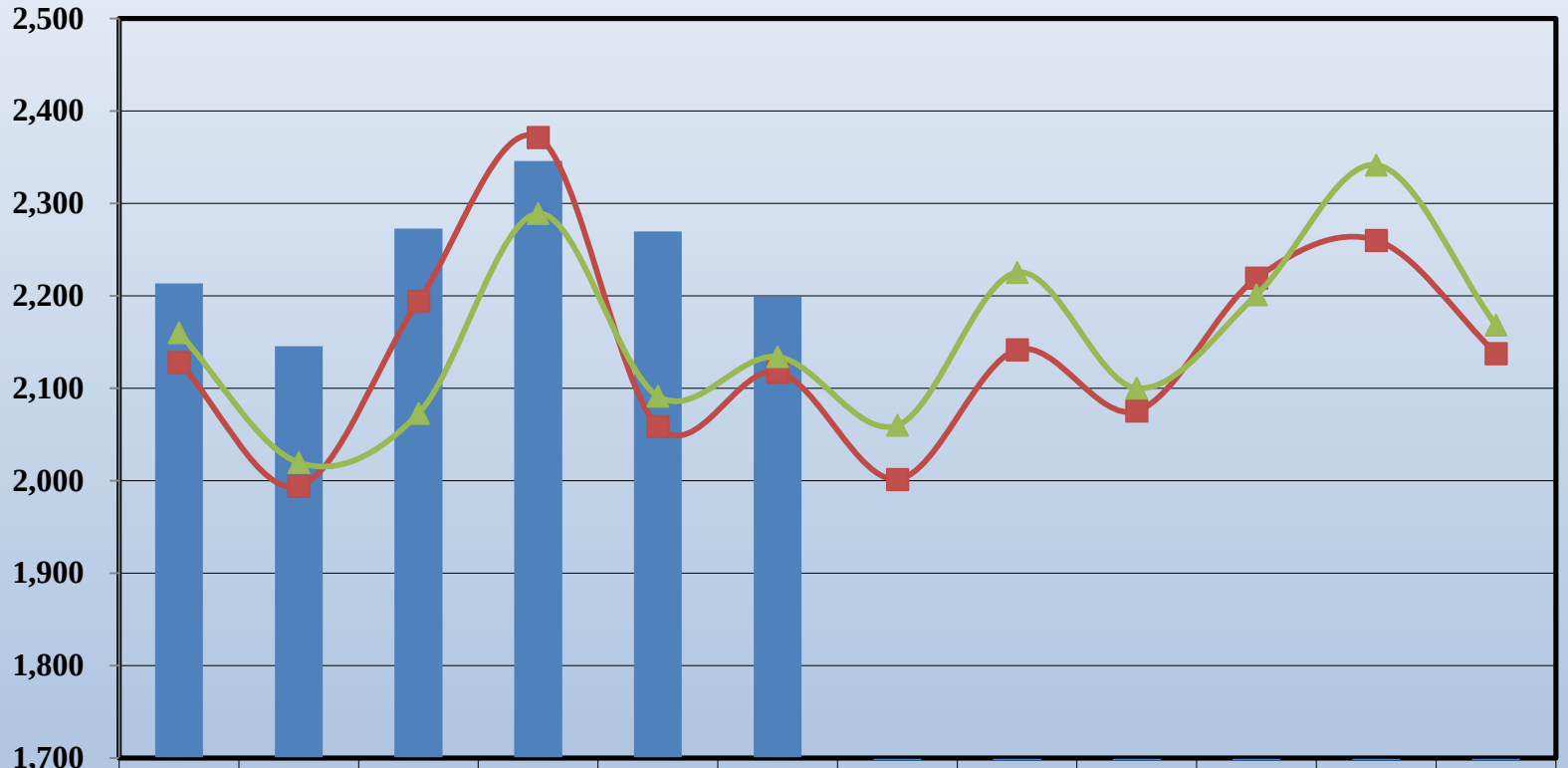
Total – Adults and NICU



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	1,129	1,110	1,190	1,273	1,144	1,189	-	-	-	-	-	-
FY 2019 Budget	1,121	1,053	1,149	1,258	1,091	1,114	1,049	1,124	1,088	1,165	1,182	1,105
FY 2018	1,131	1,063	1,160	1,270	1,101	1,124	1,059	1,134	1,098	1,175	1,193	1,115

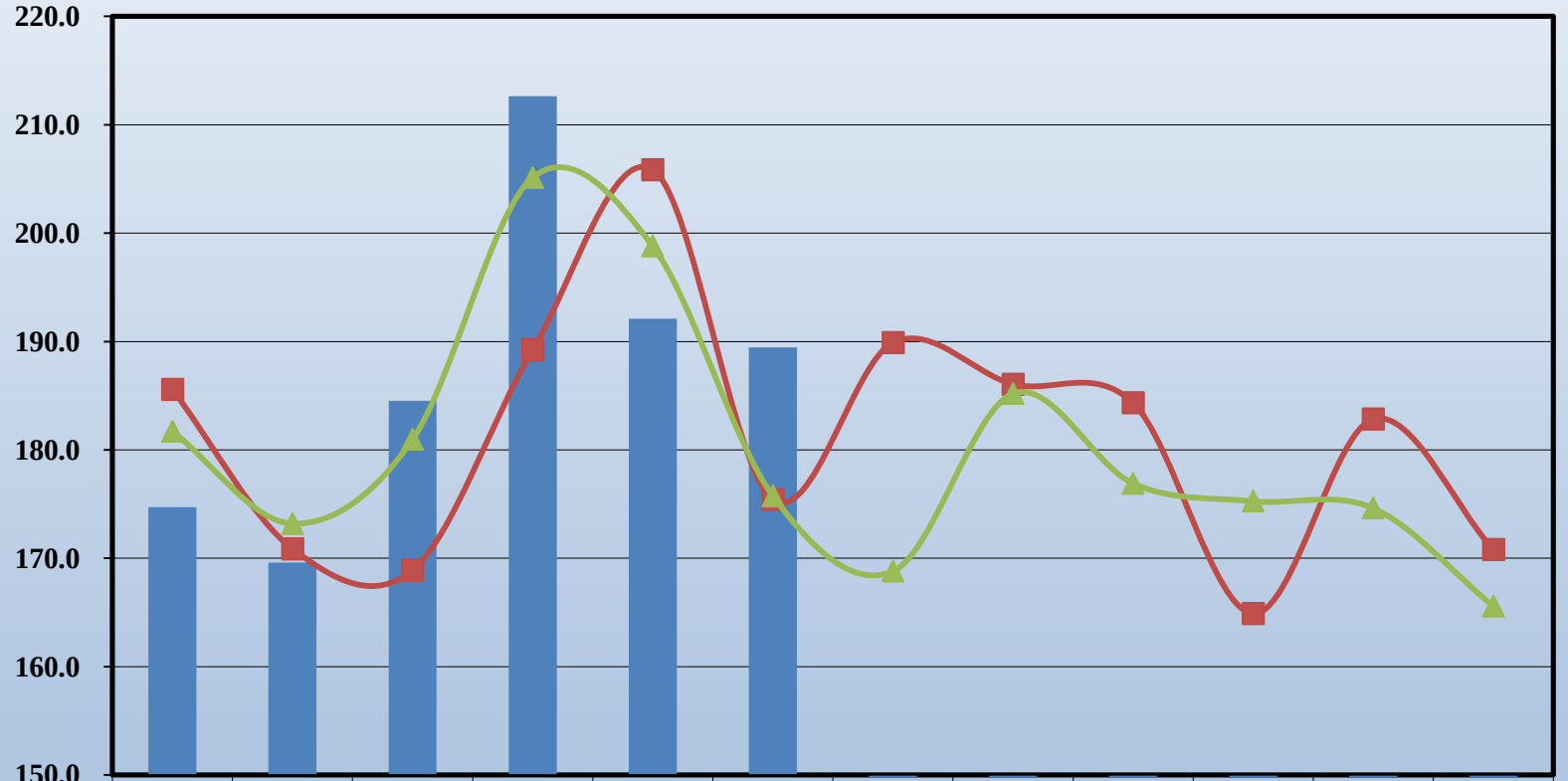
Adjusted Admissions

Including Acute & Rehab Unit



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	2,214	2,146	2,273	2,346	2,270	2,199	-	-	-	-	-	-
FY 2019 Budget	2,128	1,994	2,194	2,372	2,058	2,118	2,001	2,142	2,075	2,219	2,260	2,138
FY 2018	2,160	2,020	2,073	2,289	2,092	2,134	2,060	2,225	2,100	2,201	2,342	2,168

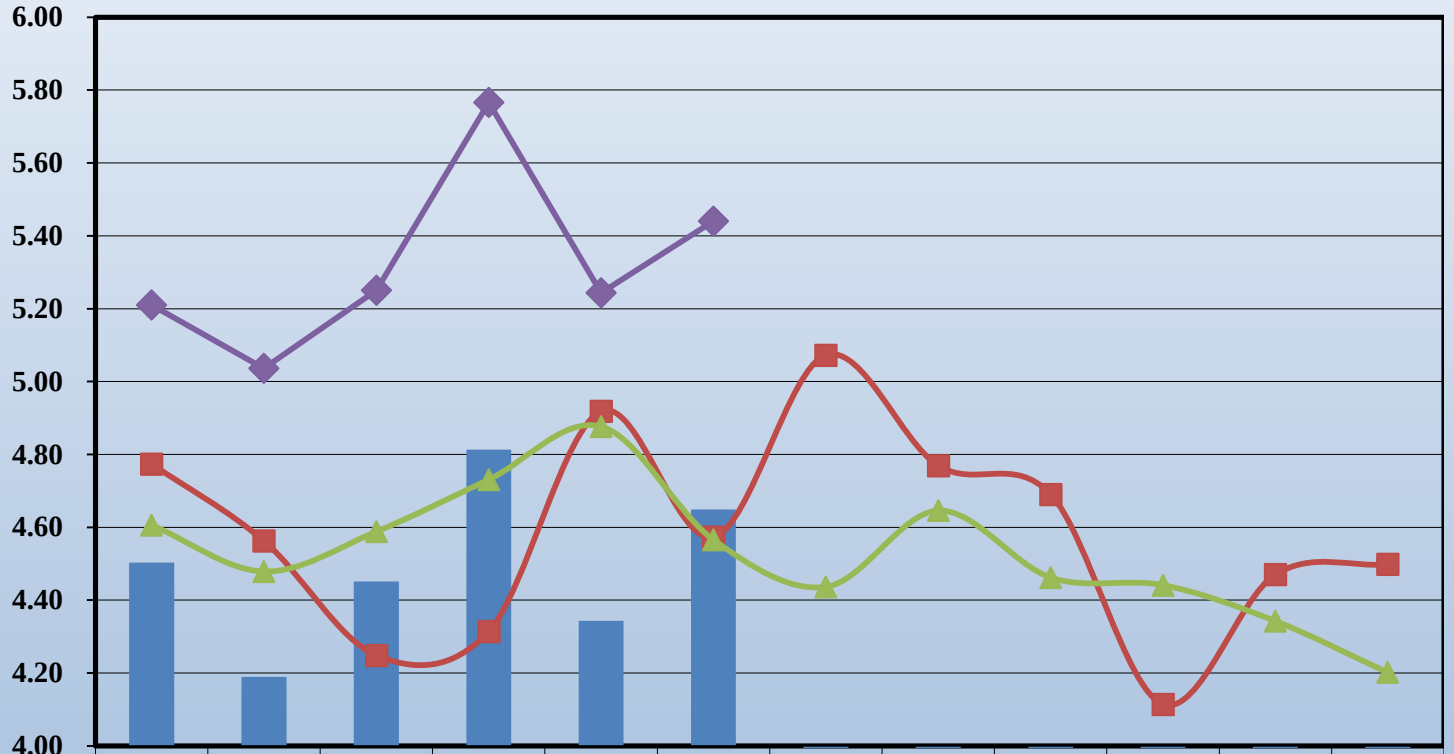
Average Daily Census



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	174.7	169.6	184.5	212.6	192.1	189.5	-	-	-	-	-	-
FY 2019 Budget	185.6	170.9	168.9	189.2	205.9	175.4	189.9	186.1	184.3	164.9	182.8	170.8
FY 2018	181.7	173.2	181.0	205.1	198.8	175.7	168.8	185.2	176.9	175.3	174.6	165.6

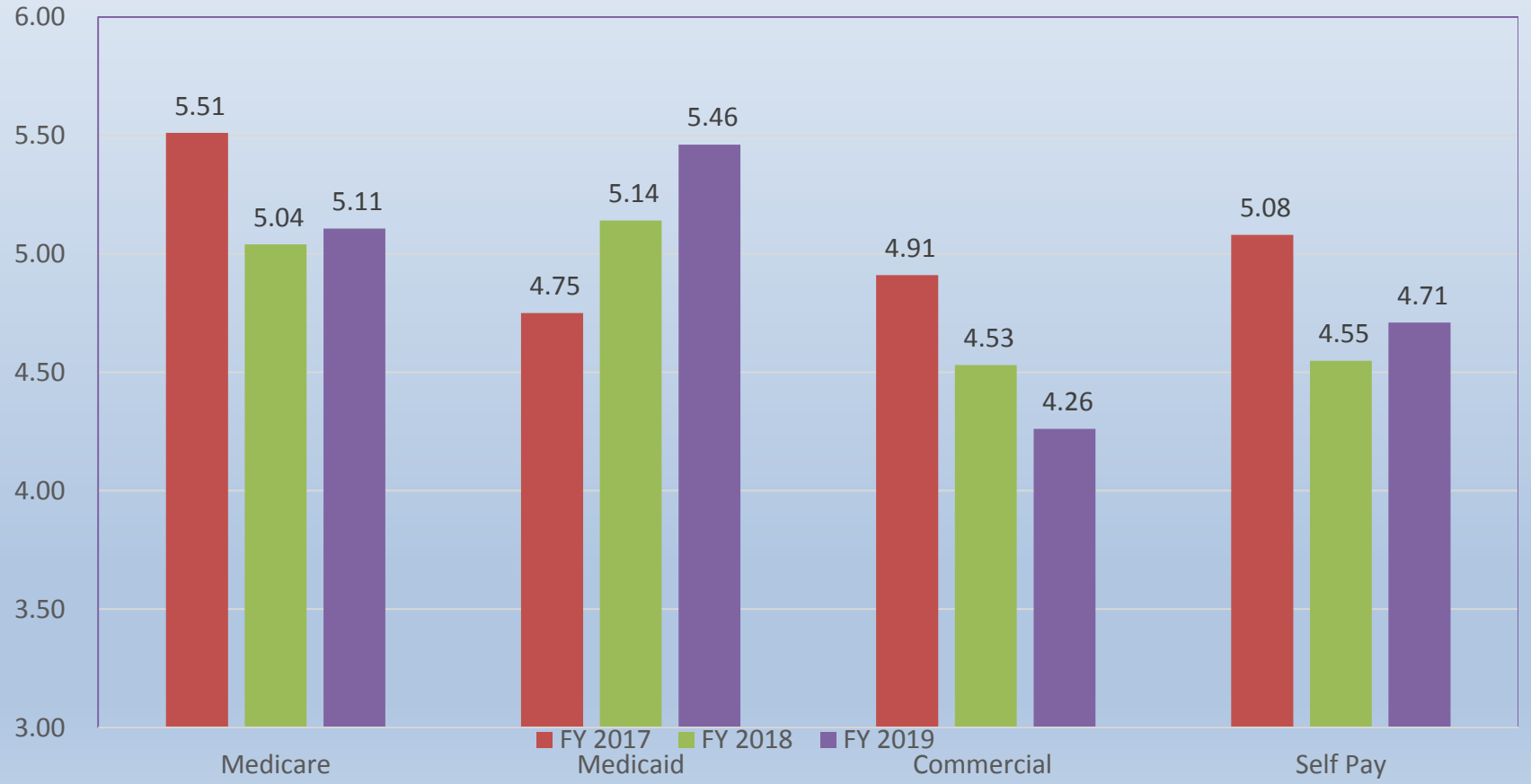
Average Length of Stay

Total – Adults and Pedi

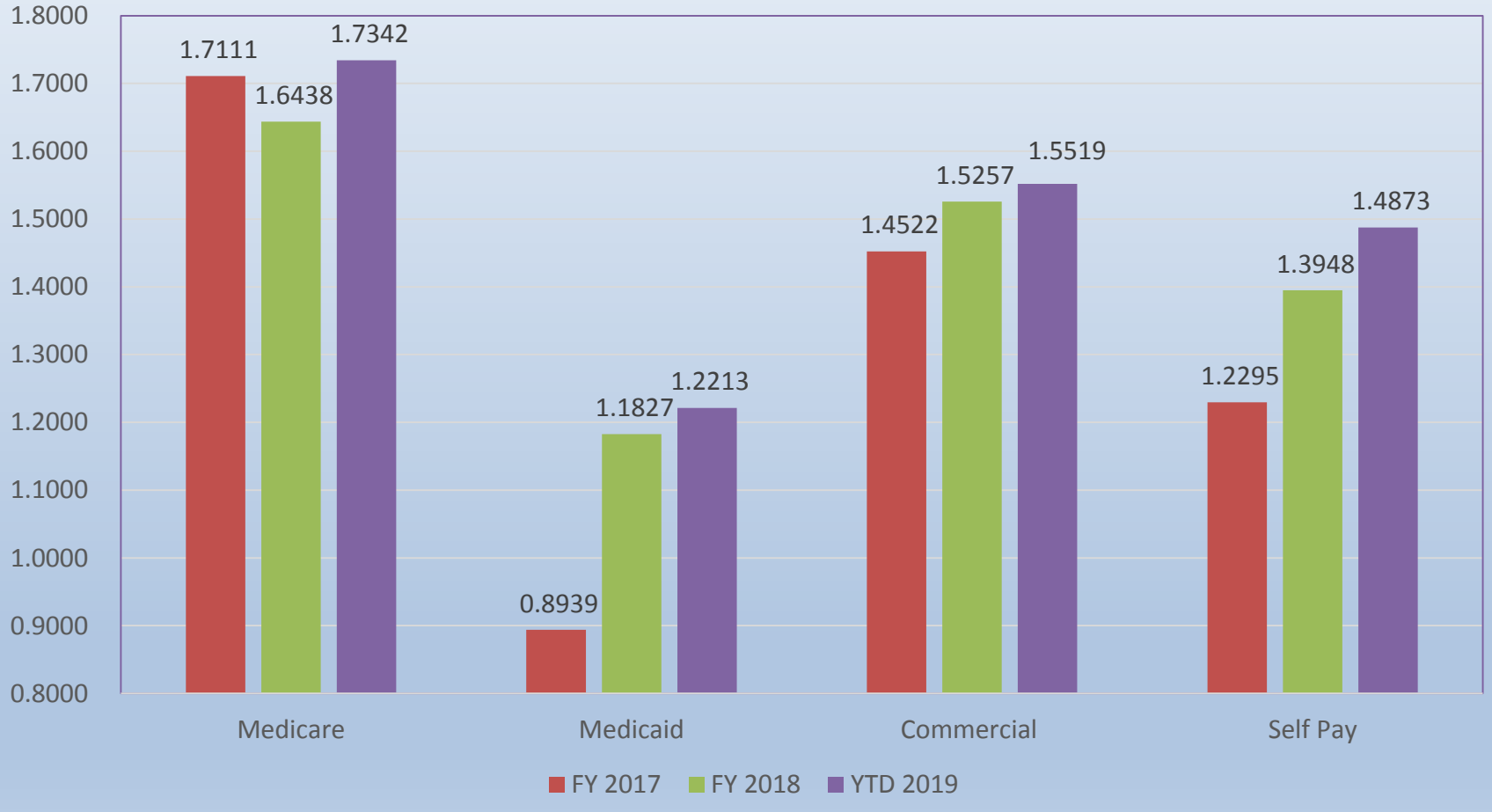


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	4.50	4.19	4.45	4.81	4.34	4.65	-	-	-	-	-	-
FY 2019 Budget	4.77	4.56	4.25	4.31	4.92	4.57	5.07	4.77	4.69	4.11	4.47	4.50
FY 2018	4.61	4.48	4.59	4.73	4.88	4.57	4.44	4.65	4.46	4.44	4.34	4.20
FY 2019 Excluding OB	5.21	5.04	5.25	5.77	5.24	5.44						

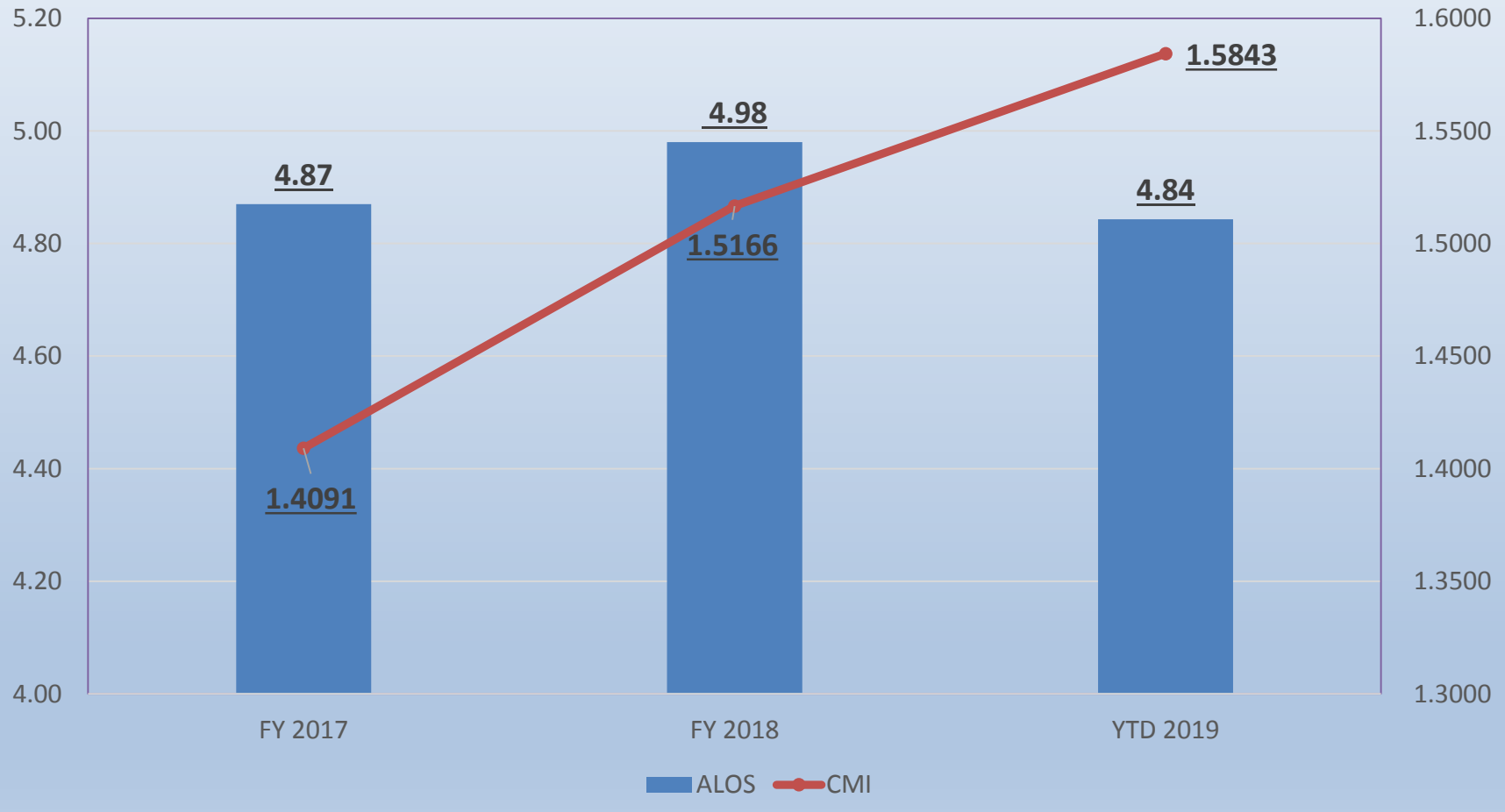
Average Length of Stay by Financial Class



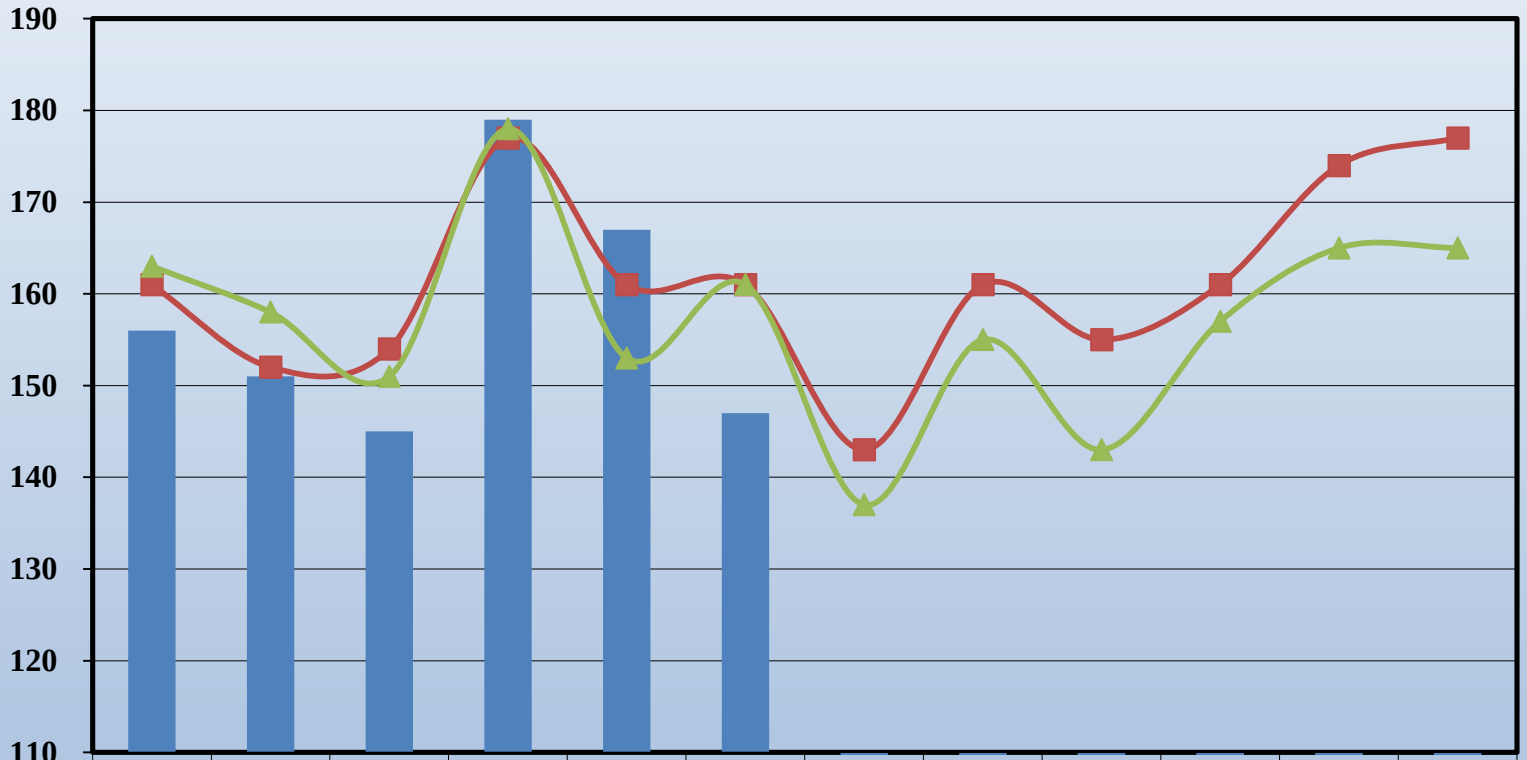
Case Mix Index by Financial Class



Total Inpatient Cases
ALOS with CMI

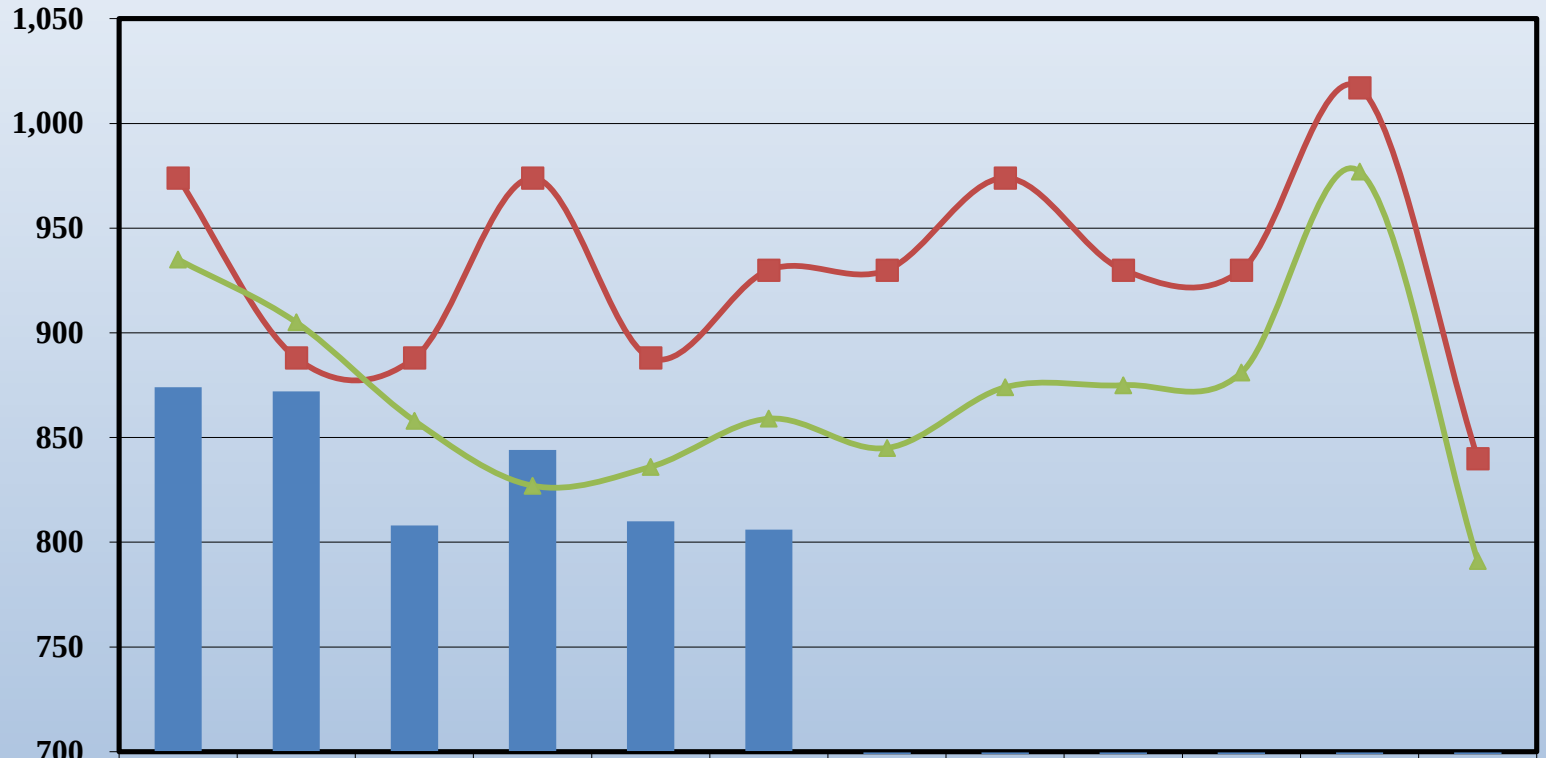


Deliveries



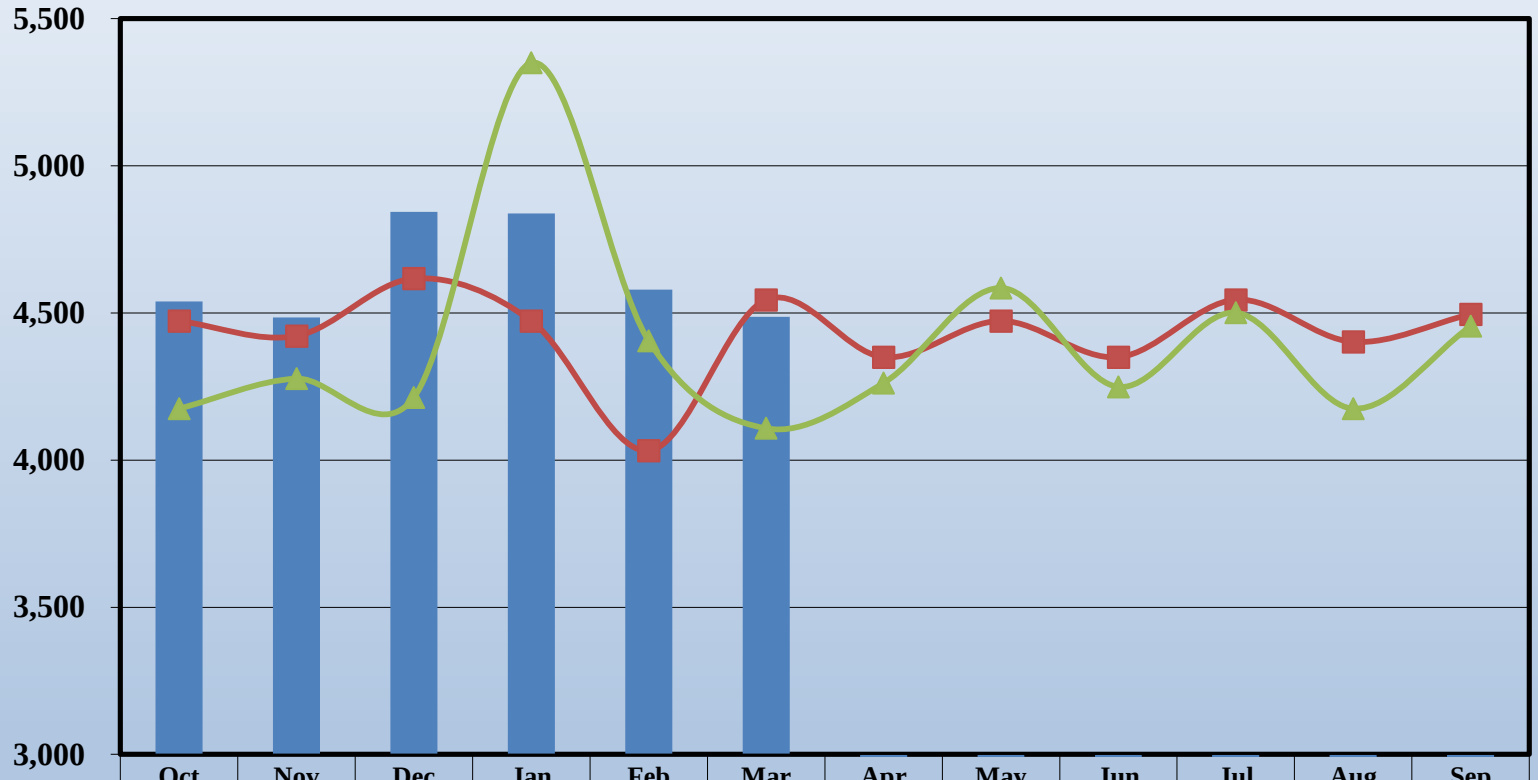
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	156	151	145	179	167	147	-	-	-	-	-	-
FY 2019 Budget	161	152	154	177	161	161	143	161	155	161	174	177
FY 2018	163	158	151	178	153	161	137	155	143	157	165	165

Total Surgical Cases



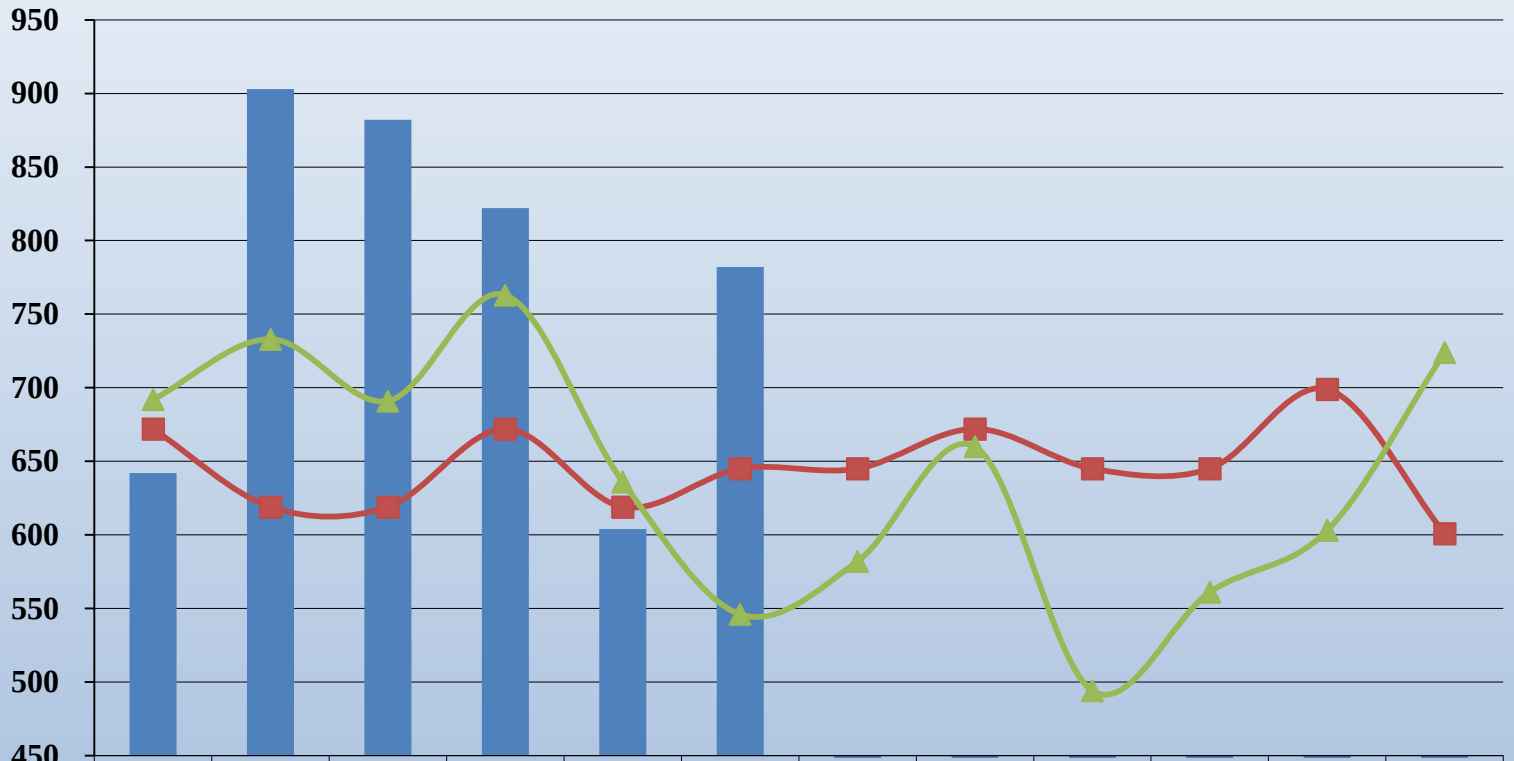
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	874	872	808	844	810	806	-	-	-	-	-	-
FY 2019 Budget	974	888	888	974	888	930	930	974	930	930	1,017	840
FY 2018	935	905	858	827	836	859	845	874	875	881	977	791

Emergency Room Visits



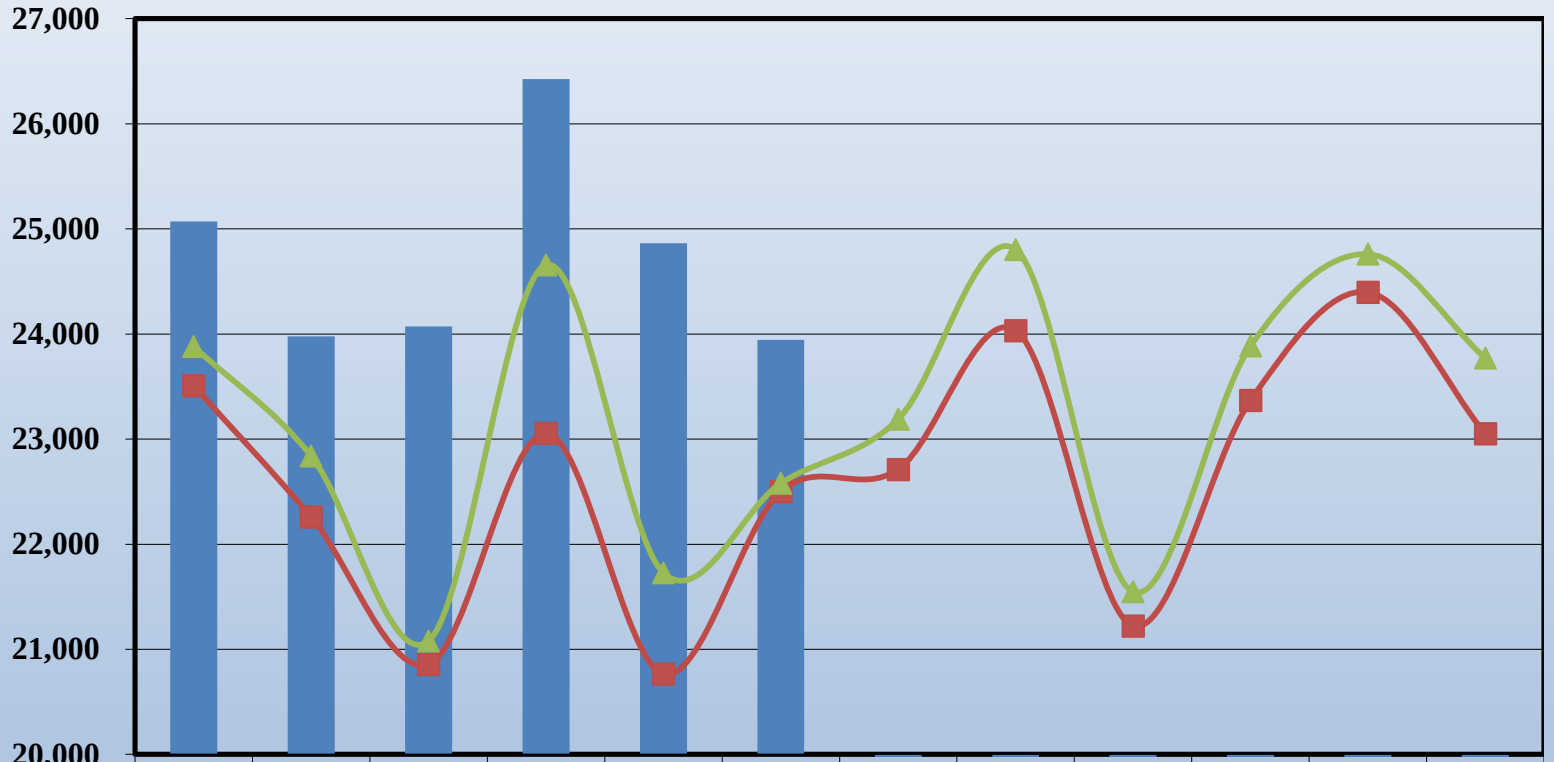
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	4,539	4,485	4,844	4,838	4,579	4,487	-	-	-	-	-	-
FY 2019 Budget	4,473	4,422	4,617	4,473	4,032	4,545	4,350	4,473	4,350	4,545	4,402	4,496
FY 2018	4,175	4,277	4,213	5,350	4,405	4,108	4,262	4,585	4,249	4,501	4,175	4,455

Observation Days



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	642	903	882	822	604	782	-	-	-	-	-	-
FY 2019 Budget	672	619	619	672	619	645	645	672	645	645	699	601
FY 2018	692	733	691	763	636	546	582	660	494	561	603	724

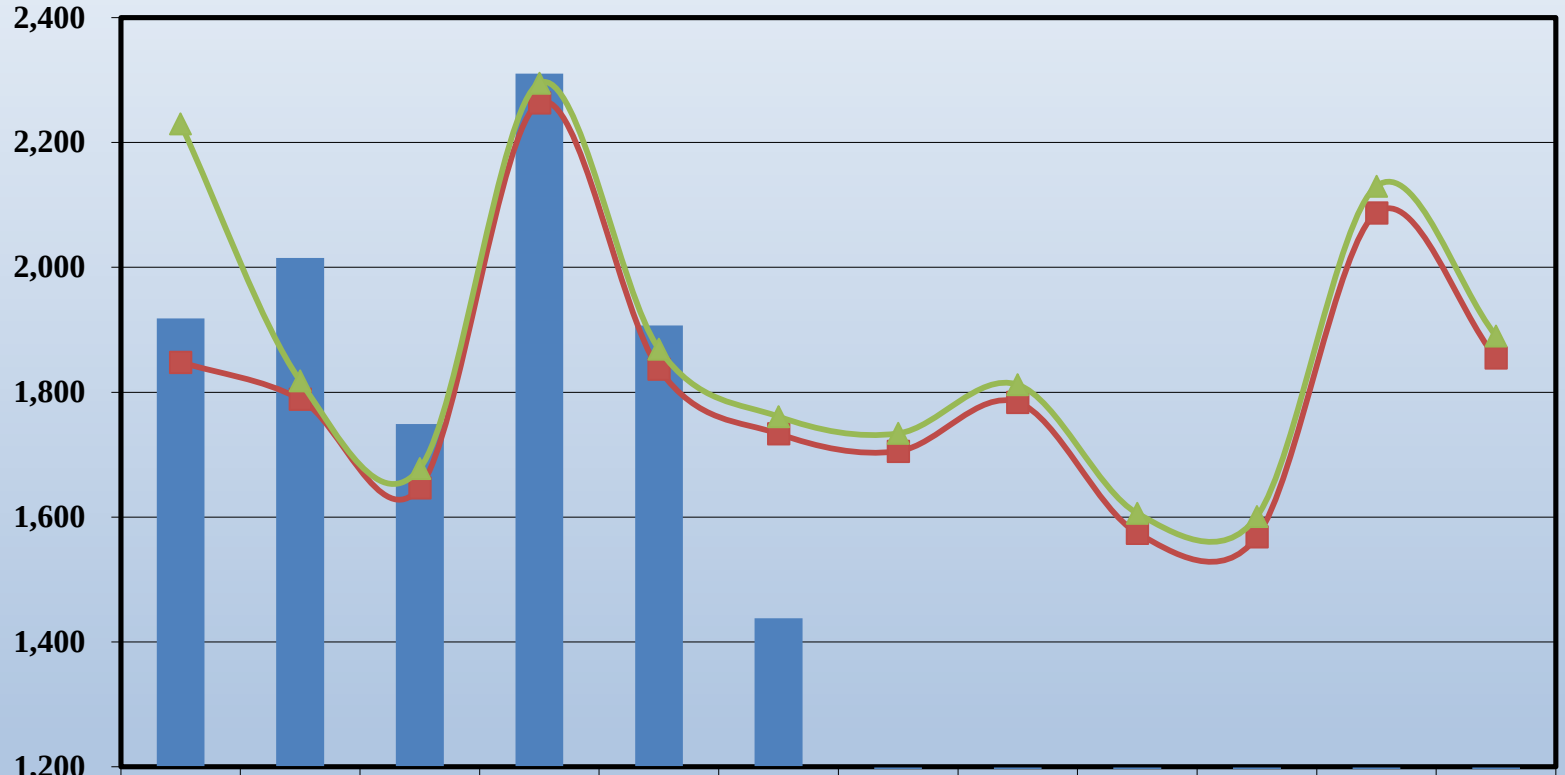
Total Outpatient Occasions of Service



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	25,070	23,979	24,072	26,425	24,865	23,943	-	-	-	-	-	-
FY 2019 Budget	23,508	22,259	20,858	23,055	20,765	22,502	22,712	24,034	21,223	23,368	24,398	23,051
FY 2018	23,881	22,839	21,080	24,658	21,727	22,580	23,190	24,804	21,547	23,885	24,760	23,770

Center for Primary Care Total Visits

(FQHC - Clements & West University)



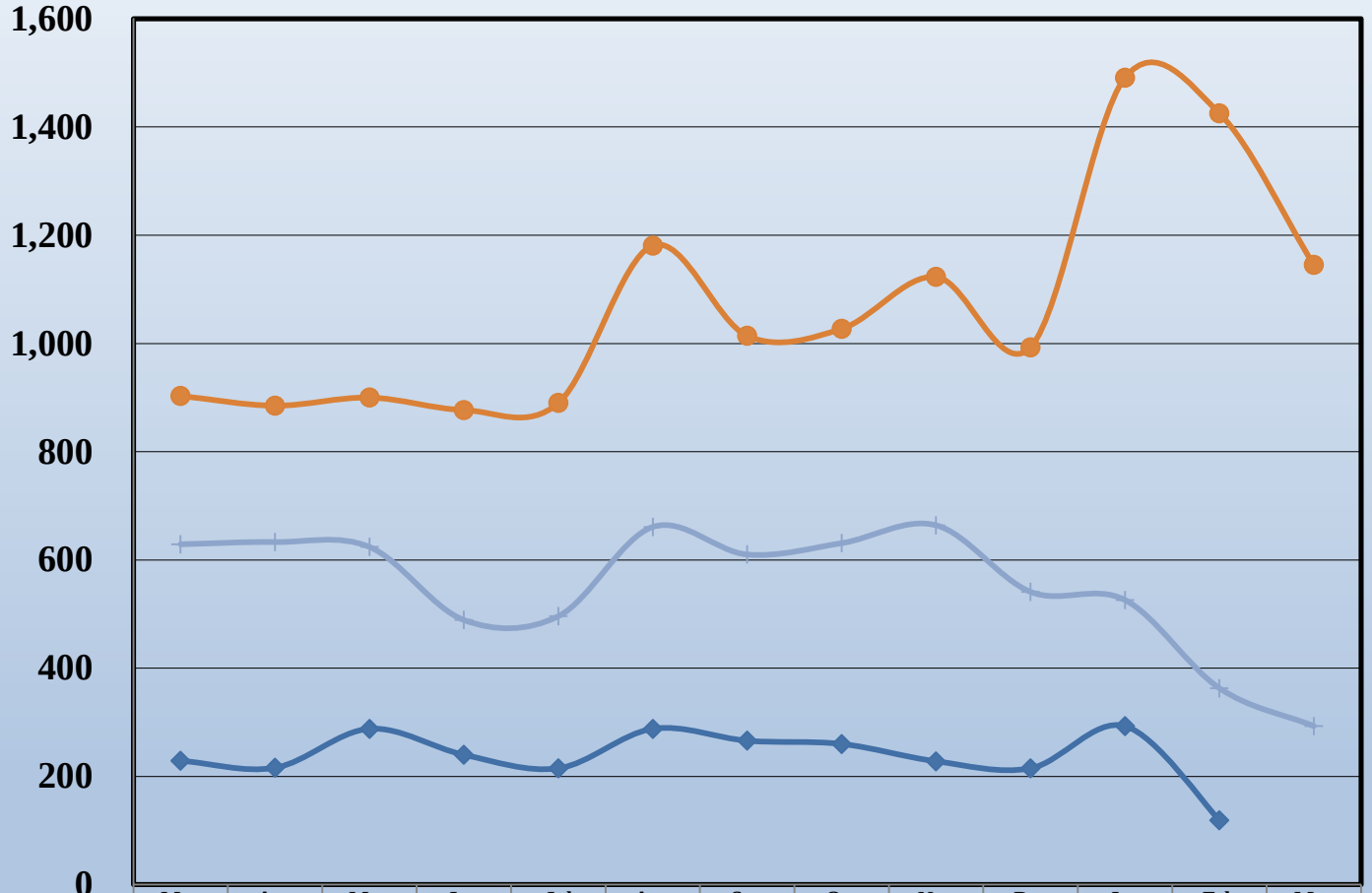
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	1,918	2,015	1,749	2,310	1,907	1,438	-	-	-	-	-	-
FY 2019 Budget	1,848	1,789	1,647	2,264	1,837	1,733	1,705	1,784	1,575	1,569	2,087	1,855
FY 2018	2,230	1,818	1,678	2,295	1,869	1,761	1,734	1,812	1,606	1,601	2,130	1,890

FY 2018 excludes Dental Clinic after 10/31/2017

Center for Primary Care Visits

(FQHC - Clements and West University)

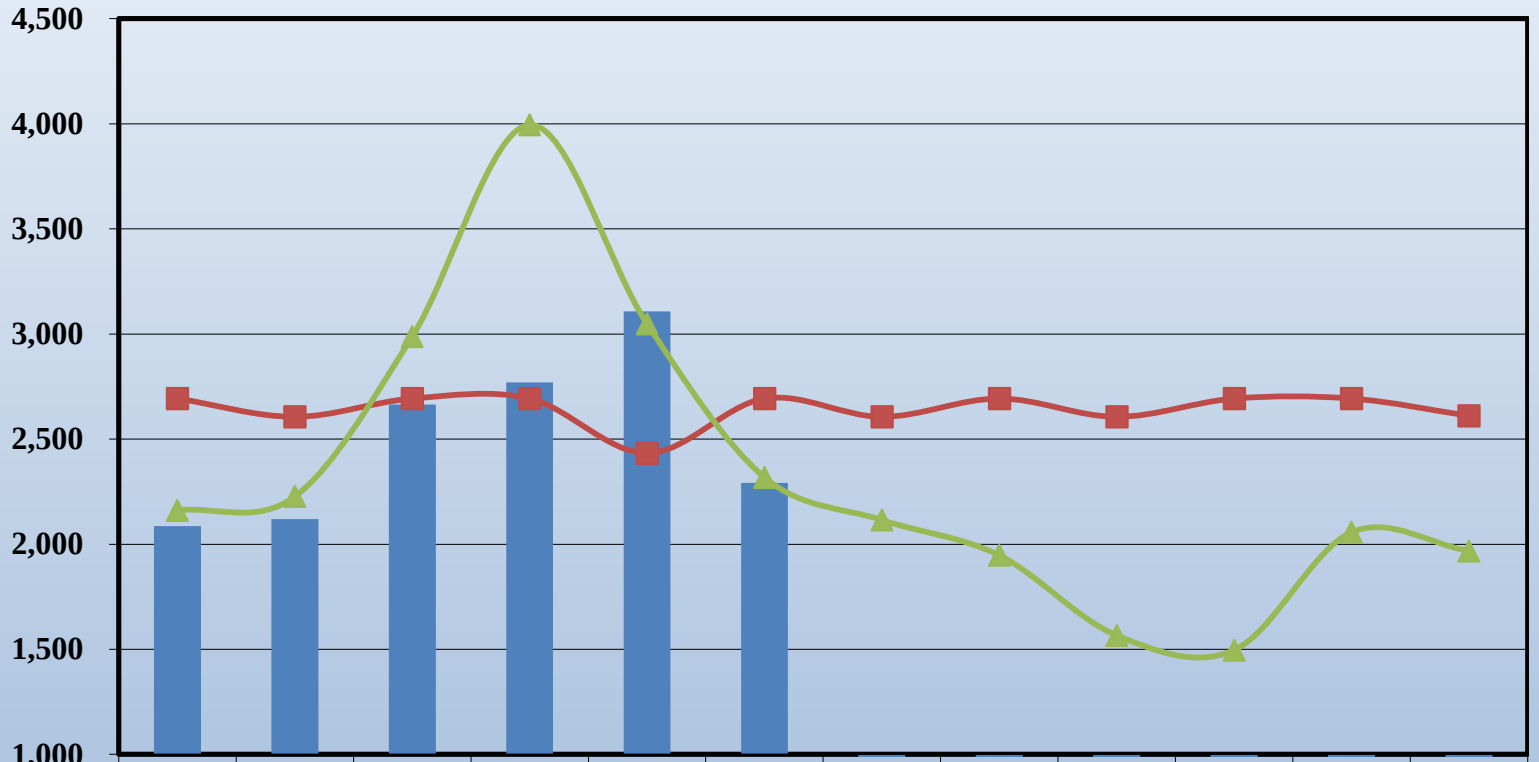
Thirteen Month Trending – Excluding Dental Clinic



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clements Medical	903	885	900	877	890	1,181	1,014	1,027	1,123	993	1,491	1,425	1,145
W. University Medical	629	633	624	489	496	661	610	631	664	541	526	363	293
W. University Optometry	229	216	288	240	215	288	266	260	228	215	293	119	

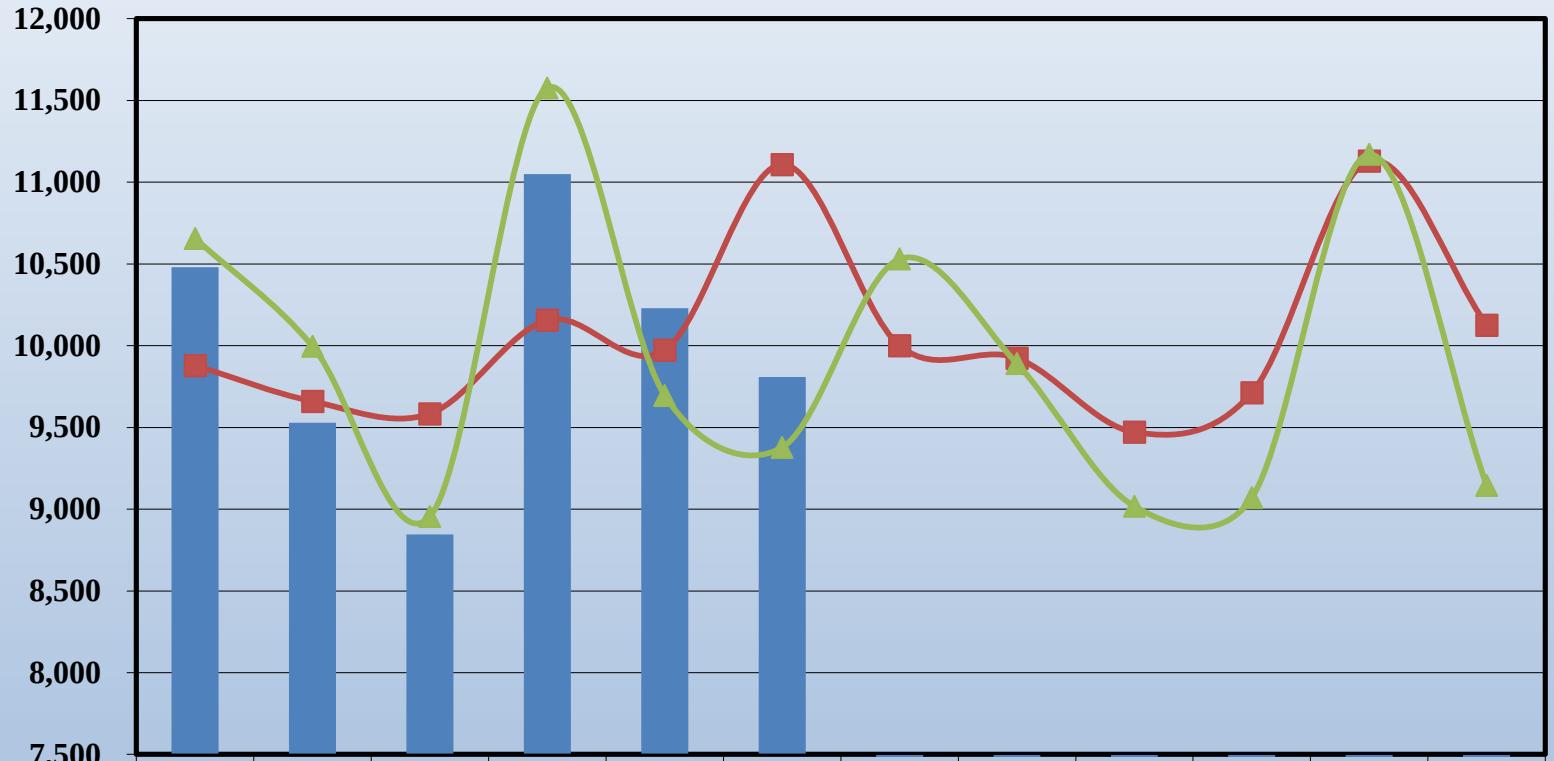
Urgent Care Visits

(JBS Clinic, West University & 42nd Street)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	2,086	2,120	2,664	2,770	3,108	2,291	-	-	-	-	-	-
FY 2019 Budget	2,693	2,606	2,693	2,693	2,433	2,693	2,606	2,693	2,606	2,693	2,693	2,611
FY 2018	2,161	2,227	2,988	3,995	3,048	2,318	2,115	1,947	1,566	1,496	2,057	1,968

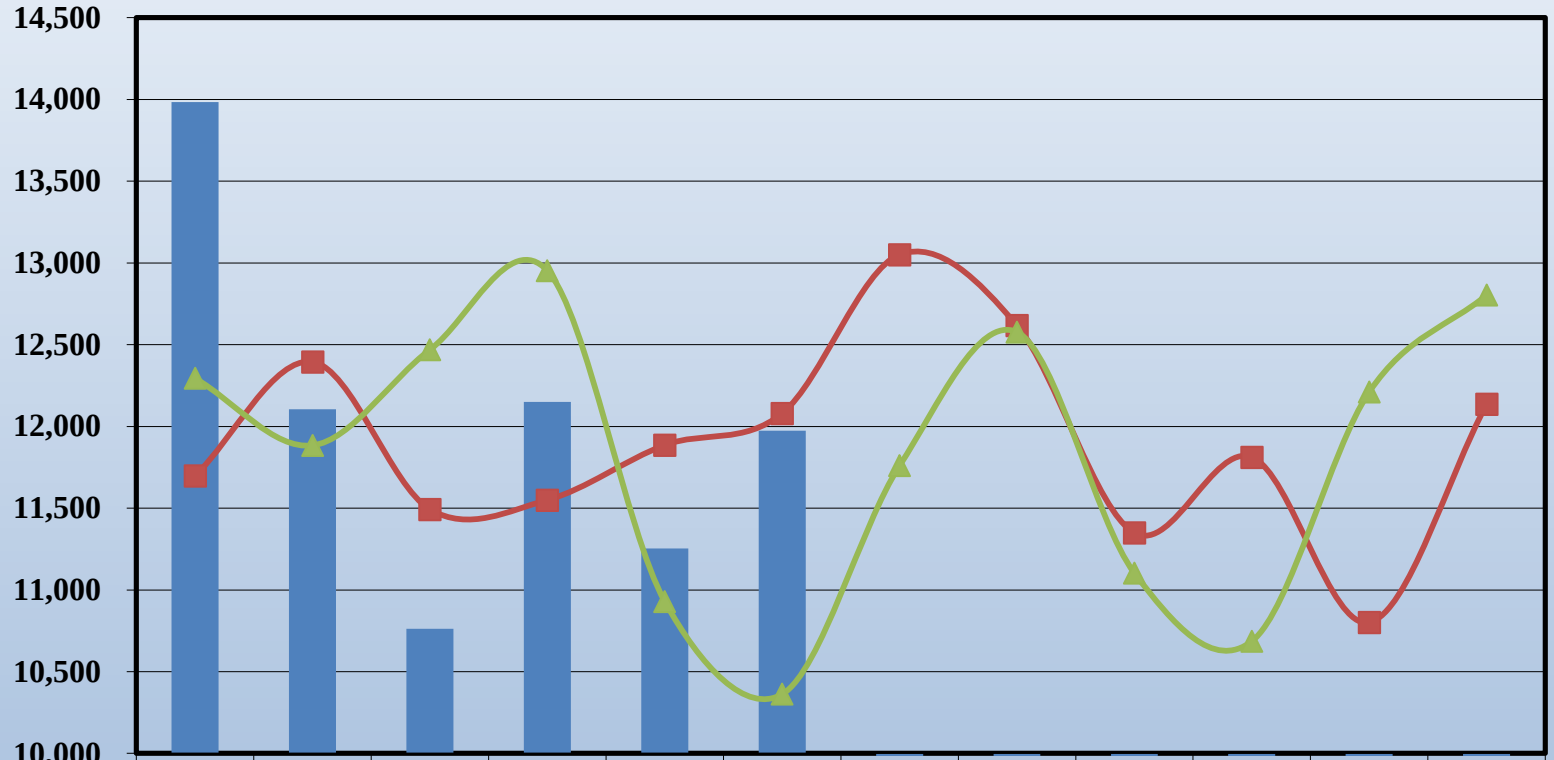
Total ProCare Office Visits



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	10,479	9,529	8,846	11,050	10,229	9,809	-	-	-	-	-	-
FY 2019 Budget	9,879	9,660	9,584	10,157	9,973	11,109	10,000	9,924	9,471	9,713	11,129	10,126
FY 2018	10,657	9,997	8,955	11,576	9,695	9,378	10,530	9,890	9,017	9,070	11,170	9,145

Total ProCare Procedures

Excluding Pathology and Radiology Procedures

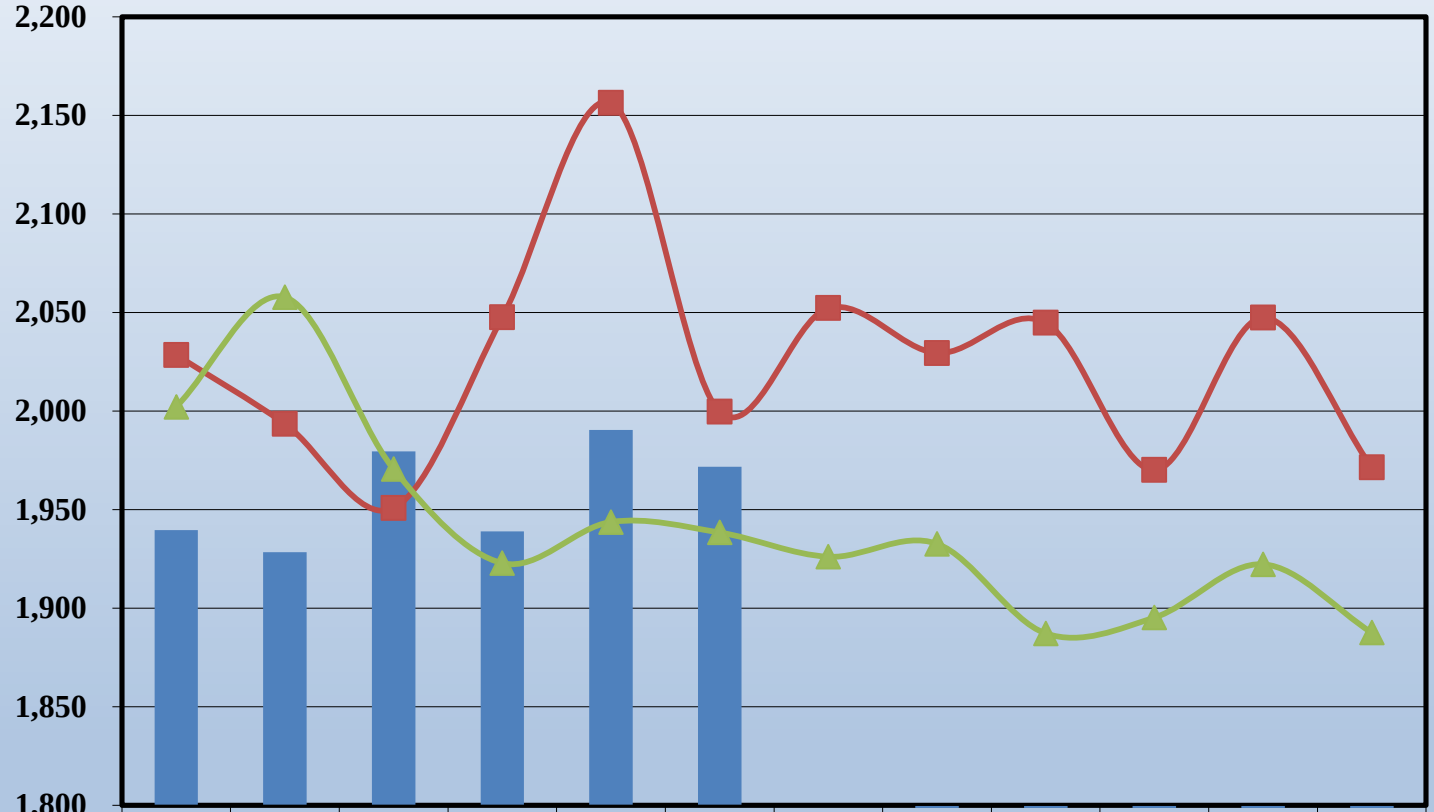


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	13,984	12,104	10,763	12,149	11,254	11,973	-	-	-	-	-	-
FY 2019 Budget	11,698	12,395	11,493	11,550	11,886	12,080	13,051	12,617	11,349	11,812	10,801	12,136
FY 2018	12,294	11,884	12,469	12,953	10,929	10,362	11,760	12,577	11,103	10,686	12,211	12,803

Staffing

Blended FTE's

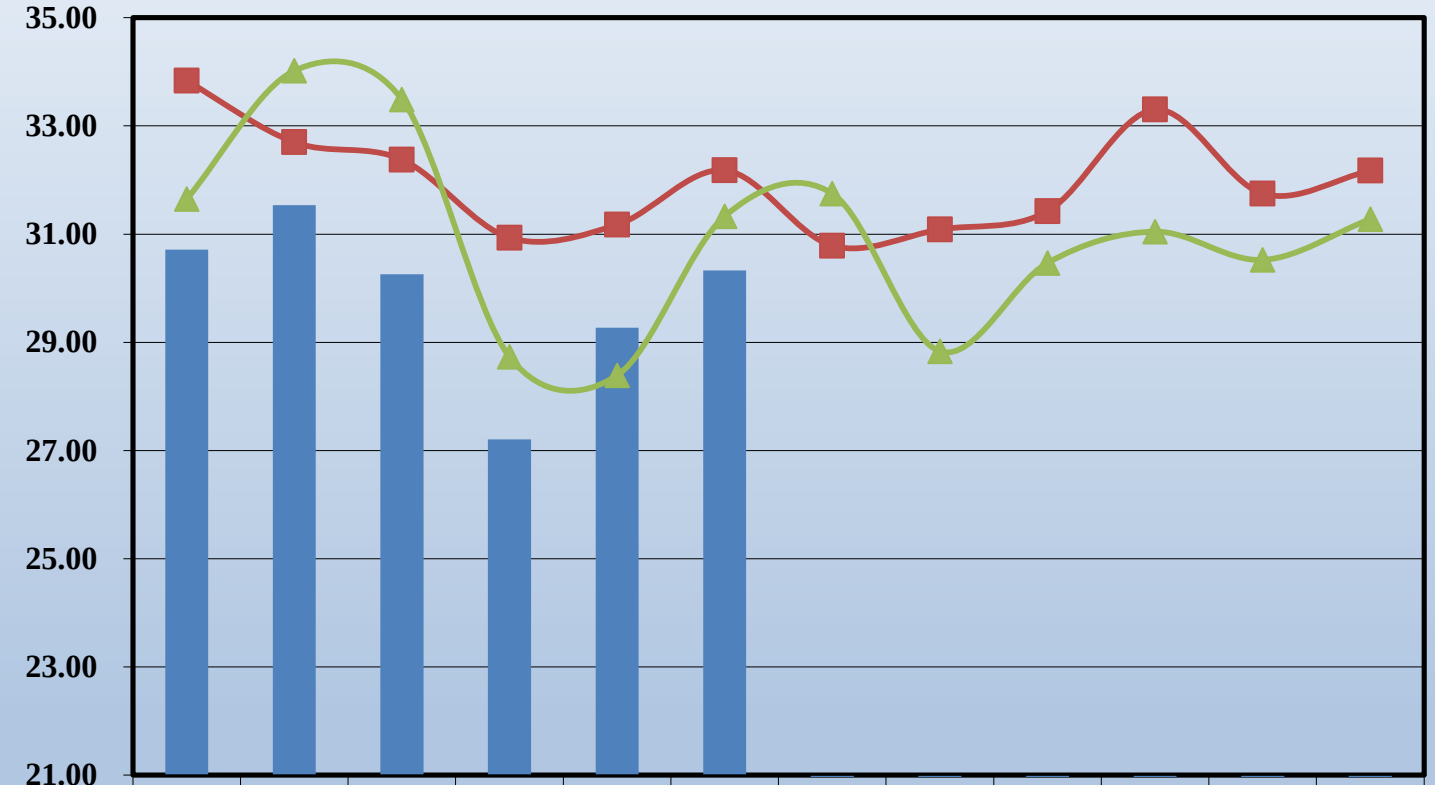
Including Contract Labor and Management Services



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	1,940	1,928	1,980	1,939	1,990	1,972		-	-	-	-	-
FY 2019 Budget	2,028	1,993	1,951	2,047	2,156	2,000	2,052	2,029	2,045	1,970	2,047	1,971
FY 2018	2,002	2,058	1,971	1,923	1,944	1,938	1,926	1,933	1,887	1,895	1,922	1,888

Paid Hours per Adjusted Patient Day

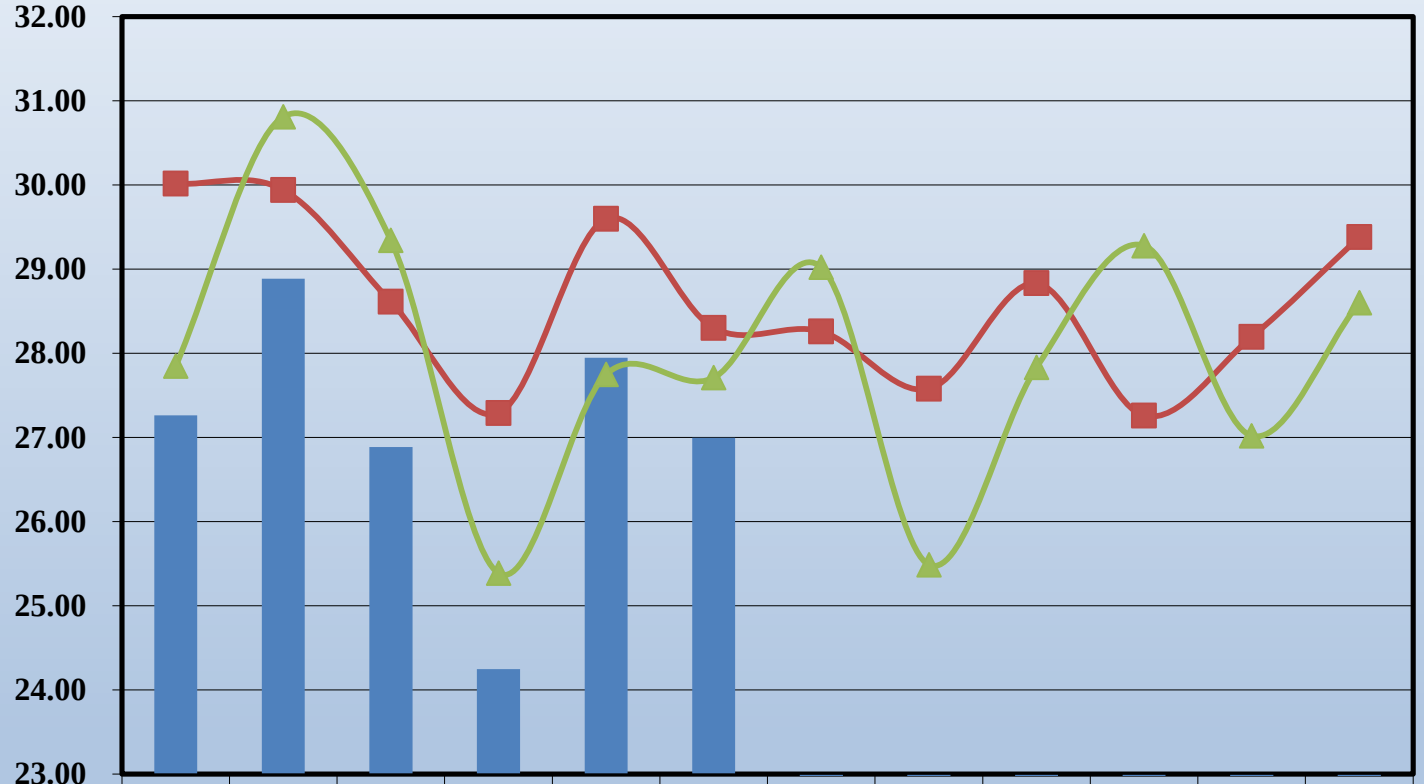
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	30.71	31.53	30.26	27.20	29.27	30.33	-	-	-	-	-	-
FY 2019 Budget	33.83	32.70	32.38	30.93	31.17	32.18	30.79	31.09	31.42	33.30	31.75	32.17
FY 2018	31.65	34.02	33.49	28.73	28.39	31.33	31.75	28.83	30.47	31.05	30.52	31.28

Paid Hours per Adjusted Patient Day

(Medical Center Hospital)

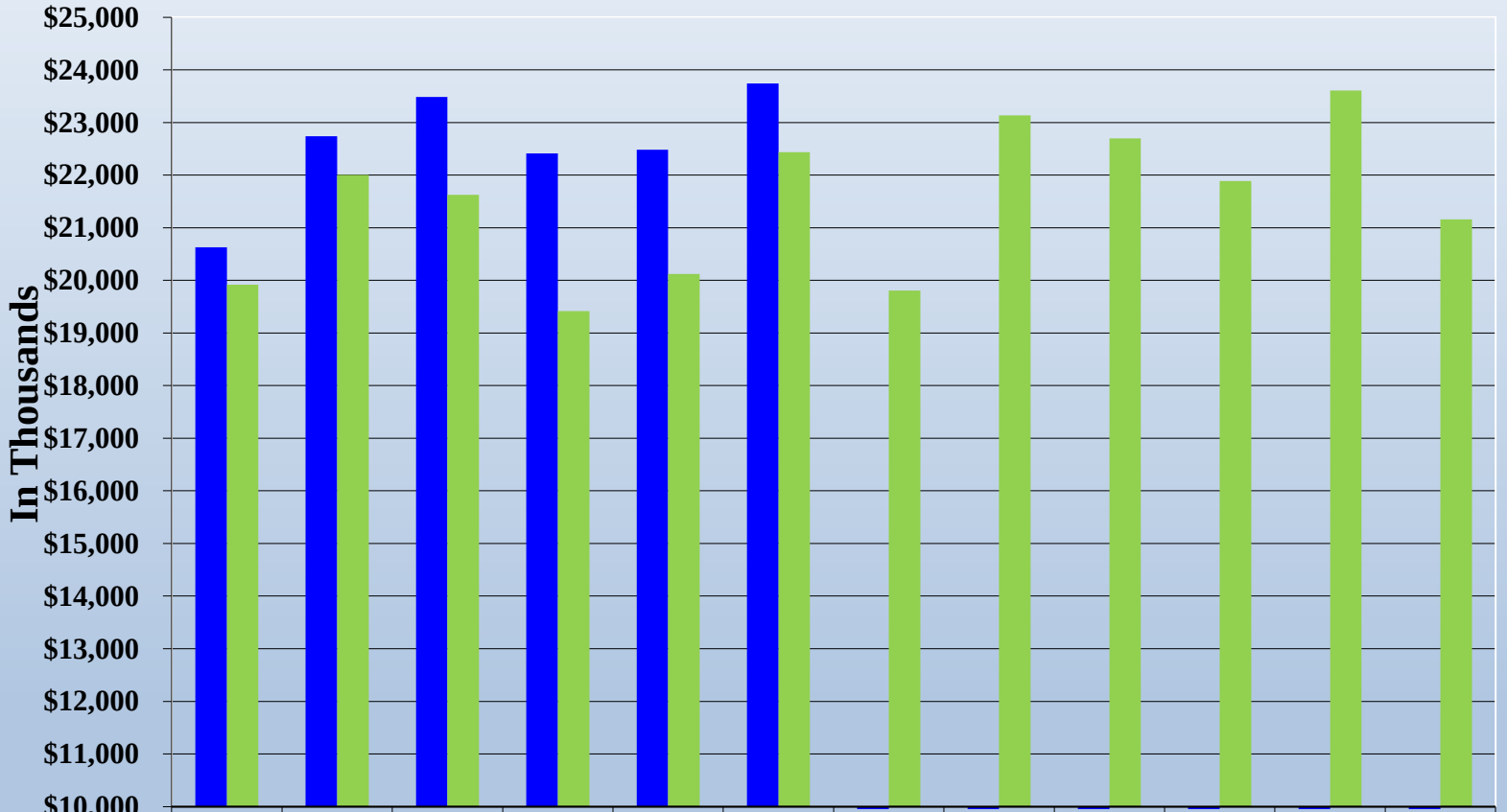


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	27.26	28.89	26.88	24.25	27.95	27.00	-	-	-	-	-	-
FY 2019 Budget	30.01	29.94	28.61	27.29	29.60	28.30	28.26	27.58	28.83	27.26	28.20	29.38
FY 2018	27.85	30.81	29.34	25.39	27.75	27.71	29.02	25.49	27.83	29.28	27.02	28.60


Accounts Receivable

Total AR Cash Receipts

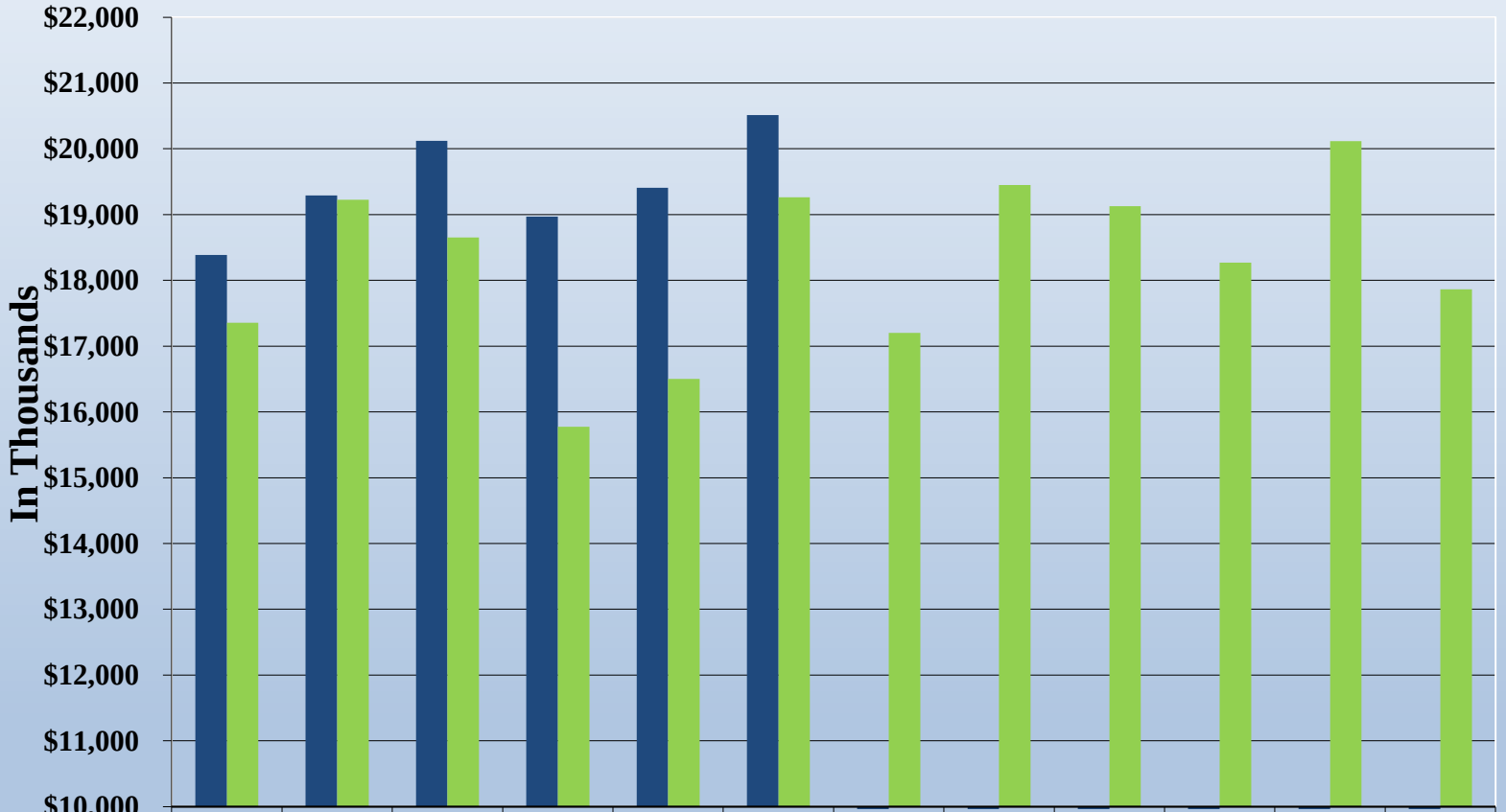
Compared to Prior Year



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	20,631	22,739	23,486	22,410	22,485	23,739	-	-	-	-	-	-
FY 2018	19,914	22,005	21,626	19,414	20,123	22,436	19,808	23,138	22,700	21,887	23,609	21,160

Hospital AR Cash Receipts

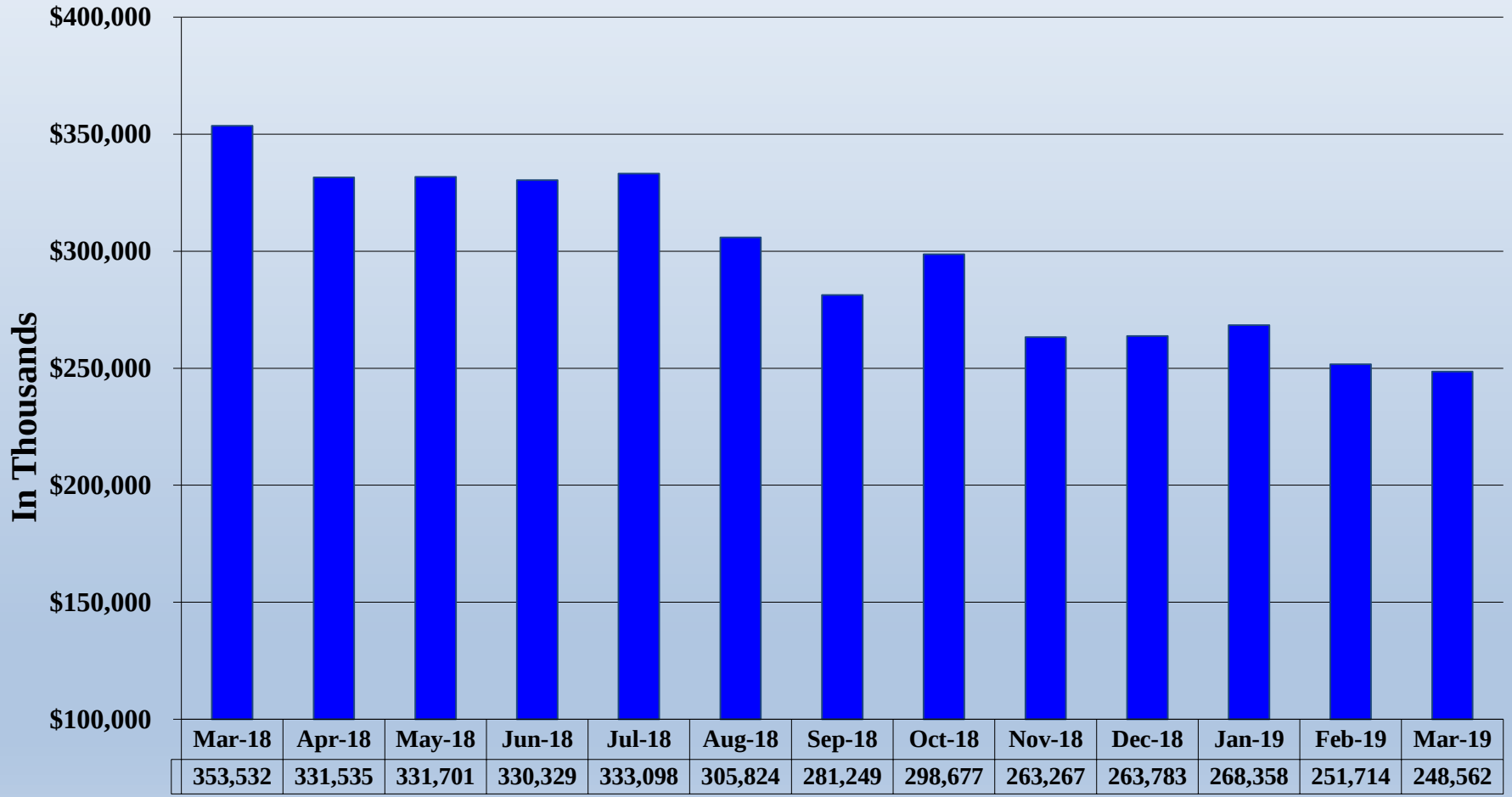
Compared to Prior Year



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	18,386	19,289	20,122	18,968	19,407	20,514	-	-	-	-	-	-
FY 2018	17,356	19,227	18,654	15,774	16,501	19,261	17,200	19,450	19,130	18,268	20,115	17,864

Total Accounts Receivable – Gross

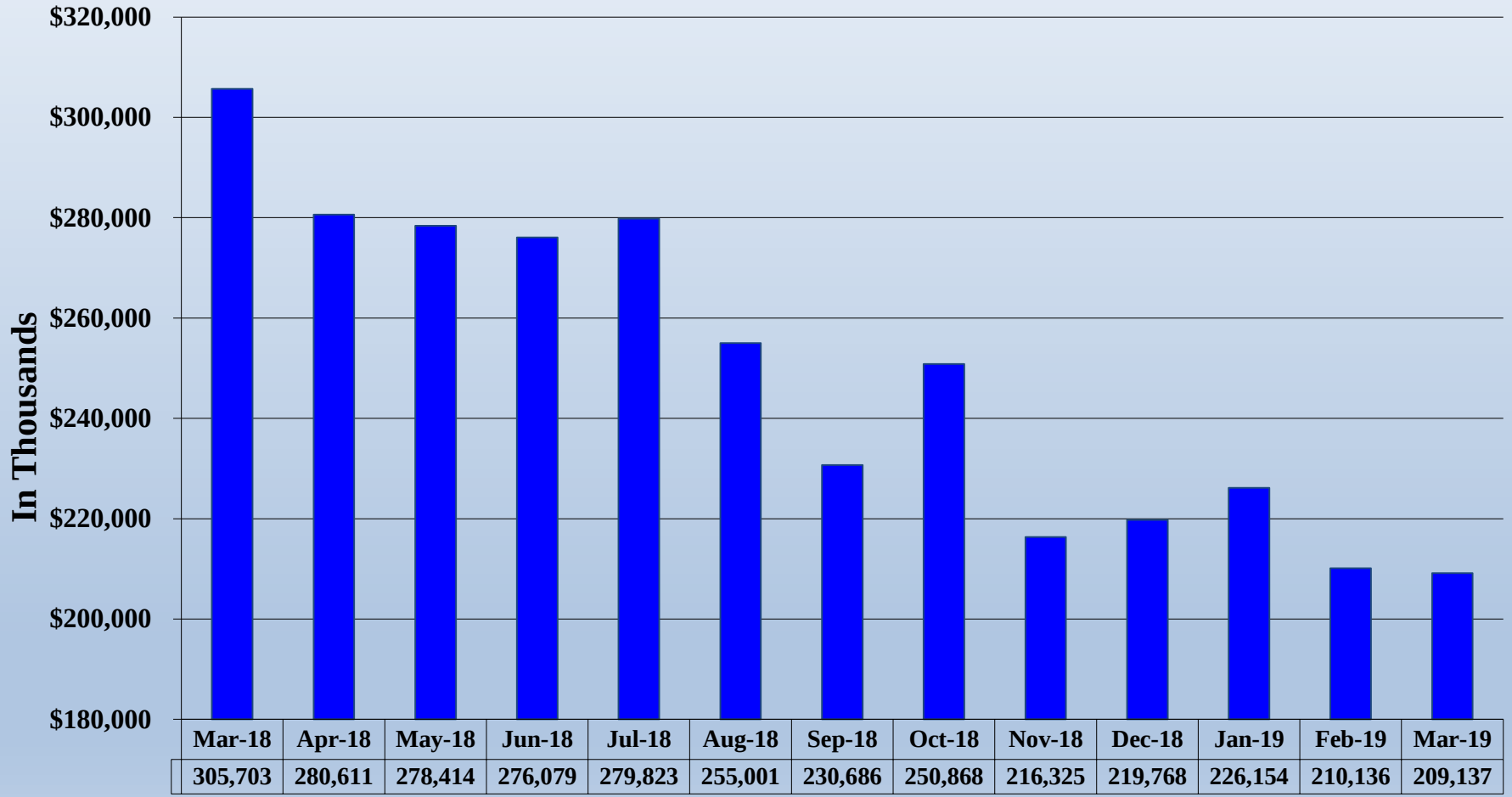
Thirteen Month Trending



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
353,532	331,535	331,701	330,329	333,098	305,824	281,249	298,677	263,267	263,783	268,358	251,714	248,562

Hospital Accounts Receivable – Gross

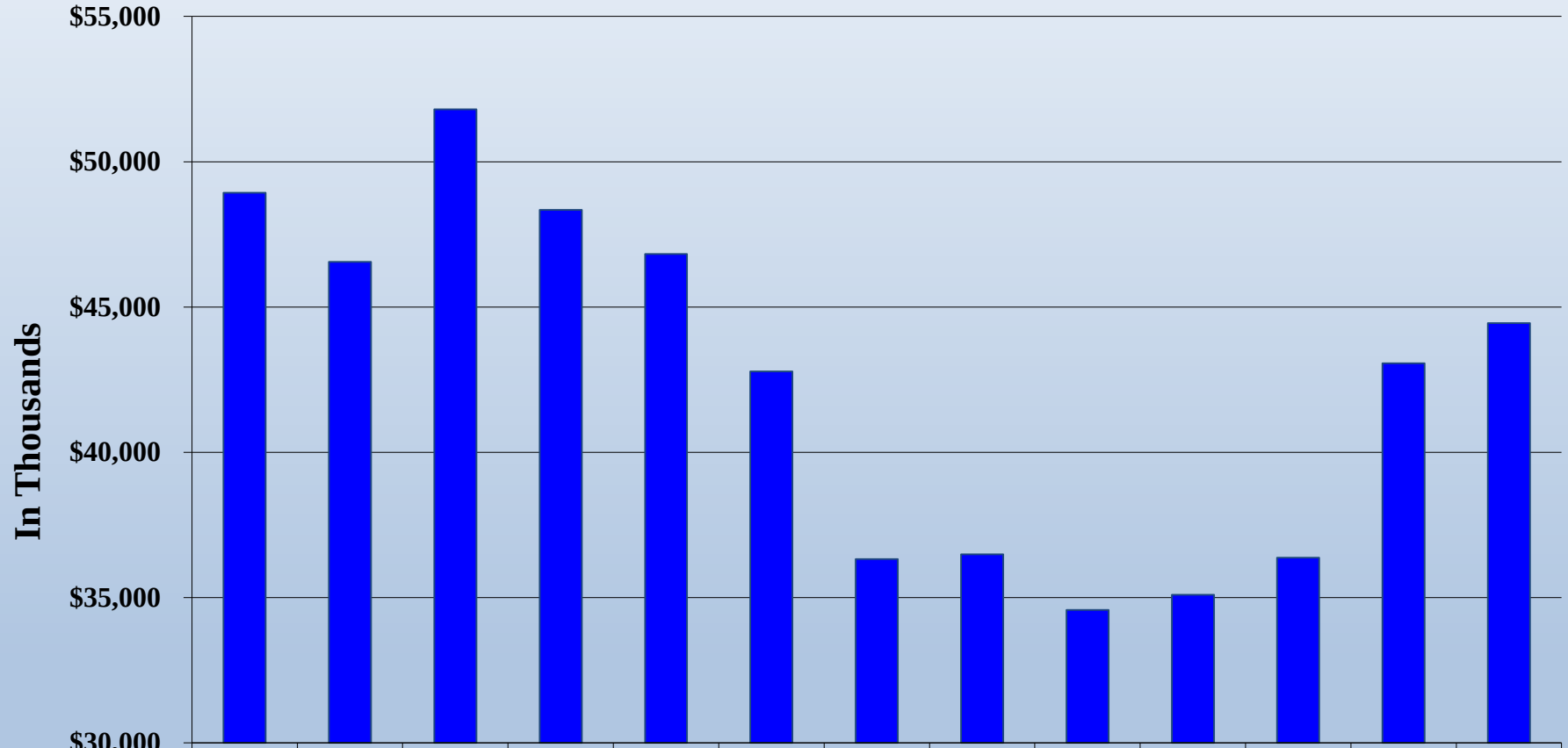
Thirteen Month Trending



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
305,703	280,611	278,414	276,079	279,823	255,001	230,686	250,868	216,325	219,768	226,154	210,136	209,137

Total Net Accounts Receivable

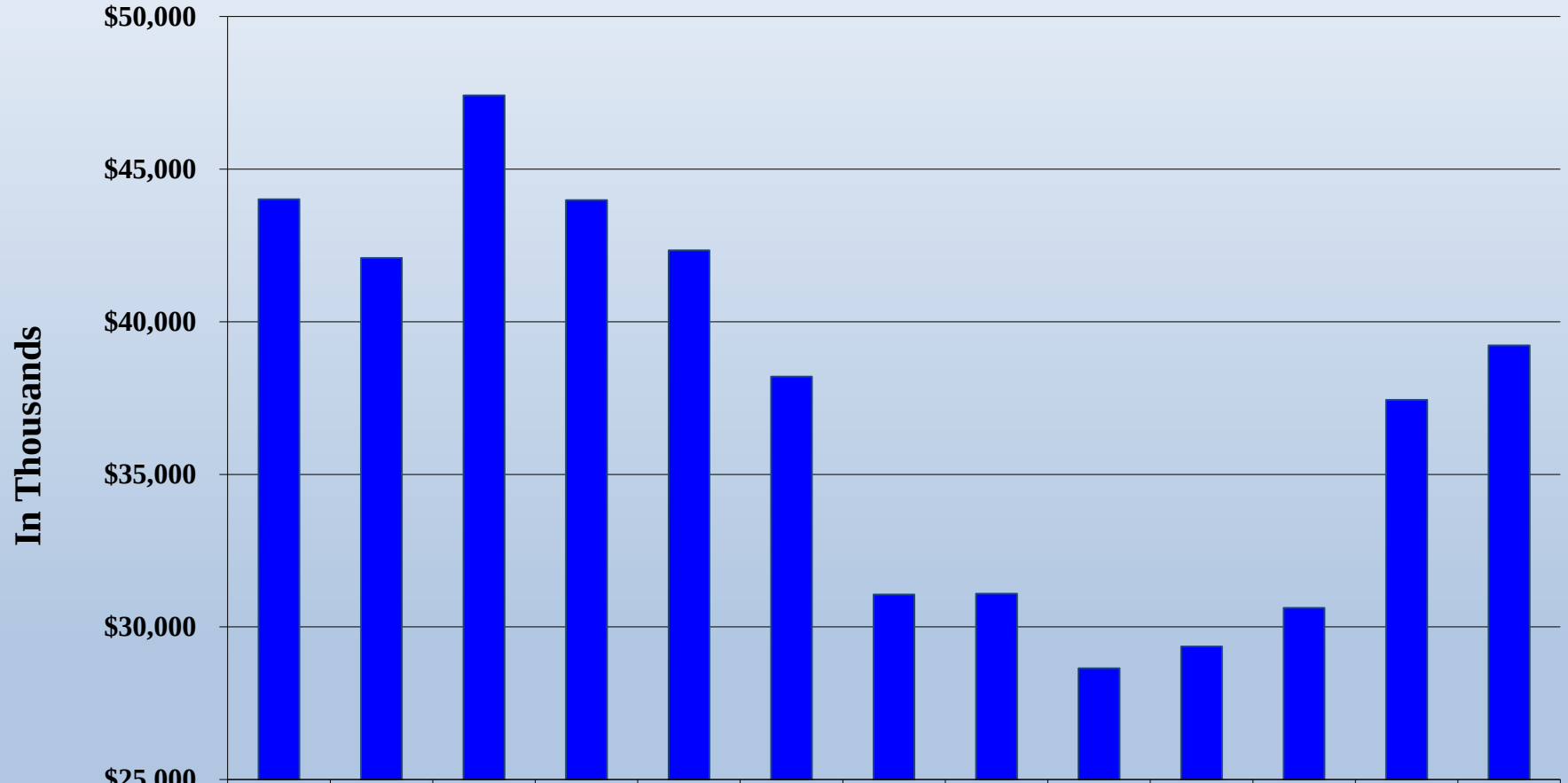
Thirteen Month Trending



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Net A/R	48,934	46,557	51,802	48,337	46,826	42,786	36,323	36,490	34,579	35,092	36,369	43,065	44,448

Hospital Net Accounts Receivable

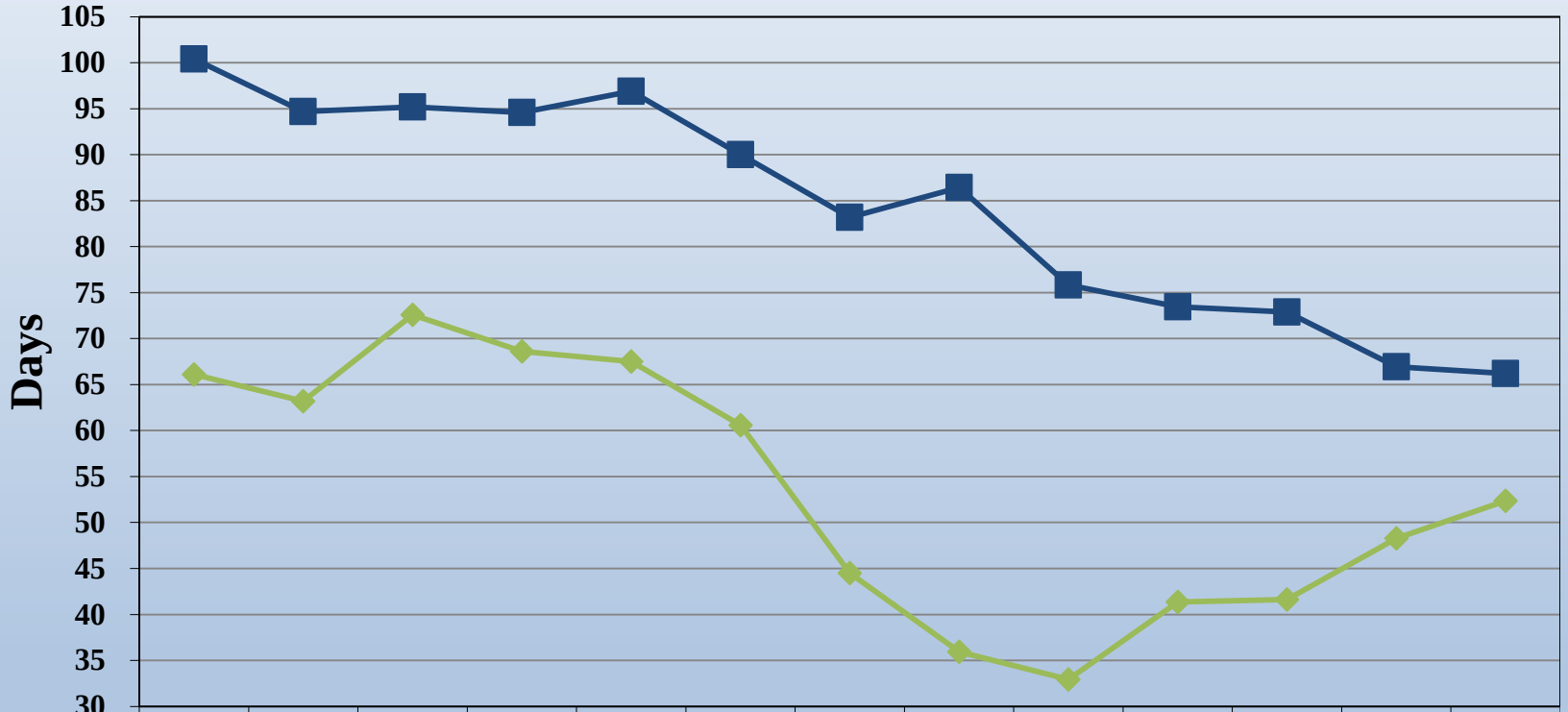
Thirteen Month Trending



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hospital Net A/R	44,016	42,095	47,417	43,985	42,340	38,207	31,060	31,087	28,642	29,361	30,623	37,437	39,225

Days in Accounts Receivable

Ector County Hospital District

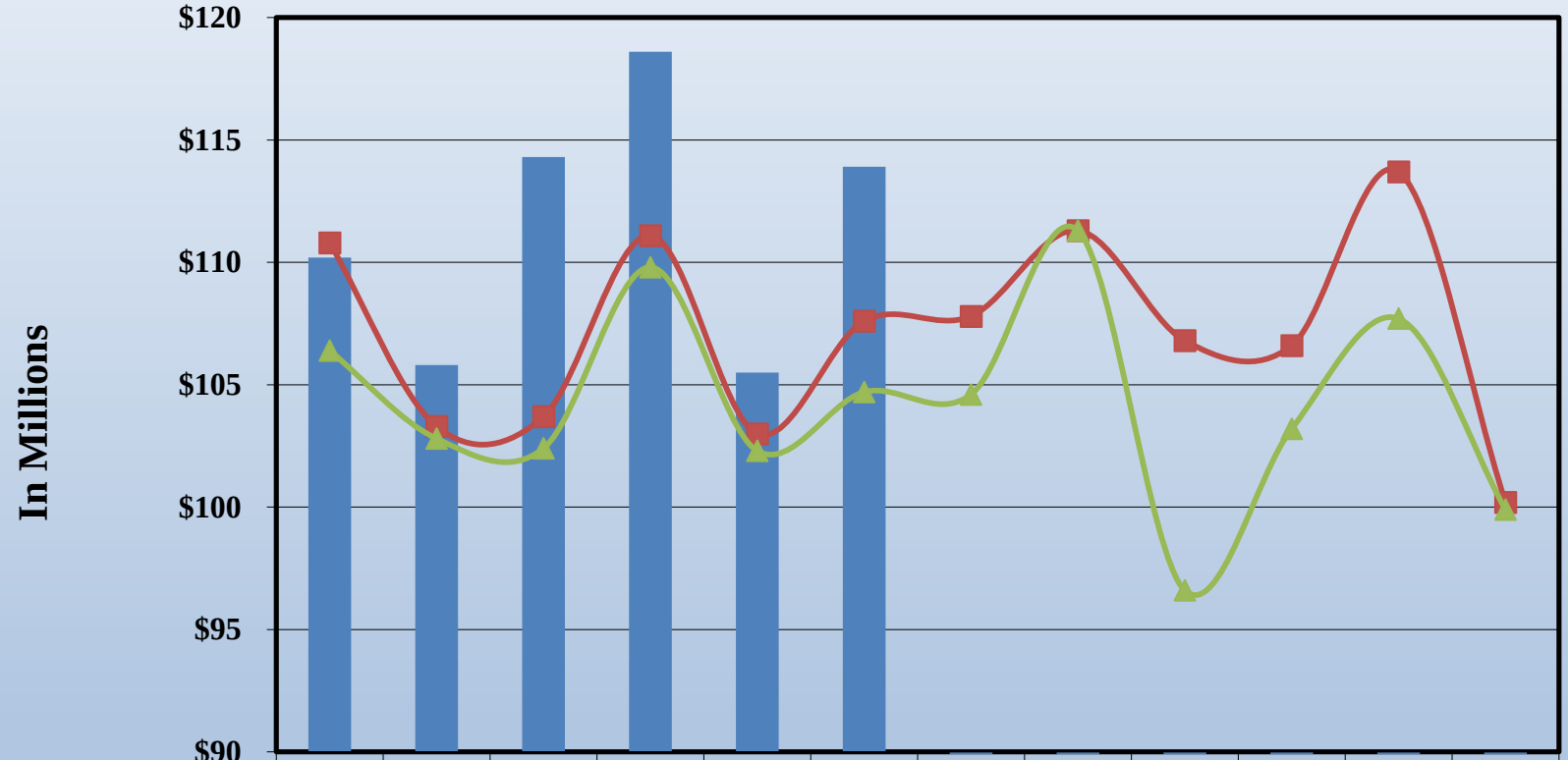


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Gross pt AR	100.4	94.7	95.2	94.6	96.9	90	83.2	86.4	75.8	73.5	72.9	66.9	66.2
Net pt AR	66.1	63.2	72.6	68.6	67.5	60.6	44.5	35.9	32.9	41.4	41.6	48.3	52.4

Revenues & Revenue Deductions

Total Patient Revenues

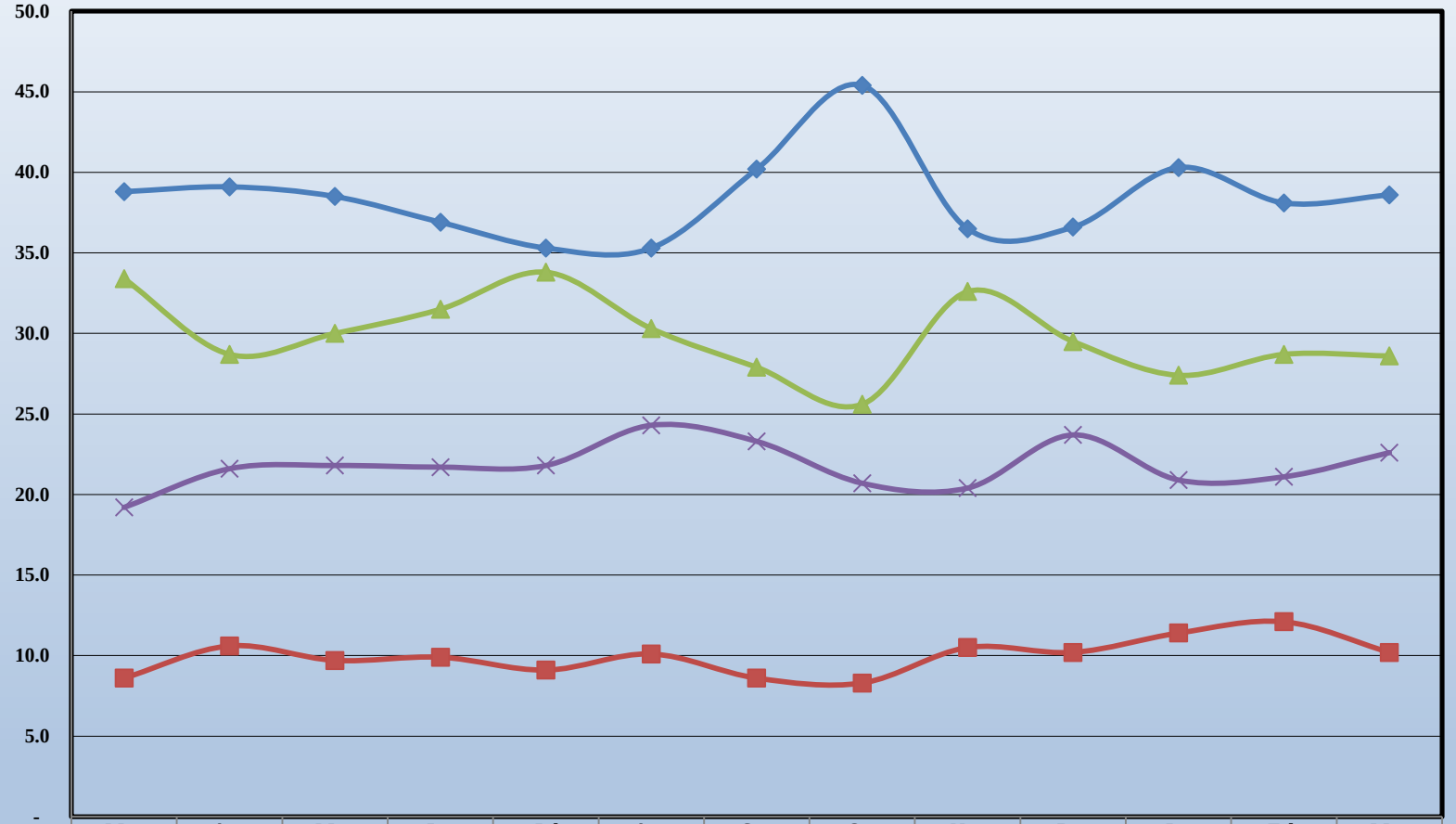
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	110.2	105.8	114.3	118.6	105.5	113.9	-	-	-	-	-	-
FY 2019 Budget	110.8	103.3	103.7	111.1	103.0	107.6	107.8	111.3	106.8	106.6	113.7	100.2
FY 2018	106.4	102.8	102.4	109.8	102.3	104.7	104.6	111.3	96.6	103.2	107.7	99.9

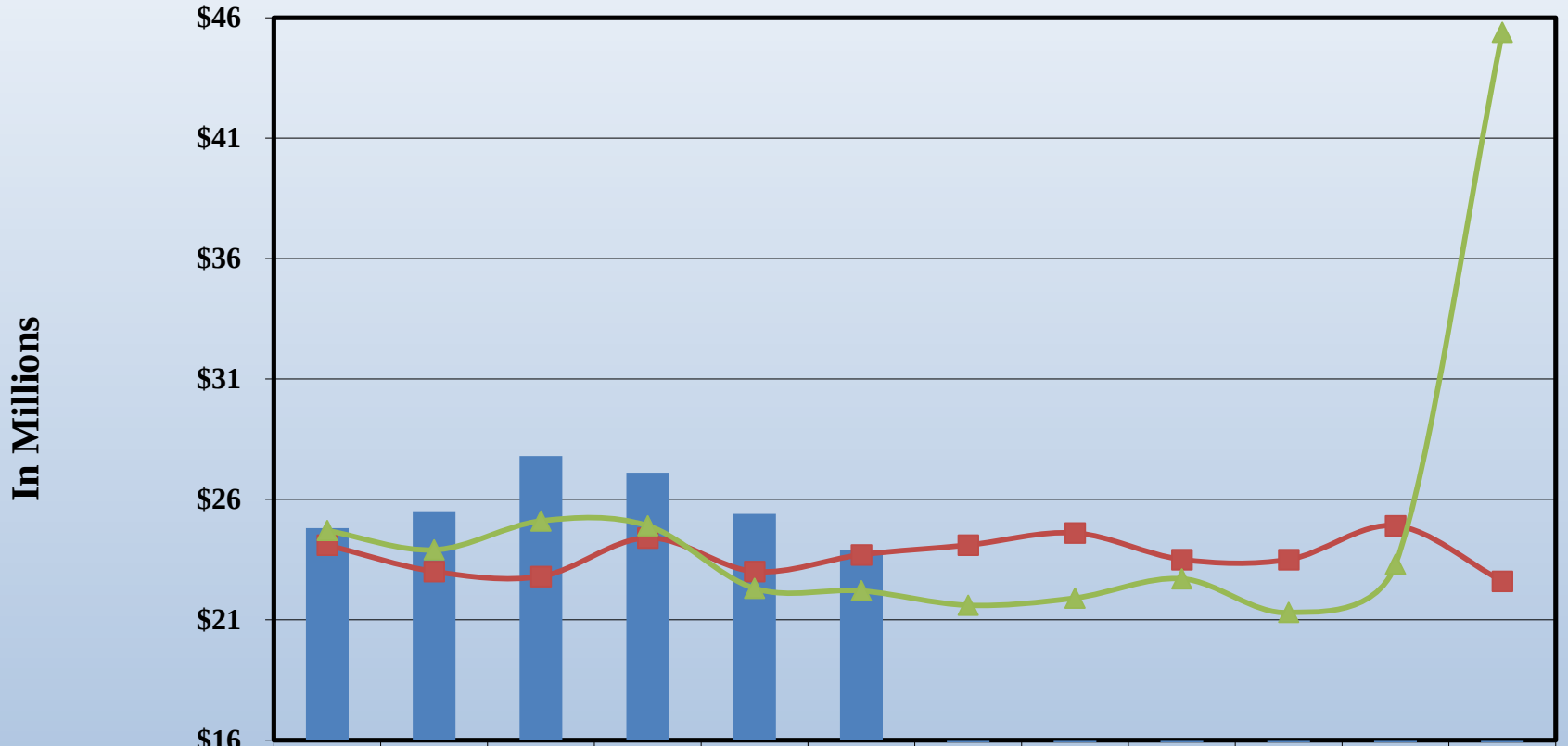
Hospital Revenue Payor Mix

13 Month Trend



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medicare	38.8	39.1	38.5	36.9	35.3	35.3	40.2	45.4	36.5	36.6	40.3	38.1	38.6
Medicaid	8.6	10.6	9.7	9.9	9.1	10.1	8.6	8.3	10.5	10.2	11.4	12.1	10.2
Third Party	33.4	28.7	30.0	31.5	33.8	30.3	27.9	25.6	32.6	29.5	27.4	28.7	28.6
Private	19.2	21.6	21.8	21.7	21.8	24.3	23.3	20.7	20.4	23.7	20.9	21.1	22.6

Total Net Patient Revenues

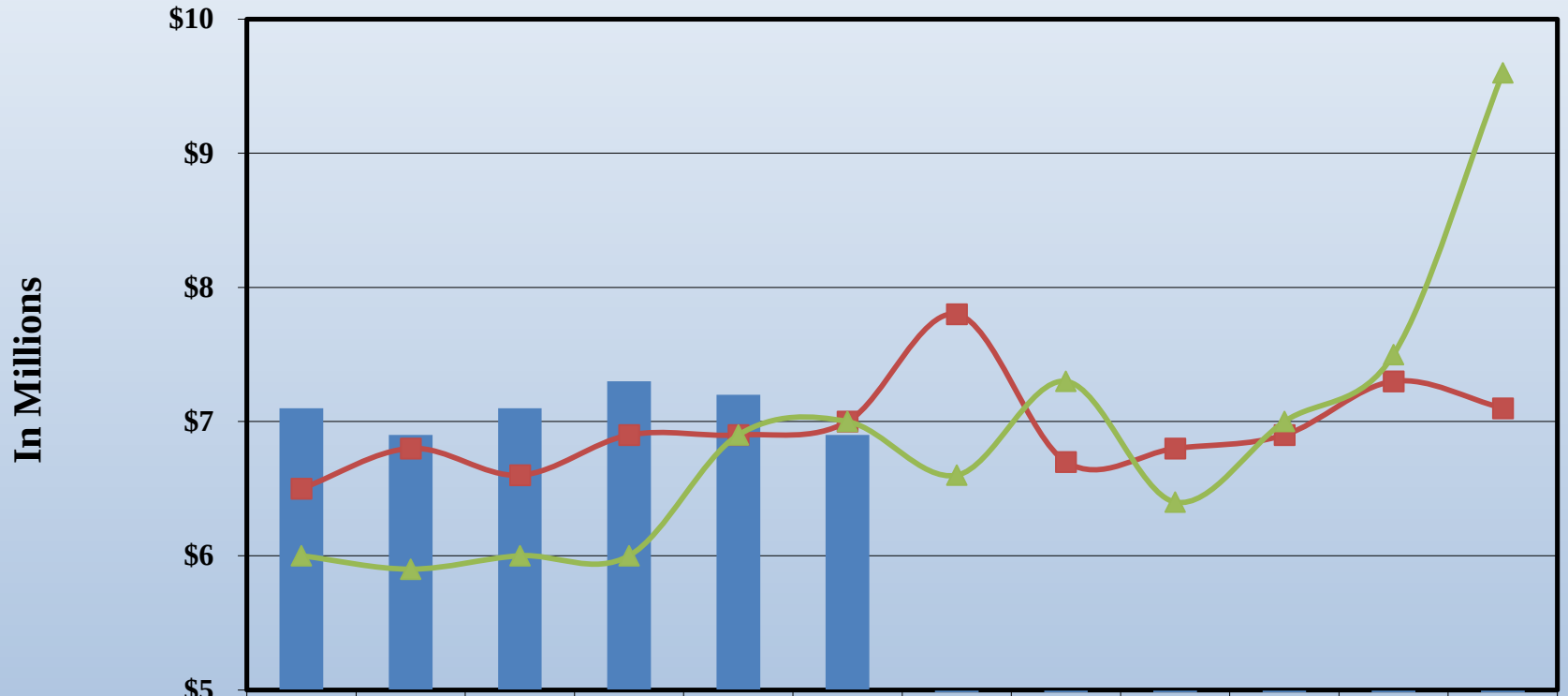


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	24.8	25.5	27.8	27.1	25.4	23.9	-	-	-	-	-	-
FY 2019 Budget	24.1	23.0	22.8	24.4	23.0	23.7	24.1	24.6	23.5	23.5	24.9	22.6
FY 2018	24.7	23.9	25.1	24.9	22.3	22.2	21.6	21.9	22.7	21.3	23.3	45.4

Other Revenue

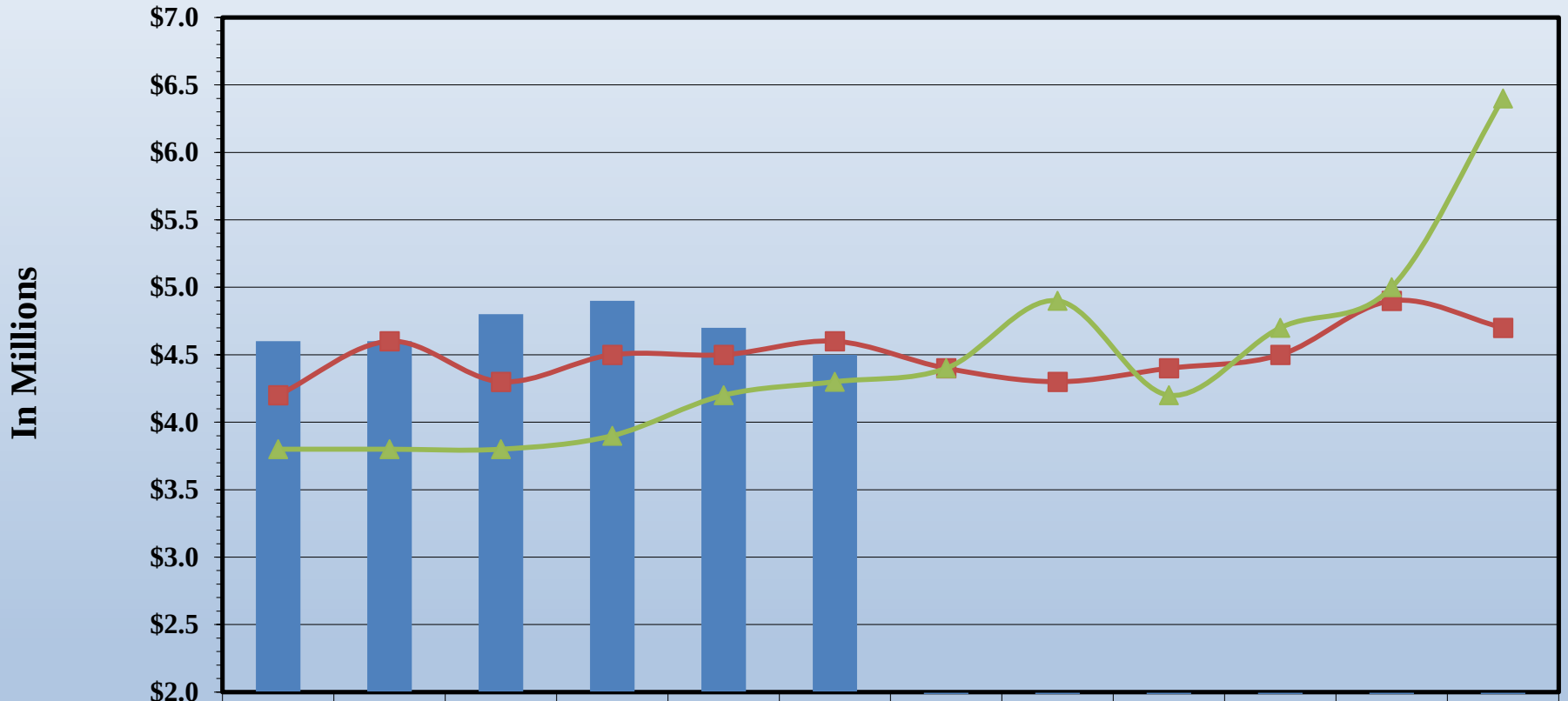
(Ector County Hospital District)

Including Tax Receipts, Interest & Other Operating Income



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	7.1	6.9	7.1	7.3	7.2	6.9	-	-	-	-	-	-
FY 2019 Budget	6.5	6.8	6.6	6.9	6.9	7.0	7.8	6.7	6.8	6.9	7.3	7.1
FY 2018	6.0	5.9	6.0	6.0	6.9	7.0	6.6	7.3	6.4	7.0	7.5	9.6

Sales Tax Receipts

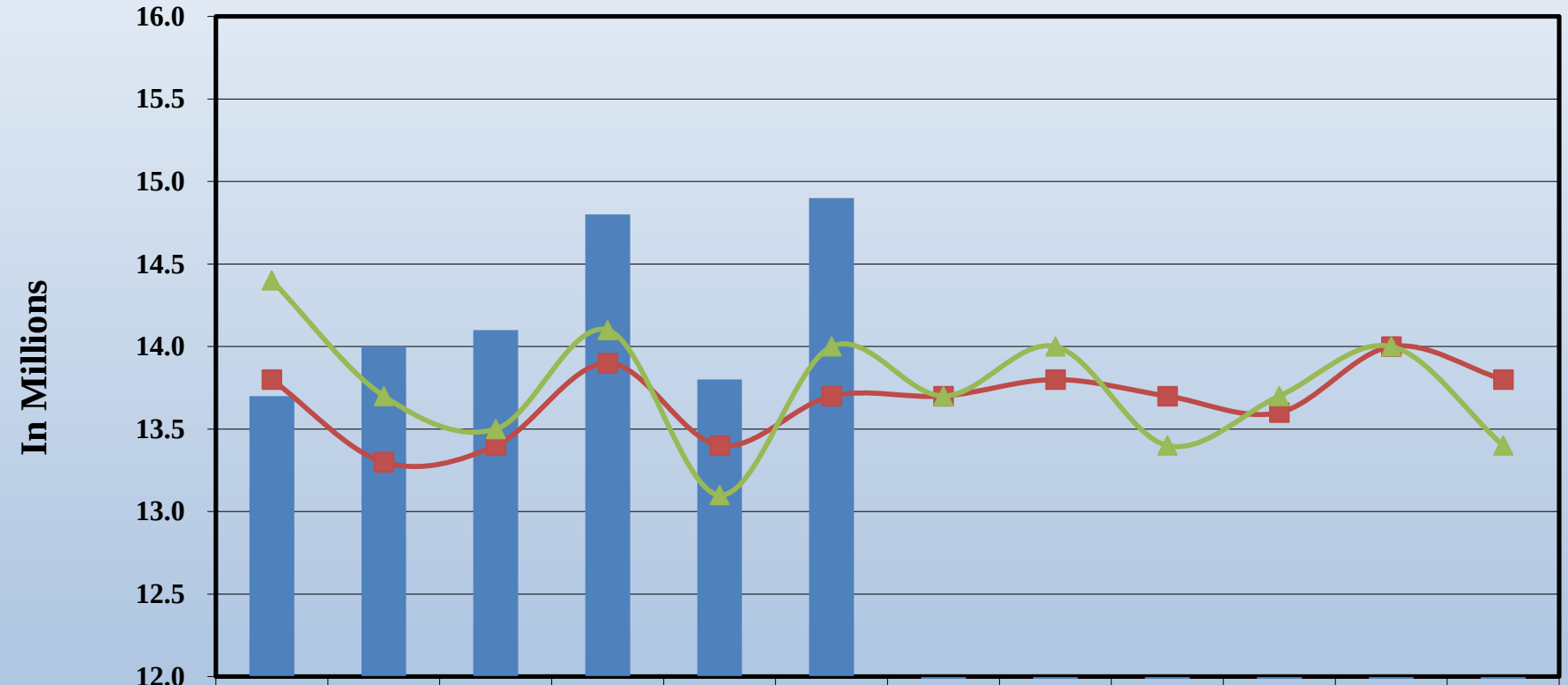


	Oct/Aug	Nov/Sept	Dec/Oct	Jan/Nov	Feb/Dec	Mar/Jan	Apr/Feb	May/Mar	Jun/Apr	Jul/May	Aug/Jun	Sep/Jul
FY 2019	4.6	4.6	4.8	4.9	4.7	4.5	-	-	-	-	-	-
FY 2019 Budget	4.2	4.6	4.3	4.5	4.5	4.6	4.4	4.3	4.4	4.5	4.9	4.7
FY 2018	3.8	3.8	3.8	3.9	4.2	4.3	4.4	4.9	4.2	4.7	5.0	6.4

Operating Expenses

Salaries, Wages & Contract Labor

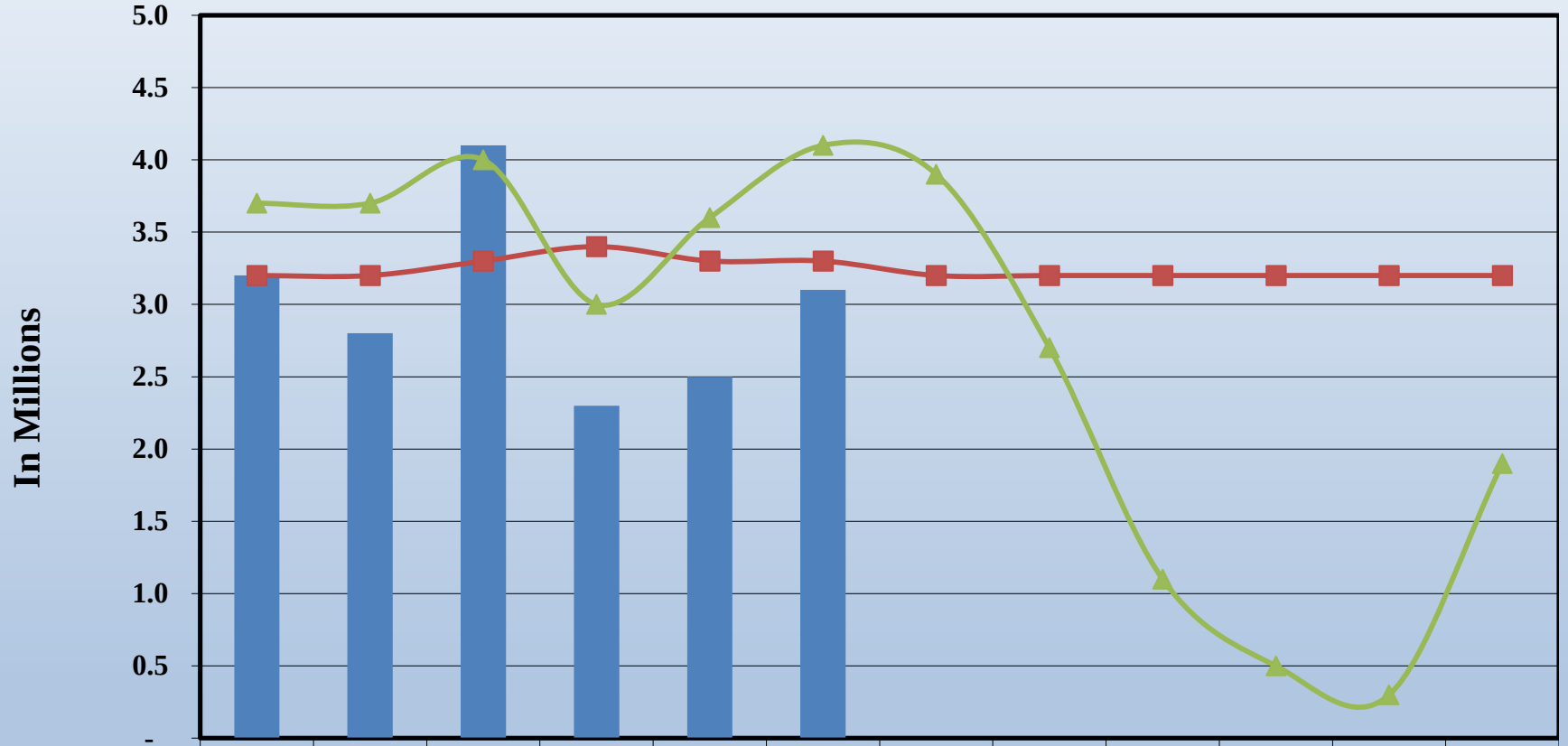
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	13.7	14.0	14.1	14.8	13.8	14.9	-	-	-	-	-	-
FY 2019 Budget	13.8	13.3	13.4	13.9	13.4	13.7	13.7	13.8	13.7	13.6	14.0	13.8
FY 2018	14.4	13.7	13.5	14.1	13.1	14.0	13.7	14.0	13.4	13.7	14.0	13.4

Employee Benefit Expense

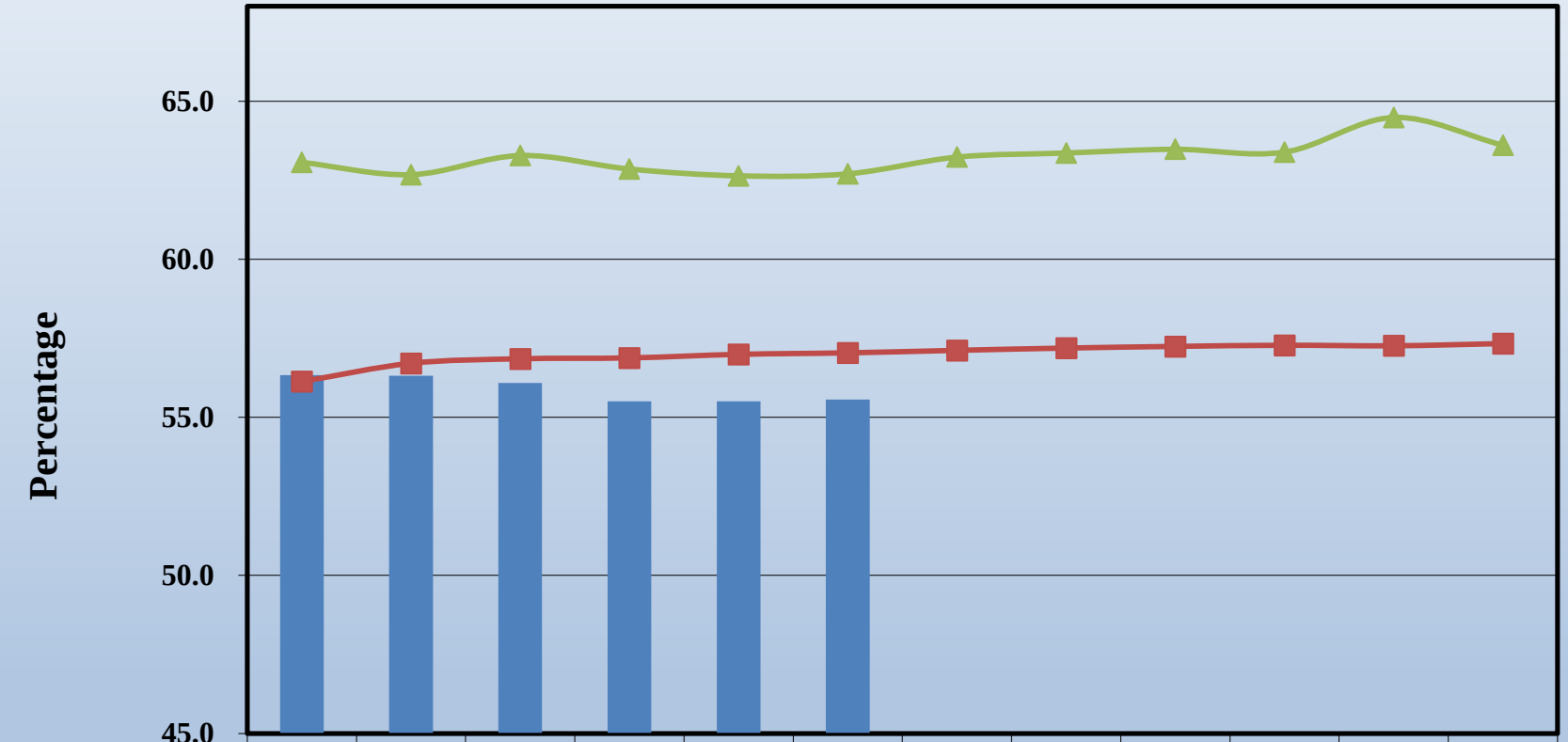
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	3.2	2.8	4.1	2.3	2.5	3.1	-	-	-	-	-	-
FY 2019 Budget	3.2	3.2	3.3	3.4	3.3	3.3	3.2	3.2	3.2	3.2	3.2	3.2
FY 2018	3.7	3.7	4.0	3.0	3.6	4.1	3.9	2.7	1.1	0.5	0.3	1.9

Salaries, Wages, Benefits, and Temp Labor as a % of Total Operating Expense Year-to-Date

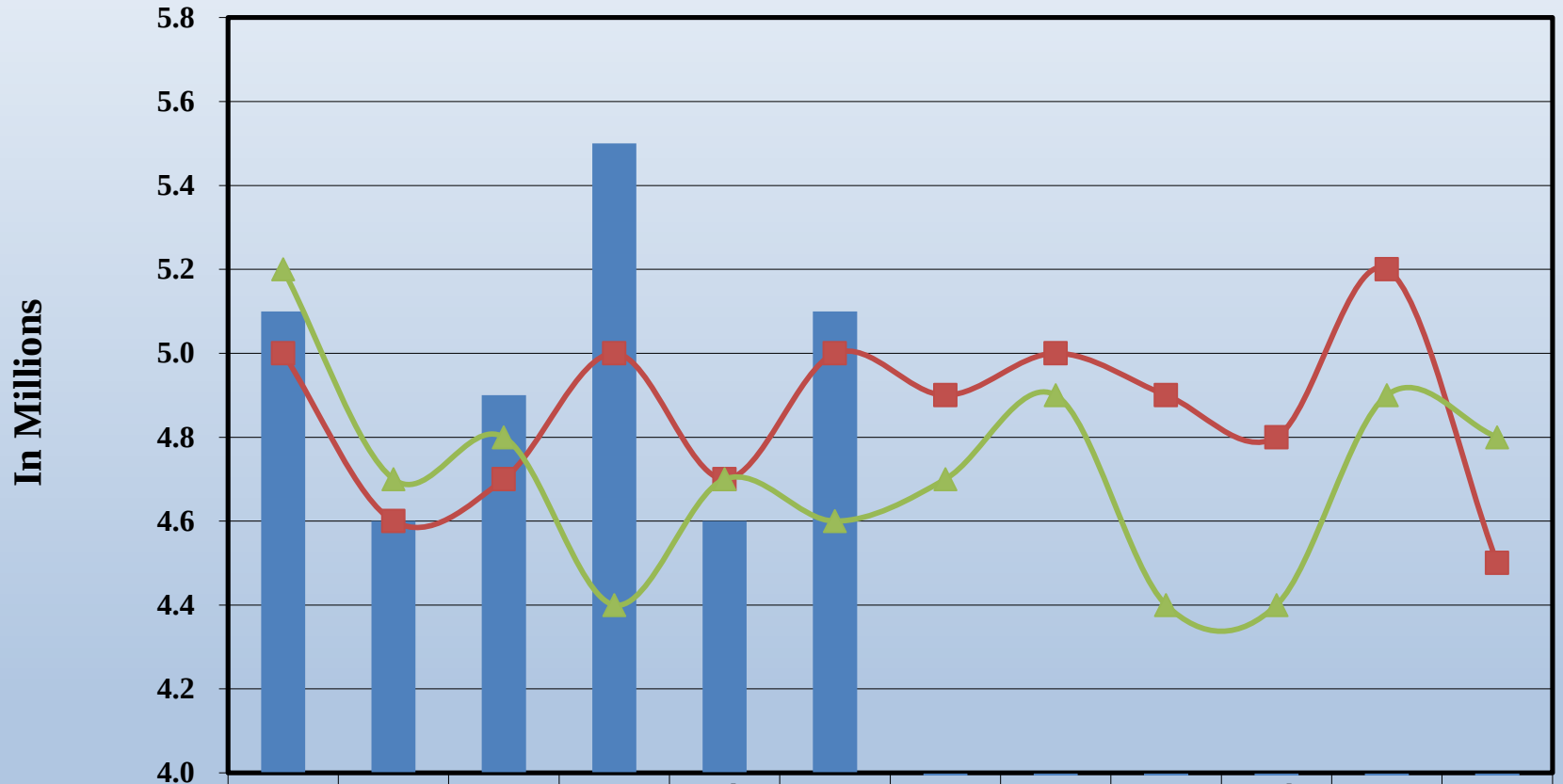
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	56.3	56.3	56.1	55.5	55.5	55.6						
FY 2019 Budget	56.1	56.7	56.9	56.9	57.0	57.0	57.1	57.2	57.2	57.3	57.3	57.3
FY 2018	63.1	62.7	63.3	62.9	62.6	62.7	63.2	63.4	63.5	63.4	64.5	63.6

Supply Expense

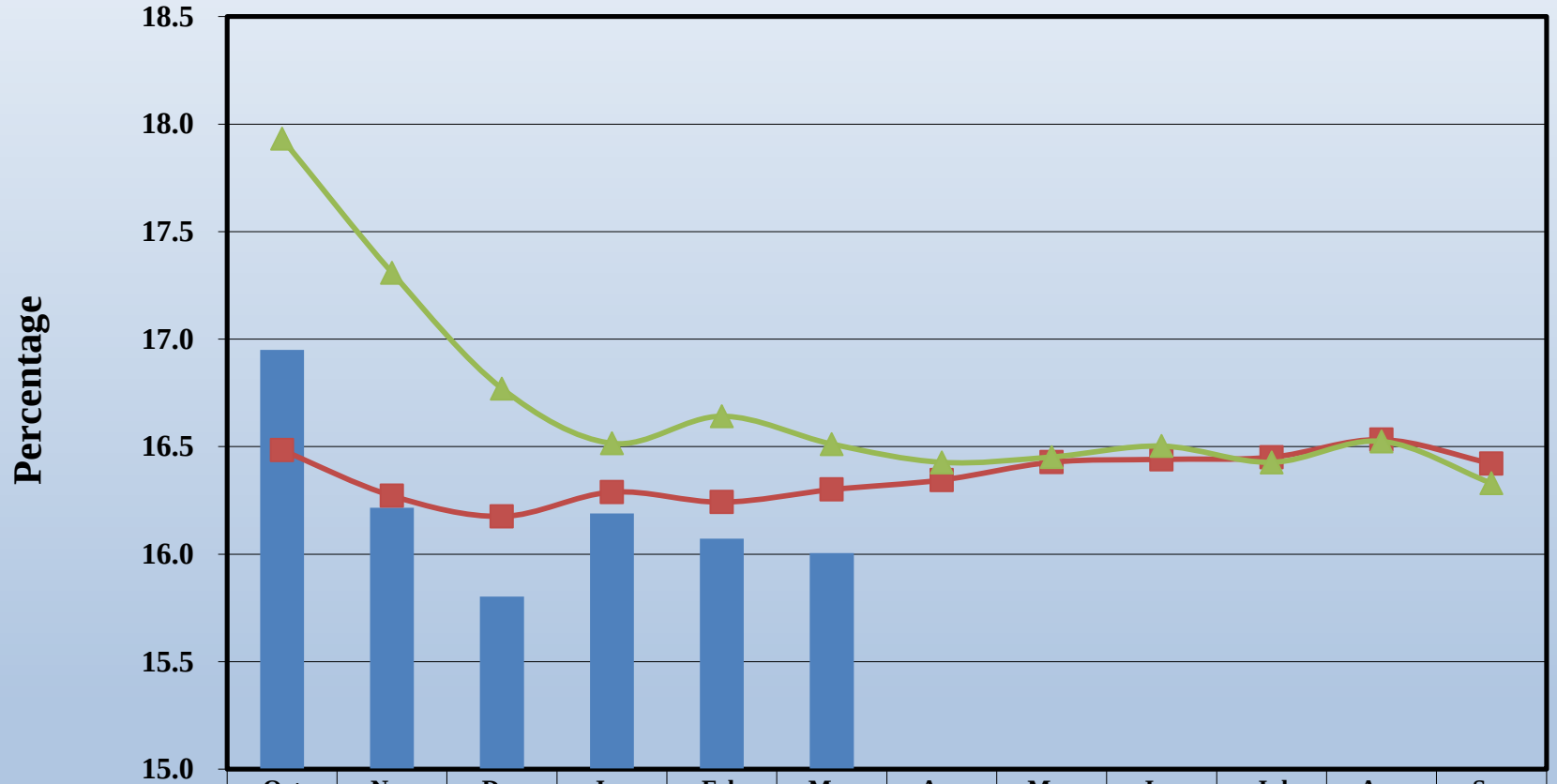
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	5.1	4.6	4.9	5.5	4.6	5.1	-	-	-	-	-	-
FY 2019 Budget	5.0	4.6	4.7	5.0	4.7	5.0	4.9	5.0	4.9	4.8	5.2	4.5
FY 2018	5.2	4.7	4.8	4.4	4.7	4.6	4.7	4.9	4.4	4.4	4.9	4.8

Supply Expense as a % of Total Operating Expense Year-to-Date

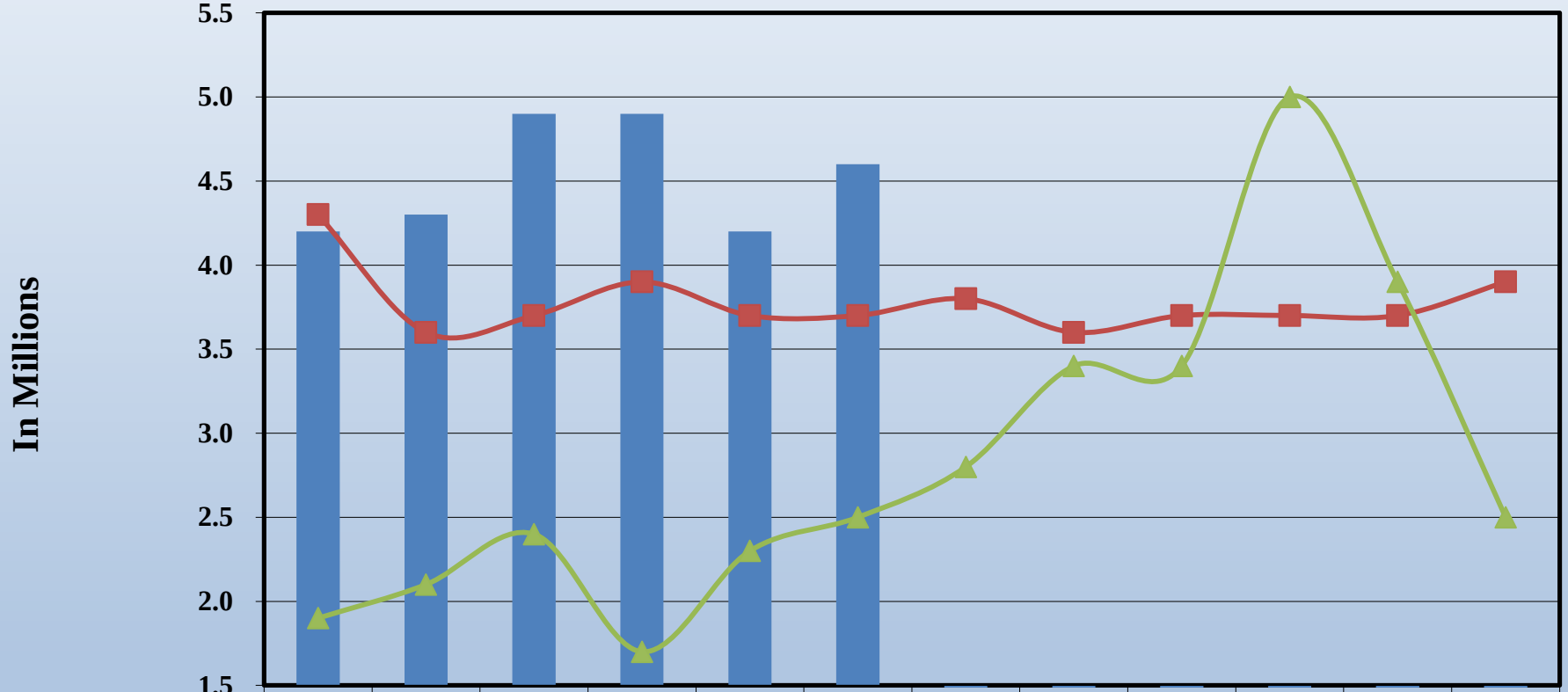
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	16.9	16.2	15.8	16.2	16.1	16.0						
FY 2019 Budget	16.5	16.3	16.2	16.3	16.2	16.3	16.3	16.4	16.4	16.5	16.5	16.4
FY 2018	17.9	17.3	16.8	16.5	16.6	16.5	16.4	16.5	16.5	16.4	16.5	16.3

Purchased Services

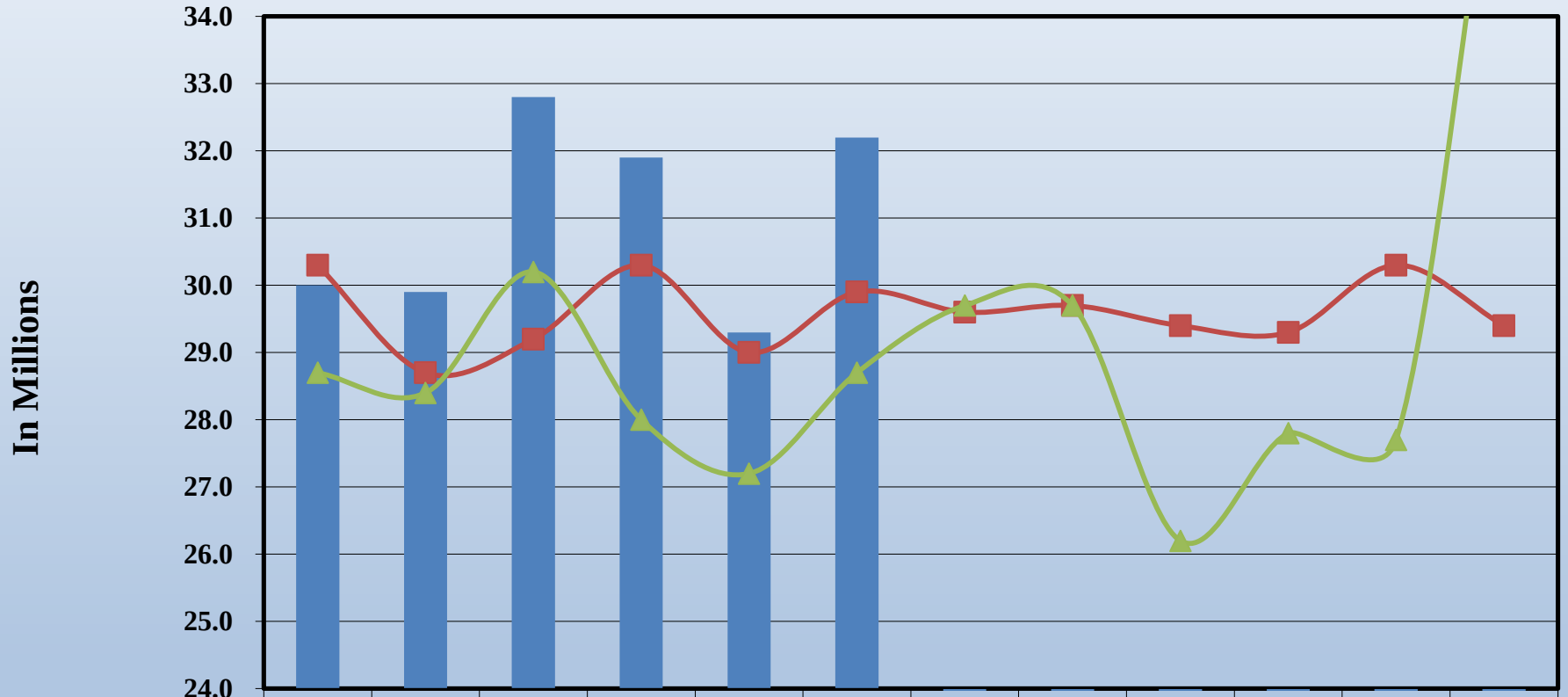
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	4.2	4.3	4.9	4.9	4.2	4.6	-	-	-	-	-	-
FY 2019 Budget	4.3	3.6	3.7	3.9	3.7	3.7	3.8	3.6	3.7	3.7	3.7	3.9
FY 2018	1.9	2.1	2.4	1.7	2.3	2.5	2.8	3.4	3.4	5.0	3.9	2.5

Total Operating Expense

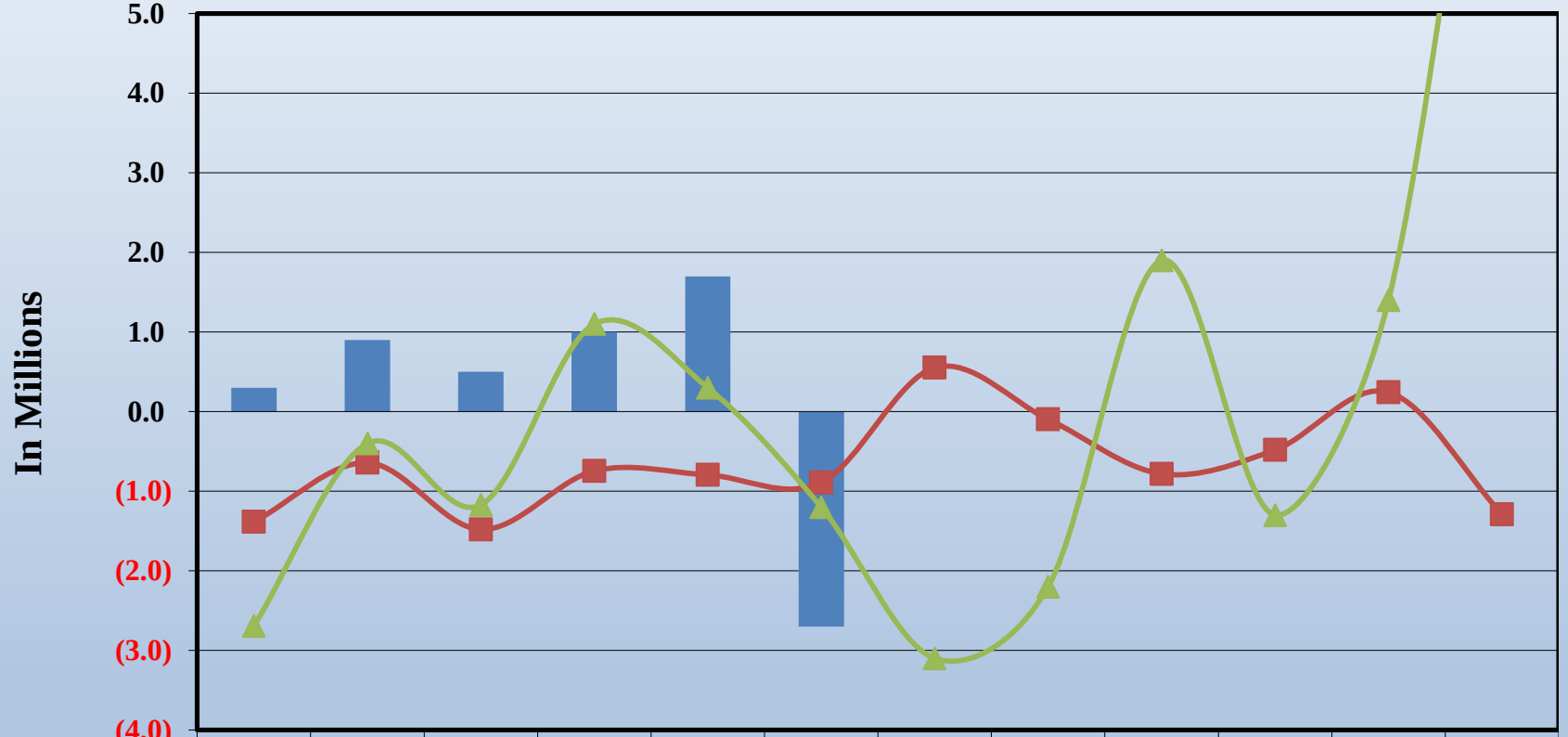
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	30.0	29.9	32.8	31.9	29.3	32.2	-	-	-	-	-	-
FY 2019 Budget	30.3	28.7	29.2	30.3	29.0	29.9	29.6	29.7	29.4	29.3	30.3	29.4
FY 2018	28.7	28.4	30.2	28.0	27.2	28.7	29.7	29.7	26.2	27.8	27.7	38.0

Change in Net Position

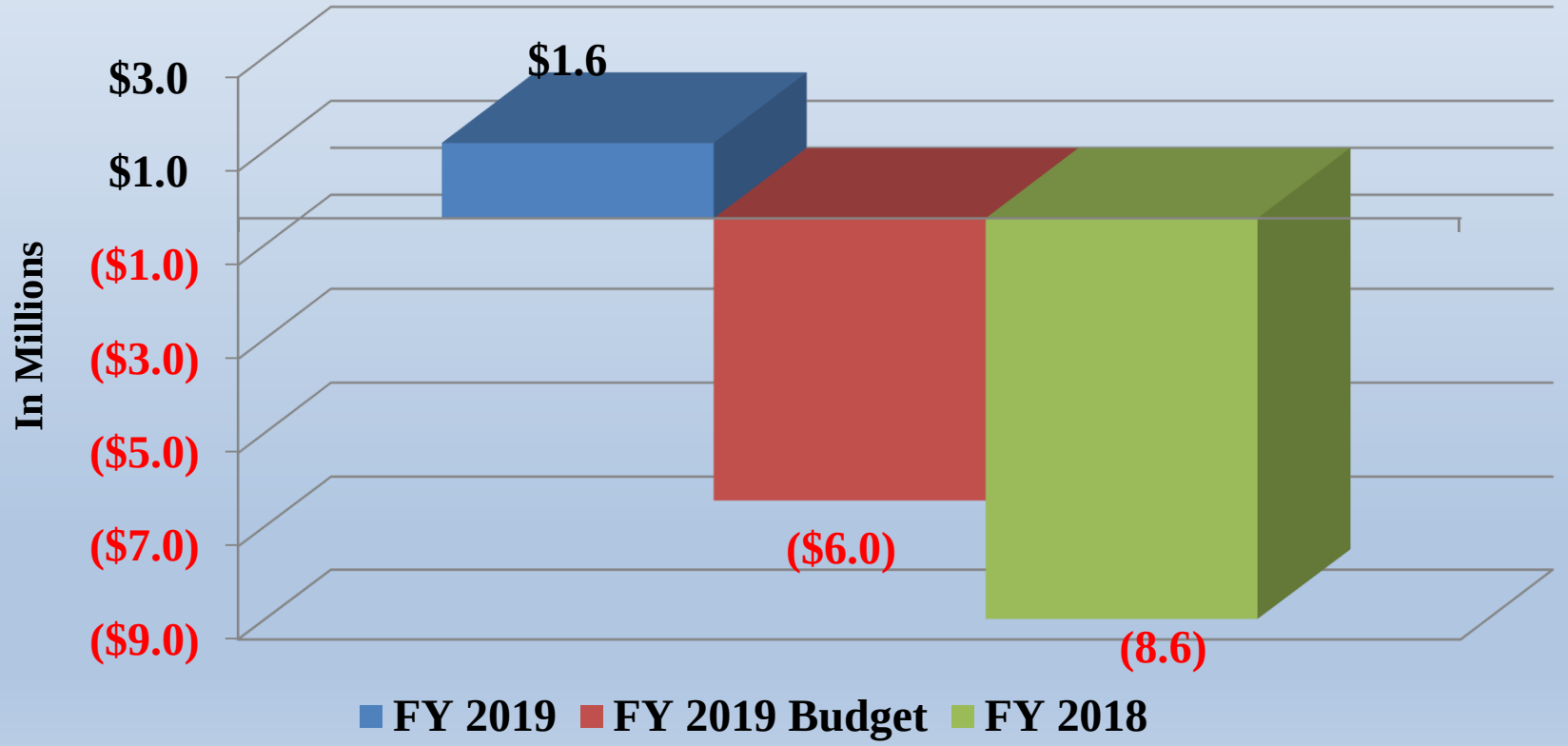
Ector County Hospital District Operations



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 2019	0.3	0.9	0.5	1.0	1.7	(2.7)						
FY 2019 Budget	(1.4)	(0.6)	(1.5)	(0.7)	(0.8)	(0.9)	0.6	(0.1)	(0.8)	(0.5)	0.2	(1.3)
FY 2018	(2.7)	(0.4)	(1.2)	1.1	0.3	(1.2)	(3.1)	(2.2)	1.9	(1.3)	1.4	10.4

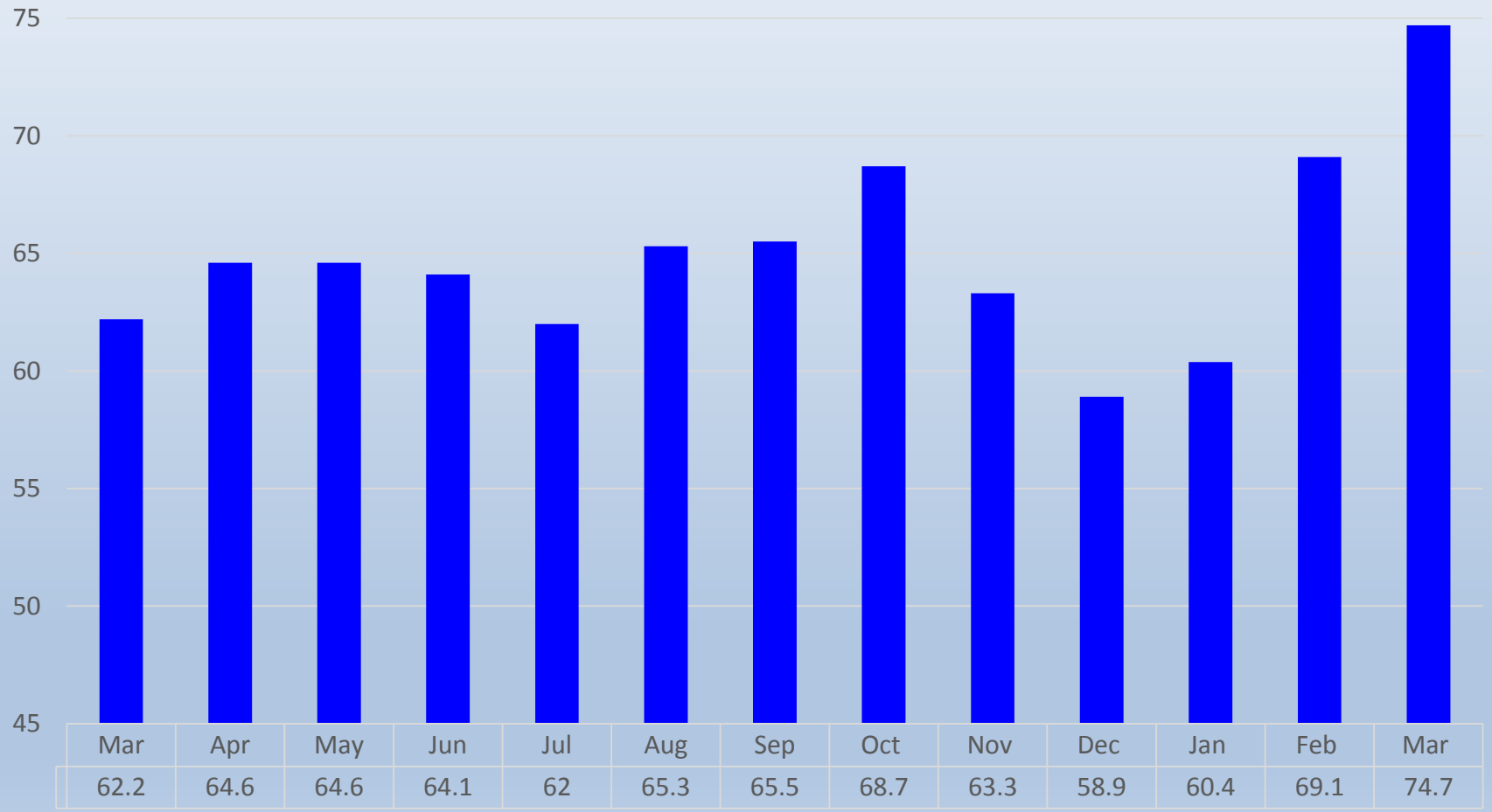
Change in Net Position

Ector County Hospital District Operations – Year to Date



Days Cash on Hand

Thirteen Month Trending



Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
62.2	64.6	64.6	64.1	62	65.3	65.5	68.7	63.3	58.9	60.4	69.1	74.7

Year-to-Date Debt Service Ratio

Must be Greater Than 110%

	Oct	Nov	Dec	Jan	Feb	Mar
DSR	721%	758%	760%	930%	838%	663%


mch
mch

FY 2019 CAPITAL EQUIPMENT REQUEST

Date: March 19, 2019

To: Ector County Hospital District Board of Directors

Through: Rick Napper, President / CEO
Christin Timmons, Interim Chief Nursing Officer

From: Don Owens, RN, ACNO Surgical Services
Cody McKee, RN, Director of Surgical Operations

Re: UDI Tracker (Tissue Tracking / Management)

Total Cost (over 3 years)	**$ 165,607.00**
Year 1 FY2019	$ 74,619.00
Year 2 FY2020	$ 45,494.00
Year 3 FY2021	$ 45,494.00
CER 6620-19-01	$ 170,193.00
Total to contingency	$ 4,586.00

OBJECTIVE

Surgical Services uses an extensive amount of biological and non-biological implants; over $986,000 spend last year. The national average of waste is 17% due to expired and lost products. Tissue management systems were created to improve patient safety and injury as part of a Joint Commission directive. MCH currently utilizes a manual tracking system which is fallible and inconsistent at best. The proposed tissue management system benefits include:

- Joint Commission compliance and tracks FDA certification, tissue bank certification, and state licenses.
- Complete tracking/documentation of chain of custody from receipt of product to implant point of use.
- Patient safety – Immediate notification of recalled products, temperature monitoring, etc.
- Cost savings – elimination of expired and lost products.
- Reduced cost and revenue loss of uncharted/unbilled tissue and implants.

HISTORY

All tissue tracking currently a manual process and is highly susceptible to flaws and Joint Commission violations.

PURCHASE CONSIDERATIONS
Champion Technologies UDI Tracker is the system recommended by Joint Commission and former Informatics Manager Wiley Haydon.

Quotes	**UDI Tracker**	**TrackCore**	**WaveMark**
1st year	$74,619	$107,963	$100,403
2nd & 3rd years	$45,494 / year	$19,790 / year	$58,098 / year
Cerner Compatible	Yes	Yes	No

FTE IMPACT
No additional FTE(s) will be required.

INSTALLATION & TRAINING
Provided by vendor.

WARRANTY AND SERVICE CONTRACT
Annual hardware and software license/maintenance fees

DISPOSITION OF EXISTING EQUIPMENT
N/A

LIFE EXPECTANCY OF EQUIPMENT
Review 3rd year

MD BUYLINE INFORMATION
Meets MD Buyline recommended pricing

COMMITTEE APPROVAL

Surgery	Mar. 18	Approved
FCC	Virtual	Approved
MEC	Apr. 18	Approved
Joint Conference	Apr. 23	Approved
ECHD Board	May 7	Pending

Medical Center Health System
Your One Source for Health

FY 2019 CAPITAL EQUIPMENT REQUEST

Date: March 19, 2019

To: Ector County Hospital District Board of Directors

Through: Rick Napper, President / CEO
Christin Timmons, Interim Chief Nursing Officer

From: Don Owens, RN, ACNO Surgical Services
Cody McKee, RN, Director of Surgical Operations

Re: (20 ea.) Medtronic ValleyLab Electrosurgical Units

Total Cost	**$ 184,005.00**
CER 6620-19-02	$ 307,000.00
Total to contingency	$ 122,995.00

OBJECTIVE

ESU (bovie) is used extensively in surgical procedures to cut, coagulate, dissect, fulgurate, and ablate tissue. The current units are past end-of-life and repairs require utilizing parts from other units. Proposal is to replace all units.

HISTORY

Current ValleyLab ESU units were purchased in 2000 and are past end-of-life. Parts are no longer available. NBV = $0

PURCHASE CONSIDERATIONS

Week-long trials were conducted with four major vendors. Based on experience, proven longevity and dependability, and overall performance, the surgeons voted to approve the ValleyLab product.

Quotes	**Olympus**	**ConMed**	**Ethicon**	**ValleyLab**
Basic ESU	$150,000	$180,000	$108,446	$196,305
Trade-In	None	$6,000	$37,500	$12,300
Total Price	**$150,000**	**$174,000**	**$70,946**	**$184,005**

FTE IMPACT
No additional FTE(s) will be required.

INSTALLATION & TRAINING
Provided by vendor.

WARRANTY AND SERVICE CONTRACT
1 year warranty

DISPOSITION OF EXISTING EQUIPMENT
Trade-in

LIFE EXPECTANCY OF EQUIPMENT
10 years

MD BUYLINE INFORMATION
Meets MD Buyline recommended pricing

COMMITTEE APPROVAL

Surgery	Mar. 18	Approved
FCC	Virtual	Approved
MEC	Apr. 18	Approved
Joint Conference	Apr. 23	Approved
ECHD Board	May 7	Pending

Medical Center Health System
Your One Source for Health

FY 2019 CAPITAL EQUIPMENT REQUEST

Date: March 19, 2019

To: Ector County Hospital District Board of Directors

Through: Rick Napper, President / CEO
Christin Timmons, Interim Chief Nursing Officer

From: Don Owens, RN, ACNO Surgical Services
Cody McKee, RN, Director of Surgical Operations

Re: Capital Lease: (18 ea.) Draeger Perseus A500 Anesthesia Machines

Total Cost (over 36 months)	**$1,606,788.00**
Capital Lease proposal: 36 months at $44,633 / month	(Not Budgeted)
Year 1 FY2019	$ 535,596.00
Year 2 FY2020	$ 535,596.00
Year 3 FY2021	$ 535,596.00

OBJECTIVE

Anesthesia machines are used extensively in surgical procedures for patient ventilation and monitoring, and anesthetic gas agent delivery. Current GE units are aging and wearing from high utilization. Maintenance requirements are continually increasing. Proposal is to replace all units via capital lease. Note: 15 units for OR, 2 for L&D, and 1 for Cath Lab.

HISTORY

Current GE Aysys anesthesia machines purchased in 2009. NBV = $0

PURCHASE CONSIDERATIONS

Week-long trials were conducted with GE, Draeger and Mindray. Mindray dismissed as inferior product for MCH workload requirements. The Anesthesia Dept. has voted on the Draeger product.

Quotes	**Draeger**	**GE**
36 month total	$1,606,788	$2,055,276
Trade-In	included	included

FTE IMPACT

No additional FTE(s) will be required.

INSTALLATION & TRAINING
Provided by vendor.

WARRANTY AND SERVICE CONTRACT
1 year warranty

DISPOSITION OF EXISTING EQUIPMENT
Trade-in

LIFE EXPECTANCY OF EQUIPMENT
10 years

MD BUYLINE INFORMATION
Meets MD Buyline recommended pricing

COMMITTEE APPROVAL

Anesthesia	Virtual	Approved
FCC	Virtual	Approved
MEC	Apr. 18	Approved
Joint Conference	Apr. 23	Approved
ECHD Board	May 7	Pending

Medical Center Health System
Your One Source for Health

To: ECHD Board of Directors
Through: Rick Napper, President / CEO
Through: Matt Collins, Vice-President of Clinical Support Services
From: Carol Evans, Divisional Director - Imaging Services
Date: March 26, 2019
RE: Acquisition of MRI Evolve Upgrade

CER 7210-19-01:	$127,000
Cost Siemens MRI Verio DOT upgrade :	129,301
From Contingency:	$ 2,301

REQUEST
The Department of Radiology is requesting approval to purchase software and hardware upgrades for the 3T Verio MRI for a total cost of $129,301.

OBJECTIVE

The Verio MRI has not been upgraded since being removed from Siemens' service contract. This upgrade is a prerequisite to any future application software upgrades. The upgrade accomplishes the following:

- Replaces hardware and provides the latest version of software.
- Replaces both computers used for reconstruction and acquisition which will in turn shorten reconstruction time and total scan time for patients.
- Upgrades system to a 32 channels which will increase signal to noise ratio and allow for the use of more advanced coils.
- Includes Syngo Blade MR Software which reduces sensitivity to movement during scans allowing for improved imaging of patients that have difficulty holding still or rapid respiration.
- Upgrade utilizes Windows 7 platform which is supported with security patches and becomes less of a liability to network security than current Windows XP platform.
- Includes clinical on-site application training for staff

IT REQUIREMENTS
Standard IT requirements for imaging equipment require ADT and order information to be sent from Cerner to the unit. Also, digital images will be sent to DR PACS and then to MCH Portal. Upgrades will use existing configurations.

VENDOR CONSIDERATION
Siemens is the only vendor that can upgrade the existing Siemens systems.

FTE IMPACT
No additional FTEs are needed.

WARRANTY & SERVICE COVERAGE
Siemens warrants new hardware will be free from defects in material and manufacturing workmanship for a period of twelve months upon availability for first patient use.

MD BUYLINE
MCH received the MD Buyline recommended discount of 35.29%.

DISPOSITION OF EXISTING EQUIPMENT
Old computers will be removed and disposed of by Siemens.

COMMITTEE APPROVALS

Capital Planning	April 2019
Radiology Section Meeting	April 2019
MEC	April 2019
Joint Conference	April 2019
ECHD Board	April 2019

Medical Center Health System
Your One Source for Health

To: ECHD Board of Directors
Through: Rick Napper, President / CEO
Through: Matt Collins, Vice-President of Clinical Support Services
From: Carol Evans, Divisional Director - Imaging Services
Date: March 22, 2019
RE: Acquisition of Portable Ultrasound Unit

CER 7310-19-02	$70,805.00
Sonosite X-porte Ultrasound unit	$73,530.00
From Contingency	$ 2,725.00

REQUEST
The Department of Radiology Special Procedures is requesting approval to purchase a Sonosite X-porte portable ultrasound unit at a total cost of $73,530.00.

OBJECTIVE
This acquisition will increase the number of ultrasound units being used in Specials Procedures to a total of 3. The current systems have both been prone to extended downtime and the addition of another system will provide redundancy. With 3 systems staff will have the ability to perform procedures on multiple patients in different locations.

IT REQUIREMENTS
Digital images will be sent to DR PACS and then to MCH Portal.

VENDOR CONSIDERATION

Vendor	Cost
Sonosite X-porte	$73,530.000
Sonosite Edge II	$70,804.00
MindRay TE 7	$60,848.00

Sonosite X-porte is the vendor of choice for the following reasons:

- Utilizes a larger screen providing the radiologist with a larger field-of-view.
- Greater functionality than the smaller laptop designs of the Edge II.
- Fast boot-up time

The MindRay TE-7 was the least popular unit after site demonstrations of all three units. Sonosite is a proven product at MCH while MindRay is a new vendor without a proven track record. Sonosite X-porte has also been the recent choice of both the Trauma department and the Critical Care departments. The system has a quicker boot up time than its competitors and is ready to perform procedures in the shortest amount of time. This is very convenient in an emergent situation.

FTE IMPACT
No additional FTEs are needed.

WARRANTY & SERVICE COVERAGE
Sonosite warrants the system will be free from defects in material and manufacturing workmanship for a period of five years upon availability for first patient use.

MD BUYLINE
MD Buyline recommended a discount of 14.00%. We received a discount of 14.00%.

DISPOSITION OF EXISTING EQUIPMENT
All current equipment will be retained for use in the Special Procedures department.

COMMITTEE APPROVALS

Radiology Section Meeting	4/11/19
FCC	Virtual
MEC	4/18/19
Joint Conference	4/23/19
ECHD Board	5/7/19

Medical Center Health System
Your One Source for Health

DATE: March 26, 2019

TO: Board of Directors
Ector County Hospital District

FROM: Robert Abernethy
Senior Vice President / Chief Financial Officer

Subject: Fitch Ratings – Full Rating Report

Attached is the Full Rating Report from Fitch Rating. Fitch affirmed our BB+ rating with a Stable outlook. The rating uses the terminology “Long-term Issuer Default Rating”, which instituted last year. The rating does not indicate that the District is in default, just indicates the likelihood of possible default in the future.

There were three key rating drivers that were used in arriving at the final rating.

- Revenue Defensibility was rated as a “BBB”. This is based on our leading market share and the fact that we are a taxing entity.
- Operating Risk was rated as a “BBB”. This area recognized the improvement in the 2018 operating profitability.
- Financial Profile was rated as a “BB” due to weak days cash on hand and cash to adjusted debt, which creates a weak leverage position.

While we had hoped for an improvement, considering the fact that ECHD had received two consecutive downgrades factored greatly into Fitch’s decision to affirm. The positive, is that we have been able to stop the downgrade trend and are positioned to move back to a higher rating as we improve the cash position and liquidity and leverage positions.

Should you have questions or want to review the Fitch report with me, please give me a call.

Ector County Hospital District, Texas

Full Rating Report

Ratings

Long-Term Issuer Default Rating	BB+

Outstanding Debt

(Medical Center Hospital) Hospital Revenue Bonds (Build America Bonds - Direct Payment)	BB+

Rating Outlook

Stable

Analytical Conclusion

The affirmation of the 'BB+' rating primarily reflects Ector County Hospital District's (ECHD) weak net leverage position under a stressed scenario in the context of its midrange revenue defensibility and operating risk assessments. The Stable Rating Outlook reflects Fitch Ratings' expectation that ECHD will continue to improve its recent weaker operating profitability levels to historical levels over the medium term while maintaining a net leverage profile commensurate with its current rating level. Additionally, the Rating Outlook incorporates the expectation of steady growth in the local economy and tax revenues over the medium term.

Key Rating Drivers

Revenue Defensibility: 'bbb'; Leading Market Share in Energy-Driven Economy

ECHD's midrange defensibility primarily reflects its leading market share in its primary service area of Ector County, which remains vulnerable to energy price volatility. Additionally, ECHD is a taxing district that collects a 0.75% sales tax and levies ad valorem taxes up to $0.15 (currently at $0.1127) on each $100 taxable assessed valuation (TAV) to support operations. While ECHD's available ad valorem taxing margin provides limited financial cushion against unexpected operating volatility, Fitch does not view the taxing margin as strong enough for a higher revenue defensibility assessment.

Operating Risk: 'bbb'; Improving Operational Performance

ECHD's midrange operating risk assessment reflects the improvement in operating profitability levels in fiscal 2018 and the five-month interim period following recent operating, efficiency and revenue cycle improvement initiatives enacted by management. The assessment also incorporates the expectation that ECHD will incrementally improve its profitability levels to historical levels over the medium term as it continues to benefit from operational improvement initiatives and further growth in its local economy and tax base.

Financial Profile: 'bb'; Weak Net Leverage Position Under a Stress Scenario

In fiscal 2018, ECHD had a weak 56 days cash on hand (DCOH), 30% cash to adjusted debt and 4.4x net adjusted debt to adjusted EBITDA (NADAE). ECHD's weak net leverage position and limited cash reserves provide minimal financial flexibility under a stressed scenario. While it is expected that ECHD will continue to improve its profitability and cash reserves over the medium term, Fitch expects ECHD to maintain a net leverage position consistent with a 'bb' financial profile under a stressed scenario. Fitch's net leverage metrics include a higher pension liability obligation following an adjustment, per criteria, of ECHD's discount rate to 6% from 8.1%.

Asymmetric Additional Risk Considerations

No asymmetric risk factors affected this rating determination.

Rating Sensitivities

Further Improvement in Operations and Net Leverage: If Ector County Hospital District continues to improve and maintain its operating EBITDA levels above 9%, while further strengthening its cash reserves and moderating its debt position, there could be upward rating

Analysts

Ryan Pami
+1 212 908-0803
ryan.pami@fitchratings.com

Gary Sokolow
+1 212 908-9186
gary.sokolow@fitchratings.com

Rating History (IDR)

Rating	Action	Outlook/ Watch	Date
BB+	Affirmed	Stable	4/16/19
BB+	Downgraded	Stable	3/23/18
BBB	Downgraded	Negative	3/29/17
A–	Affirmed	Evolving[a]	8/26/16
A–	Affirmed	Stable	3/29/16
A–	Affirmed	Positive	4/8/14
A–	Assigned	Stable	4/16/10

[a]Rating Watch.

movement over the medium term. Conversely, while not expected, operational deterioration that results in balance sheet erosion would pressure the rating.

Credit Profile

Ector County Hospital District (d/b/a Medical Center Health System) owns and operates a 402 licensed bed acute care facility located in Odessa, Texas. With 349 beds in service, the hospital remains the largest hospital in the county and provides acute patient care services, inpatient rehabilitation services, outpatient diagnostic imaging and radiation oncology services. Additionally, ECHD serves as a teaching hospital for Texas Tech University Health Sciences Center. In fiscal 2018, ECHD had total revenues of $379 million, which includes approximately $70 million in tax revenues, in the form of both sales and property taxes.

Revenue Defensibility

Payor Mix

(% Gross Revenues; Fiscal Years Ended Sept. 30)	2015	2016	2017	2018	Five Mos. Ended 2/28/19
Medicare	40.6	42.4	39.9	37.4	39.5
Medicaid	11.6	11.7	10.8	9.5	10.4
Commercial & Managed Care	29.8	28.1	29.1	29.2	28.6
Self-Pay	11.8	11.6	14.3	19.1	17.6
Other	6.2	6.2	5.9	4.8	3.9
Total	100.0	100.0	100.0	100.0	100.0

Sources: Ector County Hospital District (TX) and Fitch.

ECHD's payor mix remained somewhat weak in fiscal 2018 as self-pay and Medicaid comprised approximately 28.6% of gross revenues. This remains marginally higher than fiscal 2017 levels of a combined 25.1% of gross revenues, reflecting a 4% increase in ECHD's self-pay exposure year over year. Management attributes the growth in self-pay to an influx of uninsured new workers in the area following the recent boom in oil production in the region. Despite the recent increase in self-pay, ECHD does not expect its payor mix to continue to deteriorate. In addition to Medicaid and self-pay, Medicare and commercial payors accounted for approximately 37% and 29%, respectively, of gross fiscal 2018 revenues. Due to its exposure to indigent patients and high uncompensated care costs, ECHD received approximately $39 million in supplemental funding (Medicaid DSH, UC Pool, and DSRIP) in fiscal 2018.

ECHD remains a taxing district that has the authority to collect a 0.75% sales tax and to levy ad valorem taxes up to $0.15 on each $100 of TAV for the purpose of supporting operations. The ECHD tax base is coterminous with that of Ector County. The district's TAV and sales taxes realized a 10-year compound annual growth rates (CAGR) of 4.1% and 8.8%, respectively, through 2018. In fiscal 2018, ECHD recognized approximately $54 million in sales taxes and $16 million in property tax revenues to support operations, which combined accounted for 18.3% of ECHD's total revenues. ECHD has the independent legal ability and a demonstrated willingness to adjust its ad valorem maintenance and operations (M&O) tax rate, but the district does not have the ability to adjust its 0.75% sales tax rate.

The district currently levies $0.1127 per $100 of TAV, all of which is used for operations and support of indigent care. While the district has the ability to levy up to $0.15, if a proposed tax rate results in an 8% year-over-year M&O levy increase (adjusted for removal of new properties), the proposed tax rate increase may be subject to election if petitioned by voters. Fitch estimates that the district's tax rate capacity provides up to $5.3 million of additional

Related Research

Fitch Affirms Ector County Hospital District (TX) at 'BB+'; Outlook Stable (April 2019)

Related Criteria

Rating Criteria for Public-Sector, Revenue-Supported Debt (February 2018)

U.S. Public Finance Tax-Supported Rating Criteria (April 2018)

U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria (February 2019)

revenue based on the current TAV and tax levy. While this additional taxing capacity provides ECHD with limited financial cushion against unexpected operating volatility, it is not viewed by Fitch to be strong enough to support revenue defensibility higher than 'bbb' or midrange.

Utilization Data

(Fiscal Years Ended Sept. 30)	2015	2016	2017	2018	Five Mos. Ended 2/28/19
Operated Beds	352	349	349	349	349
Acute Adult Admissions / Discharges	13,047	12,882	13,211	13,623	5,846
Acute Adult Patient Days	69,794	68,459	67,403	65,737	28,193
Average Length of Stay (Days)	5.4	5.3	5.1	4.8	4.8
Average Daily Census	191	188	185	180	185
Occupancy (%)	54.3	53.7	52.9	51.6	53.1
Observation Cases	6,628	5,594	4,841	4,422	2,140
Hospital Stays (Admissions plus Observation Cases)	19,675	18,476	18,052	18,045	7,986
Births	1,723	1,530	1,687	1,886	798
Inpatient Surgeries	3,863	3,902	3,523	3,392	1,445
Outpatient Surgeries	7,065	7,168	7,074	7,071	2,763
Emergency Department Visits, Net of Admissions	51,759	48,766	49,047	52,755	23,285
Outpatient/Clinic Visits	302,663	352,356	314,579	278,721	50,133
Medicare Casemix Index	0.00	1.76	1.64	1.60	1.71

Sources: Ector County Hospital District (TX) and Fitch.

ECHD's Medical Center Hospital is the largest hospital in the county, a referral center for the 17-county Permian Basin region, and a teaching hospital for Texas Tech University's Health Services Center. The district's 65% primary service area market share is approximately twice that of the next competitor, Odessa Regional Medical Center. The district provides outpatient services through its network of facilities, clinics and specialty centers. The hospital's affiliated entity, Medical Center Hospital Professional Care (ProCare) employs hospital-based and clinic-based providers. Overall, hospital volumes continued to improve in fiscal 2018 as inpatient admissions increased 3.1%, births increased 12%, and emergency department volumes 7.6% year over year. Fitch expects ECHD's leading market share to continue as the organization continues to expand its relationship with Texas Tech, enhances its employed physician base, and strategically expands certain key services lines, including neurosurgery.

Ector County resides in the Permian Basin, the largest oil producing region in the U.S. The county's five-year population growth, median household income, and poverty rates all remain favorable compared to state and national averages, reflecting an expansionary cycle in the oil-rich Permian Basin. However, Fitch considers the economy's exposure to energy price volatility a credit weakness, particularly because of ECHD's reliance on sales and property taxes to support operations. Fitch believes the high exposure to energy price volatility could allow for a drastic shift in ECHD's payor mix or revenue base in a short period of time, which was confirmed during fiscal 2016 when ECHD's tax revenues fell 20% unexpectedly year-over-year.

Operating Risk

ECHD has historically produced strong profitability levels as evidenced by the average 9.9% operating EBITDA and 10.5% EBITDA margins averaged during fiscal years 2012-2014. However, beginning in fiscal 2015, ECHD's operations have steadily deteriorated year-over-year to a low point in fiscal 2017 of a negative 2.3% operating EBITDA and negative 1.6% EBITDA. Fitch attributes ECHD's rapid decline in profitability during this time period to increasing staffing costs associated with growth and expansion, a substantial and unexpected reduction in sales tax revenues due to a decline in the cyclical oil and gas industry, and

increased costs and revenue cycle disruptions following a Cerner electronic medical record (EMR) conversion in fiscal 2017.

Following some senior management turnover in fiscal 2018, ECHD has enacted various operational and revenue cycle improvements. Beginning in fiscal 2018, ECHD management has improved physician productivity, implemented operational efficiencies, and improved clinical documentation and made coding improvements by outsourcing its information technology department to Cerner. These ongoing initiatives, coupled with sizeable growth in tax revenues from an expanding local economy, have supported strong improvements in ECHD's profitability levels since fiscal 2017. In fiscal 2018, ECHD improved its operating EBITDA and EBITDA margins to 5.4% and 6%, respectively. Furthermore, ECHD has continued to demonstrate improvements through the five-month interim period (ending Feb. 28, 2019) as evidenced by its operating EBITDA and EBITDA margins of 7.5% and 8.2%, respectively. In fiscal 2018, ECHD recorded approximately $70 million in total tax revenues, which is approximately 73% higher than the $40 million it recorded in fiscal 2016. Fitch expects ECHD's operating profitability levels to continue to improve near historical levels over the medium term as it further benefits from the expanding local economy and recent operational improvements.

Fitch believes ECHD's capital needs are high given its somewhat high average age of plant of 13.6 years and its expectation to spend at or below depreciation over the next five years. Following healthy spending during fiscal years 2014 - 2017 of an average 134% of depreciation, ECHD limited capital spending to just 25% of depreciation in fiscal 2018. Lower capital outlays in fiscal 2018 reflects management's pullback of capital spending following recent profitability and cash reserve deterioration. However, Fitch expects management to gradually increase spending to depreciation levels by 2021 as it incrementally improves its operating cash flow levels and grows its unrestricted cash reserve levels.

Financial Profile

Following substantial balance sheet erosion during fiscal 2016 and 2017 due to weak profitability and elevated capital outlays for its EMR conversion, ECHD has improved its unrestricted cash and investments by 39% in fiscal 2018 to approximately $56 million. However, despite the improvement, ECHD produced a weak 29.6% cash to adjusted debt and 4.4x NADAE in fiscal 2018. Per Fitch's criteria, adjusted debt includes Fitch's adjusted net pension liability of $155 million for ECHD in fiscal 2018. This liability differs from the $16.4 million reported on ECHD's financial statements due to Fitch's change in discount rate to 6% from ECHD's 8.1%. However, despite its weak net leverage position, Fitch anticipates ECHD will continue to improve its net leverage metrics in the coming years as its debt position moderates and its cash reserves continue to grow following recent operational improvement initiatives.

Fitch's base case incorporates the expectation that ECHD's revenue growth will outpace expense growth over the next five years as the district continues to benefit from its recent operational improvement and further strengthening of the local economy, including tax revenue support. Additionally, the base case assumes that capital expenditures are approximately 60% of depreciation in fiscal 2019 and slowly ramp up to 100% by fiscal 2021. Under these assumptions, ECHD demonstrates the ability to incrementally improve its operating profitability levels to historical levels over the next five years, while continuing to grow cash reserves and moderate its debt position. ECHD improves its cash to adjusted debt to 90% and NADAE to 0.3x by year five of the base case.

Fitch's stress scenario assumes a standard stress to hospital revenues beginning in year 1 and an additional stress to property and sales tax revenues beginning in year 2, which reflects the

expected timing lag on tax revenue support following a stress scenario. The stressed scenario assumes a slight reduction to operating expenses in years 2 and 3, as well as a reduction in routine capital spending, as management's likely response to an economic downturn scenario. ECHD's investment portfolio does not experience any decline due to its conservative investment practices of all cash and fixed income investments. ECHD's thin liquidity position and weak net leverage position afford minimal financial flexibility under a stress scenario. Under the stressed scenario, ECHD improves its respective cash to adjusted debt and NADAE to 69% and 1.1x over the next five years, which is reflective a 'bb' financial profile assessment.

Asymmetric Additional Risk Considerations

No asymmetric risk considerations affected this rating determination.

The district's debt includes $44.6 million of fixed rate revenue bonds (series 2010B) maturing in 2035 and $8.8 million of bank notes maturing by 2020. A Dec. 22, 2017 amendment to the district's revenue bond indenture agreement modified the coverage calculation ratio to exclude unusual, infrequent, or extraordinary non-cash items, including non-cash items relating to GASB 68 and GASB 75. The amendment also added a days cash on hand (DCOH) covenant escalating progressively from 50 DCOH as of fiscal 2018, up to 80 DCOH as of fiscal 2020, and 100 DCOH thereafter. The district is in compliance with their amended covenant requirements. However, an inability to improve DCOH over the short term to meet the escalating covenants may warrant an asymmetric risk consideration in the future.

Financial Summary

($000, Audited Fiscal Years Ended Sept. 30)	2015	2016	2017	2018	Five Mos. Ended 2/28/19[a]
Balance Sheet Data					
Unrestricted Cash & Investments	93,249	82,868	40,212	55,737	65,392
Total Assets	396,228	401,772	365,616	343,830	352,748
Total Debt (Including Current Portion)	62,757	58,057	53,458	48,820	48,375
Adjusted Debt	180,858	220,348	229,229	204,247	48,375
Net Adjusted Debt	82,948	132,819	184,343	143,778	(21,749)
Unrestricted Net Assets	238,021	220,797	193,758	202,695	207,042
Income & Cash Flow Data					
Net Patient Revenue	231,146	245,378	236,605	260,904	130,558
Other Revenue	95,135	91,255	101,295	118,908	34,301
Total Revenues	326,280	336,632	337,900	379,812	164,860
Depreciation & Amortization	22,195	20,353	20,474	20,113	8,081
Interest Expense	2,890	2,893	2,912	3,244	1,294
Total Expenses	331,926	358,736	368,954	382,534	161,911
Income from Operations	(5,646)	(22,104)	(31,054)	(2,722)	2,948
Operating EBITDA	19,439	1,142	(7,667)	20,635	12,323
Non-Operating Gains (Losses)	2,254	2,165	2,374	2,437	1,369
Excess (Deficiency) of Revenues over Expenses	(3,392)	(19,939)	(28,680)	(285)	4,317
EBITDA	21,693	3,307	(5,294)	23,072	13,692
Total Pension Expense	6,900	12,700	18,500	9,715	—
Adjusted EBITDA	28,593	16,007	13,206	32,787	13,692
Net Unrealized Gains (Losses)	236	(36)	(385)	(167)	30
Net Capital Expenditures	17,400	32,815	26,302	5,099	1,660
Maximum Annual Debt Service (MADS)	8,017	8,017	8,017	8,017	8,017
Liquidity Ratios					
Days Cash on Hand	109.9	89.4	42.1	56.1	64.7
Days in Accounts Receivable	56.6	51.3	57.1	51.1	50.2
Cushion Ratio (x)	12.2	10.9	5.6	7.5	8.8
MADS Coverage - EBITDA (x)	2.7	0.4	(0.7)	2.9	4.1
MADS Coverage - Operating EBITDA (x)	2.4	0.1	(1.0)	2.6	3.7
MADS / Total Revenue (%)	2.5	2.4	2.4	2.1	2.0
Profitability & Operational Ratios (%)					
Operating Margin	(1.7)	(6.6)	(9.2)	(0.7)	1.8
Operating EBITDA Margin	6.0	0.3	(2.3)	5.4	7.5
EBITDA Margin	6.6	1.0	(1.6)	6.0	8.2
Capital Related Ratios					
Cash / Debt (%)	156.0	150.8	84.0	123.9	145.0
Cash / Adjusted Debt (%)	54.1	39.7	19.6	29.6	145.0
Net Adjusted Debt / Adjusted EBITDA	2.9	8.3	14.0	4.4	(0.7)
Average Age of Plant (Years)	9.8	11.5	12.4	13.6	14.5
Capital Expenditures / Depreciation (%)	78.4	161.2	128.5	25.4	20.6

[a]Unaudited. EBITDA: Earnings before interest, taxes, depreciation & amortization.
Note: Fitch may have reclassified certain financial statement items for analytical purposes.

Sources: Ector County Hospital District (TX) and Fitch.

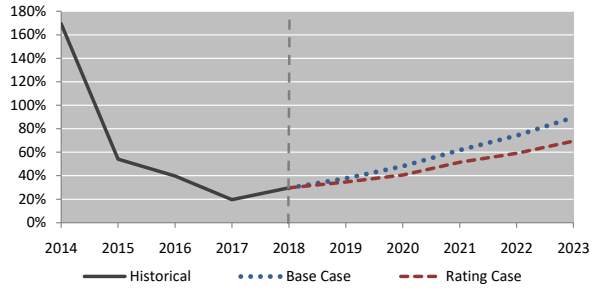
FAST - Fitch Analytical Sensitivity Tool
Portfolio & Scenario Analysis

Ector County Hospital District (TX)

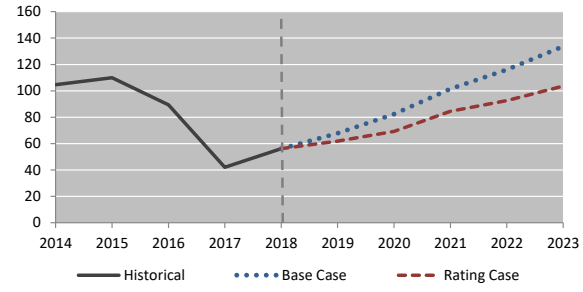
Analytical Summary

ECHD's thin liquidity and weak net leverage position afford minimal financial flexibility through the cycle under a stressed scenario, which is reflective of the 'BB' category rating.

Cash to Adjusted Debt



Days Cash on Hand



FAST Summary	Base Case					Rating Case				
	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
Balance Sheet ($000)										
Unrestricted Cash & Investments	70,539	88,893	114,409	136,673	164,379	64,246	74,344	94,437	107,923	126,185
Total Debt	44,109	39,454	37,562	35,587	33,524	44,109	39,454	37,562	35,587	33,524
Adjusted Debt	199,536	194,881	192,989	191,014	188,951	199,536	194,881	192,989	191,014	188,951
Net Adjusted Debt	124,209	101,143	73,677	49,379	19,552	130,541	115,748	93,706	78,187	57,804
Income Statement ($000)										
Total Revenues	408,298	428,304	449,719	472,205	496,288	402,966	413,790	435,733	459,816	483,258
Total Expenses	400,228	415,934	434,374	453,667	473,828	400,228	413,948	430,244	449,351	469,318
Operating EBITDA	32,239	37,204	41,019	45,114	49,977	26,907	24,570	30,944	36,812	41,219
EBITDA	34,960	40,101	44,136	48,535	53,665	29,128	27,148	33,887	39,995	44,563
Adjusted EBITDA	44,675	49,816	53,851	58,250	63,380	38,843	36,863	43,602	49,710	54,278
Metrics										
Cash / Debt	171%	238%	318%	398%	505%	156%	201%	264%	317%	391%
Cash / Adjusted Debt	38%	48%	62%	74%	90%	35%	41%	51%	59%	69%
Days Cash on Hand	68	82	101	116	134	62	69	85	93	104
Operating EBITDA Margin	7.9%	8.7%	9.1%	9.6%	10.1%	6.7%	5.9%	7.1%	8.0%	8.5%
EBITDA Margin	8.5%	9.3%	9.7%	10.2%	10.7%	7.2%	6.5%	7.7%	8.6%	9.2%
Net Adj Debt / Adj EBITDA	2.8x	2.0x	1.4x	0.8x	0.3x	3.4x	3.1x	2.1x	1.6x	1.1x
Scenario Assumptions										
GDP Growth	2.0%	2.0%	2.0%	2.0%	2.0%	-1.5%	0.5%	2.0%	2.0%	2.0%
FAST Portfolio Sensitivity	2.4%	2.4%	2.4%	2.4%	2.4%	0.7%	1.7%	2.4%	2.4%	2.4%
Revenue Growth	7.5%	4.9%	5.0%	5.0%	5.1%	6.1%	2.7%	5.3%	5.5%	5.1%
Expense Growth	4.7%	4.0%	4.5%	4.5%	4.5%	4.7%	3.5%	4.0%	4.5%	4.5%
Principal Paydown ($000)	4,711	4,655	1,892	1,975	2,063	4,711	4,655	1,892	1,975	2,063
New Issuance ($000)	0	0	0	0	0	0	0	0	0	0
Capital Expenditures ($000)	13,000	15,000	15,000	23,000	23,000	13,000	10,000	10,000	23,000	23,000

Fitch's base case incorporates the assumption that ECHD will continue to improve its operating profitability levels over the next five years as it continues to benefit from recent operational improvement initiatives and a growing local economy and tax base. Fitch's stressed scenario assumes a standard stress to hospital revenues beginning in year 1 and an additional stress to underlying property tax and sales tax revenues beginning in year 2. Additionally, the stressed scenario incorporates the expectation that management would reduce expenses and capital expenses in years 2 and 3 in response to the economic downturn scenario.

Key Definitions

Terms	Definition	Significance
Issuer Default Rating (IDR)	An expression of overall enterprise risk and relative vulnerability to default.	Provides an opinion of the relative ability of an entity to meet financial commitments, expressed as an ordinal measure of credit risk.
Adjusted Debt	Total long-term debt + unfunded pension liability below 80% PBO + 5.0x operating lease expense	Provides an inclusive evaluation of total long-term liabilities.
Cash to Adjusted Debt	Unrestricted cash and investments / adjusted debt	Indicates financial flexibility and cushion against decline in operating profitability.
Net Debt	Total debt - unrestricted cash and investments	Indicates the level of unrestricted liquid asset cushion available to cover debt.
Adjusted EBITDA	EBITDA + pension expense + annual operating lease expense	Provides an indication of cash flow available for the payment of debt service, adjusting for pension and operating lease obligations.
Net Adjusted Debt to Adjusted EBITDA	(Adjusted debt - unrestricted cash and investments) / adjusted EBITDA	Provides an indication of net total leverage position against available operating cash flow.
Base Case	The expected forward-looking case in the current macro-economic environment.	Provides the analytical starting point in the forward- looking analysis, and also informs the rating case.
Rating Case	The potential performance under a common set of assumptions.	Illustrates how cycles affect individual issuers differently, and informs the level of rating stability and credit resiliency.

The FAST scenario results are not a forecast. The results are intended only to illustrate performance under a given set of assumptions made by Fitch for a specific issuer that fall within the range of performance that is consistent with a stable rating. In this sense, the rating case scenario depicts a rating sensitivity and suggests the level of change in performance in stress consistent with the rating assigned. It should not be interpreted as a prediction of actual performance under stress. As an issuer can respond to a decline in portfolio value and profitability in the rating case in varied ways, actual metrics may also vary from those depicted in the scenario analysis.

The ratings above were solicited and assigned or maintained at the request of the rated entity/issuer or a related third party. Any exceptions follow below.