ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
MAY 5, 2020 – 5:30 p.m.
MEDICAL CENTER HOSPITAL
ADMINISTRATION CONFERENCE ROOM A (2ND FLOOR)
500 W 4TH STREET, ODESSA, TEXAS

AGENDA

I. ROLL CALL ..... Don Hallmark, President

II. CALL TO ORDER ..... Don Hallmark

III. INVOCATION ..... Russell Tippin

IV. MISSION / VISION / VALUES OF MEDICAL CENTER HEALTH SYSTEM .... Don Hallmark, p.3

V. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

VI. LEGISLATIVE UPDATE.....Brooks Landgraf

VII. PUBLIC COMMENTS ON AGENDA ITEMS

VIII. CONSENT AGENDA..... Don Hallmark, p.4-89
(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 7, 2020
B. Consider Approval of Emergency Meeting Minutes, April 21, 2020
C. Consider Approval of Joint Conference Committee, April 28, 2020
D. Consider Approval of Federally Qualified Health Center Monthly Report, March 2020
E. Consider Approval of Annual Organization Wide Risk Management Plan

IX. COMMITTEE REPORTS

A. Finance Committee..... Bryn Dodd, p.90-156
1. Quarterly Investment Report – Quarter 2, FY 2020
2. Quarterly Investment Officer's Certification
3. Financial Report for Month Ended March 31, 2020

X. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS
.....Russell Tippin, p.157-205

A. MCH Telecare Presentation
B. Consider Approval of Transfer Service Agreement
C. COVID-19 Update
D. Ad Hoc Reports

XI. 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) Deliberations regarding Personnel Matters pursuant to Section 551.074 of the Texas Government Code; and (3) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code.

XII. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements
B. Consider Approval of Letter of Agreement Amendment with NRC Health

XIII. ADJOURNMENT ..... Don Hallmark

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 7, 2020 – 5:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT:	Don Hallmark, President Bryn Dodd, Vice President
MEMBERS VIRTUALLY PRESENT:	Mary Lou Anderson David Dunn Wallace Dunn Richard Herrera Ben Quiroz
OTHERS PRESENT:	Russell Tippin, President/Chief Executive Officer Steve Ewing, Chief Financial Officer Steve Steen, Chief Legal Counsel Jan Ramos, ECHD Board Secretary
OTHERS VIRTUALLY PRESENT:	Christin Timmons, Chief Nursing Officer Matt Collins, Chief Operating Officer Toni Land, Chief Patient Experience Officer Dr. Donald Davenport, Chief of Staff Dr. Timothy Benton, Vice Chief of Staff Dr. Gary Ventolini, TTUHSC Permian Basin Various other interested members of the Medical Staff, employees, and citizens

I. ROLL CALL

Don Hallmark called the roll to establish a quorum.

II. CALL TO ORDER

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

III. INVOCATION

Russell Tippin offered the invocation.

IV. PLEDGE OF ALLEGIANCE

Due to the virtual meeting, Pledge of Allegiance to the United States and Texas flags were not recited.

V. MISSION/VISION OF MEDICAL CENTER HEALTH SYSTEM

Don Hallmark presented the Mission, Vision and Values of Medical Center Health System.

VI. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

No conflicts were disclosed.

VII. PUBLIC COMMENTS ON AGENDA ITEMS

No comments from the public were received.

VIII. CONSENT AGENDA

A. Consider Approval of Regular Meeting Minutes, March 3, 2020
B. Consider Approval of Emergency Meeting Minutes, March 20, 2020
C. Consider Approval of Joint Conference Committee, March 24, 2020
D. Consider Approval of Emergency Meeting Minutes, March 27, 2020
E. Consider Approval of Federally Qualified Health Center Monthly Report, February 2020
F. Consider Approval of Annual Scope of Service and Organizational Wide Performance Improvement Plan
G. Consider Approval of Annual Evaluation of the Infection Control Program
H. Consider Approval of MCH COVID-19 Base Inpatient Operational Plan Disease Management

Bryn Dodd moved and David Dunn seconded the motion to approve the items listed on the Consent Agenda as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

IX. COMMITTEE REPORTS

A. Finance Committee

1. Financial Report for Month Ended February 29, 2020
2. Capital Expenditure Requests
   a. Consider Approval of Stryker Neptune 3 Waste Management System
   b. Consider Approval of OR Mobile Vascular Lab

Bryn Dodd moved and David Dunn seconded the motion to approve the Finance Committee report as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

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

A. Consider Approval of Oberon Solar 1B Termination of Reinvestment Zone Tax Abatement Agreement

Steve Steen presented an agreement to terminate the Reinvestment Zone Tax Abatement Agreement with Oberon Solar IB, LLC that was entered into on April 2, 2019. This second phase of the project will not be completed, negating the need for this agreement.

David Dunn moved and Mary Lou Anderson seconded the motion to approve the termination of the Reinvestment Zone Tax Abatement Agreement as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

B. COVID-19 Update

Russell Tippin provided a report on Medical Center Hospital and the response to the COVID-19 virus. He thanked all staff and providers and discussed how the pandemic has changed healthcare and the financial strain it has put on the hospital, necessitating a reduction in procedures and hours worked in many areas.

There are currently 30 citizens of Ector County who have tested positive for the virus, and Medical Center Hospital has taken the lead with daily press conferences and communication to the public. There have been 88 tests processed that were negative, and 44 tests pending. In house today there are 4 patients who tested positive and they are in CCU and 7 Central (isolation unit) and 11 persons under investigation, waiting on test results. The Emergency Department usually sees 120-130 patients a day and that has decreased to 70-80.

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

C. Ad Hoc Reports

No ad hoc reports were provided.

XI. EXECUTIVE SESSION

Don Hallmark stated that the Board would go into Executive Session for the meeting held in closed session involving the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code; (2) Deliberations regarding Personnel Matters pursuant to Section 551.074 of the Texas Government Code; and (3) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code.

ATTENDEES for the entire Executive Session: ECHD Board members Don Hallmark, Bryn Dodd; Russell Tippin, Steve Steen, Adiel Alvarado, and Jan Ramos. **Virtual attendees:** ECHD Board members Mary Lou Anderson, David Dunn, Wallace Dunn, Richard Herrera, and Ben Quiroz.

Adiel Alvarado, President MCH ProCare, reported to the Board of Directors regarding Pro Care and hospital provider agreements during Executive Session.

Russell Tippin provided the Board of Directors with an update on staffing.

Executive Session began at 5:54 pm.
Executive Session ended at 7:03 p.m.

No action was taken during Executive Session.

XII. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements

Don Hallmark presented the following renewal:

- Jannie Tang, M.D. This is a three year renewal for Anesthesia.

Don Hallmark presented the following new contracts:

- Yvonene Gochango, CRNA. This is a three year agreement for Anesthesia.
- Ellen Novicio, NP. This is a three year agreement for Cardiology.
- Luis Gomez, M.D. This is a three year agreement for Vascular.

Bryn Dodd moved and David Dunn seconded the motion to approve the ProCare provider agreements as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

Don Hallmark presented the following new Trauma On-Call agreements:

- Thomas Cook, M.D. This is a one year agreement for Maxillofacial.
- Rajesh Gutta, DDS. This is a one year agreement for Maxillofacial.

Bryn Dodd moved and David Dunn seconded the motion to approve the Trauma On-Call provider agreements as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

Don Hallmark presented the following new agreement:

- Daniel Babbel, M.D. This is a three year agreement for Orthopedics.

Bryn Dodd moved and David Dunn seconded the motion to approve the Trauma On-Call provider agreements as presented. The roll call vote was as follows:

Don Hallmark	Aye
Bryn Dodd	Aye
Mary Lou Anderson	Aye
Richard Herrera	Aye
David Dunn	Aye
Wallace Dunn	Aye
Ben Quiroz	Aye

The motion carried unanimously.

XIII. ADJOURNMENT

There being no further business to come before the Board, Don Hallmark adjourned the meeting at 7:07 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
EXECUTIVE MEETING
APRIL 21, 2020 – 4:00 p.m.

MINUTES OF THE MEETING

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

OTHERS PRESENT: Russell Tippin, President/Chief Executive Officer
Steve Steen, Chief Legal Counsel
Christin Timmons, Chief Nursing Officer
Natalie Chapman
Lindsey Duncan
Jan Ramos, ECHD Board Secretary

I. CALL TO ORDER

Don Hallmark called the meeting to order at 4:00 a.m. in the Board Room of Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

a. Mr. Hallmark read the following notice:

An emergency meeting of the Ector County Hospital District Board of Directors is scheduled on Tuesday, April 21, 2020 at 4:00 p.m. in the Board Room of Medical Center Hospital at the call of the Chief Executive Officer.

Anyone interested in listening to the meeting and/or providing public comment may do so by calling 832-791-2356 and using access code 972 537 374#.

II. EXECUTIVE/CLOSED SESSION

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

The individuals present during Executive Session were Don Hallmark, Bryn Dodd, Mary Lou Anderson, David Dunn, Wallace Dunn, Richard Herrera, Ben Quiroz, Russell Tippin, Steve Steen, Christin Timmons, Natalie Chapman, and Lindsey Duncan.

Executive Session began at 4:01 p.m.
Executive Session ended at 5:15 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 5:15 p.m.

Respectfully submitted,

Jan Ramos, Secretary
Ector County Hospital District Board of Directors

Medical Center Hospital
A Member of Medical Center Health System

May 5, 2020

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

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

Statement of Pertinent Facts:
Pursuant to Article 3 of the Medical Staff Bylaws, the application process for the following Medical Staff and Allied Health Professional applicants is complete. The Joint Conference Committee and the Medical Executive Committee recommend approval of privileges or scope of practice and membership to the Medical Staff or Allied Health Professionals Staff for the following applicants, effective upon Board Approval.

Medical Staff:

Applicant	Department	Specialty/Privileges	Group	Dates
Rania Saleh, MD	Internal Medicine	Infectious Disease	Eagle Telemedicine	05/03/2020- 05/02/2021
Visalakshi Sethurman, MD	Pediatrics	Neonatal-Perinatal	TTUHSC	05/03/2020- 05/02/2021

Allied Health:

Applicant	Department	AHP Category	Specialty/Privileges	Group	Sponsoring Physician(s)	Dates
Alexandra Fierro, PA	Cardiology	APC	Physician Assistant	ProCare	Dr. Boccalandro and Dr. Amaram	05/03/2020- 05/02/2022
Yvonne Gochangco, CRNA	Anesthesia	APC	Certified Registered Nurse Anesthetist	ProCare	Dr. Bhari, Dr. Price, Dr. Mishra, and Dr. Bryan	05/03/2020- 05/02/2022
Marie Gue, CRNA	Anesthesia	APC	Certified Registered Nurse Anesthetist	ProCare	Dr. Bhari, Dr. Price, Dr. Mishra, and Dr. Bryan	05/03/2020- 05/02/2022
Angelina McMurray, CRNA	Anesthesia	APC	Certified Registered Nurse Anesthetist	ProCare	Dr. Bhari, Dr. Price, Dr. Mishra, and Dr. Bryan	05/03/2020- 05/02/2022

***Please grant temporary Privileges**

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

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

Medical Center Hospital
A Member of Medical Center Health System

May 5, 2020

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

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

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

Medical Staff:

Applicant	Department	Status Criteria Met	Staff Category	Specialty/Privileges	Group	Changes to Privileges	Dates
Jonathan Foral, MD	Radiology	Yes	Telemedicine	Telemedicine	Virtual Radiology	None	05/01/2020- 04/30/2022
Cordell Cunningham, MD	Emergency Medicine	Yes	Associate	Emergency Medicine	BEPO	None	06/01/2020- 05/31/2021
Hashmi Rafeek, MD	Internal Medicine	Yes	Associate to Active	Infectious Disease	TTUHSC	None	06/01/2020- 05/31/2022
Christopher Enakpene, MD	OB/GYN	Yes	Associate	Maternal/Fetal Medicine	TTUHSC	Yes	07/01/2020- 06/30/2021
Cristina Cavazos, MD	Radiology	Yes	Telemedicine	Telemedicine	Virtual Radiology	None	07/01/2020- 06/30/2022

Allied Health Professionals:

Applicant	Department	AHP Category	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Amanda Hughes, NP	Pediatrics	APC	Nurse Practitioner	TTUHSC	Dr. Sheth, Dr. Bennett and Dr. Mudduluru	None	06/01/2020- 05/31/2022
Tabatha Pittman, PA	Family Medicine	APC	Physician Assistant	ProCare	Dr. Jorge Alamo	None	06/01/2020- 05/31/2022

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

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

Medical Center Hospital
A Member of Medical Center Health System

May 5, 2020

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Change in Clinical Privileges

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

Change in Clinical Privileges:

Staff Member	Department	Privilege
Mary Bridges, MD	OB/GYN	**ADD: Obstetrics Management; Amniocentesis, appendectomy, incidental during an open procedure; breech deliveries; cerclage, transvaginal; cesarean section delivery; episiotomy, repair and revision; external version of breech presentation; fetal assessment; hernia repair (incisional or umbilical); hysterectomy, cesarean section; management of labor; multifetal deliveries; obstetric forceps, use of; obstetrical diagnostic procedures; oncology, revention & diagnosis, and treatment; placenta, manual removal of; procedures for pelvic organ prolapse & genitourinary fistula; second trimester abortion by medical or surgical means; vacuum extractor, use of; vaginal births after previous cesarean delivery; circumcision.**
Christopher Enakpene, MD	OB/GYN	**ADD: Pituitary disorders, diagnose and management of; Fetal echocardiography**

***Pending Department Meeting Approval**

Advice, Opinions, Recommendations and Motions:

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

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

May 5, 2020

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 Article 4 of the Medical Staff Bylaws.

Resignation/ Lapse of Privileges:

Staff Member	Staff Category	Department	Effective Date	Action
Erik Baker, CRNA	AHP	Anesthesia	04/12/2020	Resignation
Phani Bodavula, MD	Associate	Pediatrics	03/23/2020	Lapse in Privileges
Maskim Efremov, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Bryan Fleming, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Guy Gibson, DO	Active	Radiology	03/29/2020	Resignation
Phillip Hernandez, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Daniel Howell, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Eileen Li, MD	Affiliate	Pediatrics	01/15/2020	Resignation
Sabino Lopez, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Sigrid Marfo, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Genaro Marquez, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Chastin Mortensen, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Diane Moschouris, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Suzanne Owens, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Elena Velasquez, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Jonathan Wildy, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Lauren Williams, CRNA	AHP	Anesthesia	03/31/2020	Resignation
Alicia Wyatt, CRNA	AHP	Anesthesia	03/31/2020	Resignation

Advice, Opinions, Recommendations and Motion:

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

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

May 5, 2020

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
Hashmi Rafeek, MD	Internal Medicine	Associate to Active

Changes to Credentialing Dates:

Staff Member	Staff Category	Department	Dates
None			

Changes of Supervising Physician(s):

Staff Member	Group	Department
Brian Griifin, NP	Trauma to Emergency Medicine	Emergency Medicine
Michael Cuizon, NP	OHI to Diabetes Center	Medicine
Ma Ellen Novicio, NP	Dr. Gibbons to OHI	Cardiology

Leave of Absence:

Staff Member	Staff Category	Department	Effective Date	Action
Garry Kennebrew, MD	Associate	Emergency Medicene	04/15/2020	Returning Date 04/15/2020

Advice, Opinions, Recommendations and Motion:
If the Hospital District Board of Directors concurs, the following motion is in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee to approve the staff category changes, changes to the credentialing dates, changes of supervising physicians and leave of absence.

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

May 5, 2020

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

- ICU Admission Criteria for Covid
- Covid Cardiac Arrest Protocol
- Covid Protocols
- Health & Wellness Guidelines Update
- Guidelines for NICU and NBN
- Guidelines for Pediatric Admissions

Statement of Pertinent Facts:

The Medical Executive Committee and the Joint Conference Committee recommends the request below on the protocols and guidleines for covid-19. These protocols and guidelines are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

- ICU Admission Criteria for Covid
- Covid Cardiac Arrest Protocol
- Covid Protocols
- Health & Wellness Guidelines Update
- Guidelines for NICU and NBN
- Guidelines for Pediatric Admissions

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 protocols and guidelines(s).

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

Medical Center Hospital
A Member of Medical Center Health System

May 5, 2020

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

- Maternal Triage Stabilization and Transfer
- Perinatal Behavior Health Screening and Risk Assessment
- Venous Thromboembolism for Maternal populations
- Trial of Labor after Cesarean (Tolac) Vaginal Birth after Cesarean (Vbac)
- Discharge Planning of Mother and/or Baby from the Hospital
- Admission of Newborn 4E Postpartum

Statement of Pertinent Facts:

The Medical Executive Committee and the Joint Conference Committee recommends the request below on the policies. These policies are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

- Maternal Triage Stabilization and Transfer
- Perinatal Behavior Health Screening and Risk Assessment
- Venous Thromboembolism for Maternal populations
- Trial of Labor after Cesarean (Tolac) Vaginal Birth after Cesarean (Vbac)
- Discharge Planning of Mother and/or Baby from the Hospital
- Admission of Newborn 4E Postpartum

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 policies(s).

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

ICU ADMISSION CRITERIA FOR COVID-19 INFECTION

The following is a list of risk factors that will help clinician to identify those patients at higher risk of complications and will need closer monitoring.

Epidemiologic factors:

Age > 60

Chronic pulmonary disease

CKD

DM2

HTN

Cardiovascular disease

Immunosuppression

Clinical factors:

RR > 24

HR >125

SO2 < 90% in room air

Laboratory factors:

D-dimer > 1000 ng/ml

CK > 2 times the upper limit

CRP > 100

LDH > 245

Elevated troponin

Abs lymphocyte count < 0.8

Ferritin > 300

Consider Critical Care consult to triage patients before ICU transfer in patients with confirmed or highly suspected COVID-19 infection when:

1. Provider concern for patients with high risk of deterioration
2. Rapid increase O2 requirements with RR > 26 and increased work of breathing < 24 hours
3. Patients with FIO2 requirements > 40% on high flow O2 NC (Flow up to 40 L) or venturi mask
4. SBP < 90 with need for vasopressors after adequate fluid resuscitation
5. pH < 7.3, PaCO2 > 60 or increase from baseline after adequate treatment optimization
6. Lactic acid > 4 after adequate fluid resuscitation
7. Patients with altered mental status and GCS < 10.

COVID-19 CARDIAC ARREST PROTOCOL

The goal of this policy is to provide recommendations to minimize exposure of healthcare workers while providing high quality CPR based on ACLS recommendations for patients under investigation or confirmed cases of Covid-19 infection.

Key point: *THERE IS NO EMERGENCY DURING A PANDEMIA UNTIL PROVIDER IS APPROPIATELY PROTECTED.*

GENERAL RECOMMENDATIONS:

1. "Protected" code blue will be called for all adult inpatients with suspected or confirmed Covid-19 infection.
2. One person should be identified as the PPE observer/officer and remain at the patient's room entrance. The PPE observer will ensure that all members of the Code team will appropriately use PPE including N-95 respirator before entering the room.
3. Only the minimum amount of team members required to perform ACLS should enter the room.
4. Staff providing CPR to the patient should have at minimum: N-95 respirator, gown, cap, gloves and face shield/eye protection.
5. Team inside the room may be formed by:
   - MD/Airway expert
   - Respiratory therapist from ED, 7C or CCU (depending on the location of the code)
   - 3 RNs with ACLS certification/experience
6. Timekeeper, pharmacist and other healthcare staff may communicate from outside the room if possible.

CPR FOR NON-INTUBATED PATIENTS:

1. Once cardiac arrest is identified and healthcare providers are using appropriate PPE, **DO NOT START CHEST COMPRESSIONS** until patient's mouth is protected as outline below:

   - **If Covid intubation package available:**

     -Attach a viral filter to a NIV mask
     -Place NIV mask on the patient with viral filter attached. Make sure there is no leaks around the face of the patient
     -AFTER NIV MASK AND VIRAL FILTER ATTACHED IS IN PLACE, IS OK TO START CPR WITH CHEST COMPRESSIONS

- **If Covid intubation package not available:**

  Place a surgical mask over the patient's face and cover the head/neck of the patient with a plastic bag if available, or a blanket

2. After patient's mouth is protected, start CPR with **CHEST COMPRESSIONS ONLY**. (Multiple studies have shown that compression-only CPR is non inferior than standard CPR).

3. If the patient has a shockable rhythm, perform defibrillation as soon as possible.

4. I**ntubation should be attempted at the earliest feasible opportunity** as directed by the Code Captain and/or airway expert (all team present must be appropriately protected). Consider using video laryngoscopy (Glidescope) if available to maximize first pass attempt and avoid close distance of provider's face to the patient.

5. Intubation attempt must be performed during pulse check and with **NO chest compressions**, CPR will not be resume until ETT is in place and cuff inflated.

6. If the pause in chest compressions is prolonged or intubation not possible consider resume CPR with chest compressions only. May consider using LMA or another airway device in the next attempt.

7. Once ETT is in placed with the cuff inflated may start BVM ventilation with a viral filter attached.

CPR FOR INTUBATED PATIENTS

1. **One of the team priorities should be avoid any ventilator/ETT circuit disconnection to avoid aerosolization and increase risk of contamination.**

2. Start CPR with Chest compressions according to ACLS guidelines.

3. **Do not disconnect the ventilator.** Modify ventilator settings as follows: A/C mode, tidal volume 6-7 ml/kg ideal body weight, place RR 10 per min, FIO2 100%, PEEP 8-10, adjust trigger off to prevent vent to auto-triggering.

4. If unable to ventilate on mechanical ventilation may start BVM ventilation as follows:

- Clamp the ETT
- Place BVM with a viral filter attached
- Assure the BMV tubing fits tightly to the ETT prior to opening the circuit

5. If shockable rhythm, defibrillate as soon as possible.

CPR FOR PATIENTS IN PRONE POSITION

For intubated patients in prone position avoid turning the patient to supine position unless able to do it safely without risk of disconnection and aerosolization.

- Consider doing CPR with the patient remaining in prone with hands in the standard position at the level of T7-T10 vertebral bodies.
- Attach defibrillator pads in the anterior-posterior position.

TERMINATING RESUSCITATIVE EFFORTS

1. Avoid prolonged resuscitation > 10 minutes if there is no easily reversible etiology identified and/or failure to achieve a sustained ETCO2 > 10 mmHg by waveform capnography if available.

2. As a general rule consider avoid prolonged CPR specially in patients with poor pre-morbid functional status, multiple comorbidities, metastatic cancer, multiorgan failure, poor hemodynamic status (multiple vasopressors) prior to CPR.

GENERAL COVID-19 MANAGEMENT PRINCIPLES FOR NON-INTUBATED PATIENTS

1. Management of Covid-19 patients is mainly supportive
2. Recommended initial laboratory:
   CBC with diff, CMP, Mg, D-dimer, CRP, Ferritin, LDH, troponin, PT/PTT, Procalcitonin
   Influenza PCR
3. Cultures if clinical suspicion of infection. If suspected pneumonia check serologies for strep, legionella, mycoplasma
4. Obtain baseline EKG
5. No need for daily CXR unless changes in clinical condition or XR will change management
6. Consider every 48-72 hours (based on clinical condition):
   D-dimer, CRP, Ferritin
7. Avoid unnecessary testing, use clinical judgment
8. Use fluid restrictive strategy for most patients if no signs of hypovolemia or hemodynamic instability
9. Hold ACE inhibitors/ARB if warranted by clinical condition
10. Avoid use of NSAIDs
11. Consider use of DVT chemoprophylaxis for all Covid-19 patients unless absolute contraindications or platelet count < 40 K. **Covid-19 has demonstrated to promote a prothrombotic state with several complications.** Use chemoprophylaxis as follows:

    - Normal renal function and BMI < 40: Enoxaparin 30 mg Q 12 hours
    - Normal renal function and BMI > 40: Enoxaparin 40 mg Q 12 hours
    - For impaired renal function, AKI, GFR < 30: SQ heparin 5000 units Q 8 hours

    If D-Dimer levels are trending up consider US duplex to screen for DVT. Have a low threshold for anticoagulation if no contra indications.

12. Avoid the use of B2 nebulization as may increase risk of aerosolization. Consider the use of MDIs inhalers only if indicated: COPD/Asthma patients, evidence of active bronchospasm.

OXYGEN THERAPY

1. Use oxygen in hypoxic patients, target SO2 92-96%
2. Start with Oxygen nasal cannula, titrate up to 6 L/min
3. If persistent hypoxia may consider use dry venturi mask, flow up to 10 L and FIO2 up to 40%
4. If need to escalate oxygen also consider the use of High Flow O2 nasal cannula.

High Flow O2 NC

- Should be used in a negative pressure room under strict airborne precautions
- Use adequate PPE/N-95 when assessing/treating the patient
- Make sure nasal probes are in good position all the time to avoid leaks
- Place a regular facemask on the patient while using high flow

- Avoid flow rates higher than 40 L, theoretically may increase risk of aerosolization but evidence of risk of transmission is not consistent
- Titrate FIO2 accordingly, if FIO2 > 40% required consider transfer patient to ICU.

Non-Invasive Ventilation

- NIV (CPAP) may be considered in a **case by case basis**. Although evidence is not consistent, has been associated with higher risk of aerosolization, but for some patients there is potential benefit in avoiding the need for intubation.
- CPAP is recommended over BIPAP as CPAP will provide the greatest amount of mean airway pressure without affecting tidal volumes and decreasing the risk of lung injury.
- May provide benefit especially for patients with hypoxic respiratory failure, mild ARDS, atelectasis.
- **Recommendations for use:**
- Should be used in a negative pressure room under strict airborne precautions
- Use adequate PPE/N-95 when assessing/treating the patient
- Make sure there is adequate seal around the mask with no leaks
- Limit the pressure up to 15-18 cm if tolerated.

AWAKE PRONING

Proning in Covid-19 intubated patients has reported as a method to improve oxygenation. Awake proning for non-intubated patients may be considered as a strategy to avoid intubation.

Benefits:

1. May improve secretion clearance
2. May recruit atelectatic lung
3. May improve V/Q mismatch.

Procedure:

1. Consider awake proning in non-intubated patients with worsening oxygenation.
2. Patient must be cooperative with intact mentation.
3. Can be combined with low flow or high flow oxygen nasal cannula.
4. Make sure support devices and catheters are well secured.
5. Help the patient lie in their abdomen in a prone position. For patients with difficulty maintaining the position may consider lying on alternate sides.
6. Ideally proning positioning should be maintained for at least 12-16 hours if possible.
7. Follow oxygenation and FIO2 requirements. If no improvement of oxygenation in 2-4 hours consider no benefit of further proning.

COVID-19 INTUBATION PROTOCOL

Indications for intubation:

Evidence suggest recommendations for early planed intubation rather than emergent intubation but clinical judgement should be used when assessing the patient and decide if the patient requires intubation and mechanical ventilation. The following are some guidelines to consider the need for intubation:

- FIO2 requirements >60% to maintain SO2 92-96%. **For some patients higher threshold for FIO2 can be considered especially if hypoxia is not accompanied by respiratory distress ("silent hypoxia" has been described in some Covid-19 patients).**
- RR > 30
- Increased work of breathing
- Presence of hypoxia with worsening mental status
- Clinician concern for rapid respiratory deterioration

PROCEDURE

Endotracheal intubation is considered a high-risk aerosol generating procedure for which all medical personnel involved must adhere to strict airborne precautions, hand hygiene and donning of adequate PPE according to hospital policies.

Suggested protocol:

1. Intubation should be performed in a negative pressure isolation room
2. Reduced provider exposure with adequate PPE
3. Minimize personnel in patient's room to only essential staff (e.g. Physician, RT, ICU nurse)
4. Intubation should be performed by the most experienced provider to minimize intubation attempts.
5. May consider the use of intubation box as an extra barrier of protection.

Pre-oxygenation procedure:

If Covid intubation package if available:

-Attach a viral filter to a NIV mask
-Place a regular O2 nasal cannula to the patient with flow at 6 L and leave it on during the entire intubation procedure (this will improve oxygenation during the procedure)
-Place NIV mask on the patient with viral filter attached. Make sure there is not leaks around the face of the patient
-Attach a BVM with a PEEP valve to the NIV mask, place Oxygen flow to the BMV at least 15-20 L/min, adjust PEEP valve as indicated.

If Covid intubation package not available:

-Pre-oxygenate with a non-rebreather mask (NRB)
-Place simple mask over exhalation ports to avoid aerosolization

6. AVOID BAG MASK VENTILATION IF POSSIBLE, AT ALL
7. Rapid sequence intubation is the preferred method for intubation, use adequate dose of NMBA to avoid coughing or vomiting
8. Use video laryngoscopy (Glidescope) to maximize first pass attempt and avoid close distance of provider's face to the patient
9. Once endotracheal tube in place, inflate the cuff immediately, DO NOT BAG BEFORE CUFF IS INFLATED to avoid leakage
10. Consider clamping the ETT until is connected to the ventilator via a viral filter and a EtCO2 waveform capnography device if available
11. Minimize detachments from the ventilator
12. Avoid auscultation if adequate waveform capnography, use a EET depth calculator based on patient's height to determined best ETT position
13. Order portable CXR to confirm tube position.

Recommendations to consider for HCP during the COVID-19 Outbreak:

a) Guidelines for staff members regarding COVID-19 exposure:
    a. Members of the medical staff should promptly self-report symptoms or signs of COVID-19 like illness as new onset of subjective or measured (≥100.4oF or 38.0oC) fever OR cough OR shortness of breath OR sore throat that cannot be attributed to an underlying or previously recognized condition to the MCH employee office of health and wellness. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

    b. It is recommended to medical staff members with COVID-19 like illness to consider testing promptly if available.

    c. **Medical staff members that had been at risk of acquiring COVID-19 due to close contact with potential infected patients without proper PPE, and with no signs of COVID-19 like illness**, will use a mask at all times, at least for a period of two weeks if no manifest illness in addition to standard precautions. These physicians will be under self-monitoring with delegated supervision by the MCH employee office of health and wellness on daily basis, and will be under the obligation to report any COVID-19 like illness symptoms immediately and will keep a twice a day temperature logs for a minimum for two weeks - which also will be reported daily to the MCH employee office of Health and wellness. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

    d. **Medical staff members with COVID-19 like illness** will be relieved of their direct in-patient clinical duties unless an emergent situation - as determined by the MEC. These physicians should quarantine until their return to work-criteria as bellow stated is met. They could serve using telehealth while avoiding direct patient care. Decisions about return to work for medical staff members with COVID-19 like illness include a test-based strategy or a non-test-based strategy. Use the Test-based strategy as the preferred method for determining when HCP may return to work.
        i. If COVID-19 Testing is available **(Preferred):**
            1. Resolution of fever without the use of fever-reducing medications and
            2. Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
            3. Negative results of an FDA emergency use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected

≥24 hours apart (total of two negative specimens). The second requested test should be obtained only after the initial test had been resulted negative. If the first test is positive is recommended to repeat the test in 1 week.

ii. If COVID-19 Testing is not available:
    1. At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
    2. At least 7 days have passed since symptoms first appeared.

e. **Asymptomatic medical staff members that had tested positive for COVID-19**, will be relieved of their direct in-patient clinical duties unless an emergent situation - as determined by the MEC. These physicians should quarantine until their return to work-criteria as bellow stated is met. They could serve using telehealth while avoiding direct patient care. Decisions about return to work for asymptomatic medical staff members that had tested positive for COVID-19 include a test-based strategy or a non-test-based strategy. Use the Test-based strategy as the preferred method for determining when the medical staff member may return to work.
    i. If COVID-19 Testing is available **(Preferred):**
        1. Medical staff members will quarantine for a minimum of two weeks.
        2. The medical staff member could return to work once has negative results of an FDA emergency use authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens) obtained after the quarantine period is completed. The second requested test should be obtained only after the initial test had been resulted negative. If the first test is positive is recommended to repeat the test in 1 week.

    ii. If COVID-19 Testing is not available:
        1. After 30 days have passed since initial positive COVID-19 test was obtained, in the absence of any COVID-19 like-symptoms, the medical staff member may be able to return to work.

f. Medical staff members could return to work offering direct patient after being cleared by the medical staff health and wellness committee chairman, CMO, or chief of staff in consultation with the MCH

employee office of health and wellness. Final return to work in direct patient care will be approved by the MEC in their next conveyed meeting.

g. The MCH employee office of health and wellness will notify promptly any medical staff member regarding any potential COVID-19 inpatient exposure. Initial modes of communication may include telephone calls or any electronic or internet-based means of communication. A letter also will be mailed to the medical staff member.

h. The MCH employee office of health and wellness will report every Friday or more often if necessary, to the chairman of the Medical Staff Health and Wellness committee the status of physicians under delegated supervision. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

i. The MCH employee office of health and wellness will coordinate testing dates and times with the medical staff members to collect the necessary testing, preferably through the state lab by verbal order from employee health, and specimen sent to state lab to ensure proper timing and accountability.

j. It will be the obligation of the individual medical staff member to: a) notify MCH employee office of Health and wellness of COVID-19 like illness symptoms of concern, high-risk exposure or positive testing for COVID-19 regardless of symptoms, b) Log patient contacts in the patient's rooms designated logs, to help track inpatient contact exposure while in the hospital, c) To follow the monitoring and testing schedule recommended by the MCH health and wellness committee in consultation with the medical staff health and wellness committee, Chief of staff, CMO or MEC. C) To request clearance to return providing direct patient care before resuming clinical duties from the MCH employee office of health and wellness, in consultation with the medical staff health and wellness committee chairman, the chief of staff or CMO.

k. The current contact for the MCH employee health and wellness will be Anita McDowell (AMcdowell@echd.org). Office hours: Monday through Friday. 7:30 am to 12:00 noon, and 1:00 pm to 4:30 pm. Telephone: 432-640-1154.

Brief guidelines for NICU at MCH (3/30/2020)

Visitor Policy:

- In NICU: only mother allowed.
- In NBN: only mother and a significant other allowed.

Delivery:

- Non COVID suspected routine C-section: Only Charge RN to go.

- **Guidelines are same for mother SUSPECTED or POSITIVE COVID19**
    - If mother is asymptomatic and exposed to other positive COVID patient → treat her as **SUSPECTED.**
    - If mother is **SUSPECTED** with any symptoms (mild/critically sick) regardless if COVID positive or negative → treat as **POSITIVE.**

- *There is LOW risk of vertical transmission from current available evidences.*
- NO need for NICU attendance unless there is any other reason.
- The initial resuscitation should be in same room but at least 6 feet away from mother.
- NO skin to skin contact.
- NO delayed cord clamping.
- If NICU attendance needed → In ANY case, for all the NICU staff, wear appropriate PPE.

- **If baby is ASYMPTOMATIC → NO need for NICU attendance at delivery or NICU admission**
    - Baby can go to NBN.
    - Isolate baby from the mother (*even if the COVID test for mother is pending or negative with strong clinical suspicion).*
    - Mother can give EBM to baby.
    - Continue all routine care for the infant (Hep B vaccine, Erythromycin, Vit K etc.).
    - NO labs needed for the baby pertinent to COVID.
    - Recommend isolation to baby from mother for at least 14 days at home since mother's initial symptom.

- **NOTE:** mother may refuse separation. If mother refuses she must wear a mask and perform hand hygiene prior to feeding.

- **If baby is symptomatic and needs NICU admission for any reason:**
    - Admit in negative pressure room.
    - Keep the baby in the incubator.
    - Strict visiting policy.
    - Nurse patient ratio when caring for a COVID patient should be 1:1, 1:3, or 1:4 dependent on patient acuity.
    - Can use long tubing and keep the pumps outside of the room.
    - **For intubation**→ everyone in the room needs to have N95 mask (or any substitute), Goggles and hat. (Attempts should be made to keep baby in the incubator when intubating).

Brief guidelines for NICU at MCH (3/30/2020)

Rounds:

- Teleconference through Zoom daily and/or in-person physician rounds.

Emergency Department (ED):

- No admission to NICU from ED.
- For neonatal code in ED → only one NICU Charge nurse and physician/NNP.

Social distancing

- Update parents with a safe distance or preferably on phone.
- Call parents once a day.

Guidelines for Pediatric Admissions

Non-COVID Admissions: sickest in back to well patients in front

1. Respiratory patients
    a. admit to 518, 520, 521 FIRST
    b. 517and 522 next
    c. 519 for isolation patient only unless absolutely no other choice on 5W
2. Newborns with hyperbiliruben – admit in 502, 514
3. Surgeries, etc. in the middle
4. If 5 West is full, admit into 5 North starting at room 503 (if this happens, we need to leave room 502 open for parents/patients to shower).

Covid Patients – Persons Under Investigation (PUI) or Positive

NOTIFY Tammy Immediately – no matter the time!! Admit the PUI or positive patient to room 519, if this room is occupied move patient to 5N.

If admitting a PUI or Positive COVID patient, room 502 must be left open for family and patient to shower.

1. If admitting a PUI or Positive COVID patient, please admit to room 506 on 5 north.
2. If 2 or more PUI/COVID patients are admitted to pediatrics, all patients will be moved to 5N who are positive or suspected with assigned staff to care for these patients.
3. For additional PUI/COVID patients, continue with 505, 504, and then 503.
4. The former waiting room will become the anti-room.
5. If needed, we can use portable monitors in the rooms.
6. We will need to request an additional code cart that is appropriate for the size of the patient. If we admit 2 or more, determine what type of code cart is needed for each patient.

Maternal Child

MATERNAL TRIAGE, STABILIZATION, AND TRANSFER GUIDELINE

PROCEDURE:

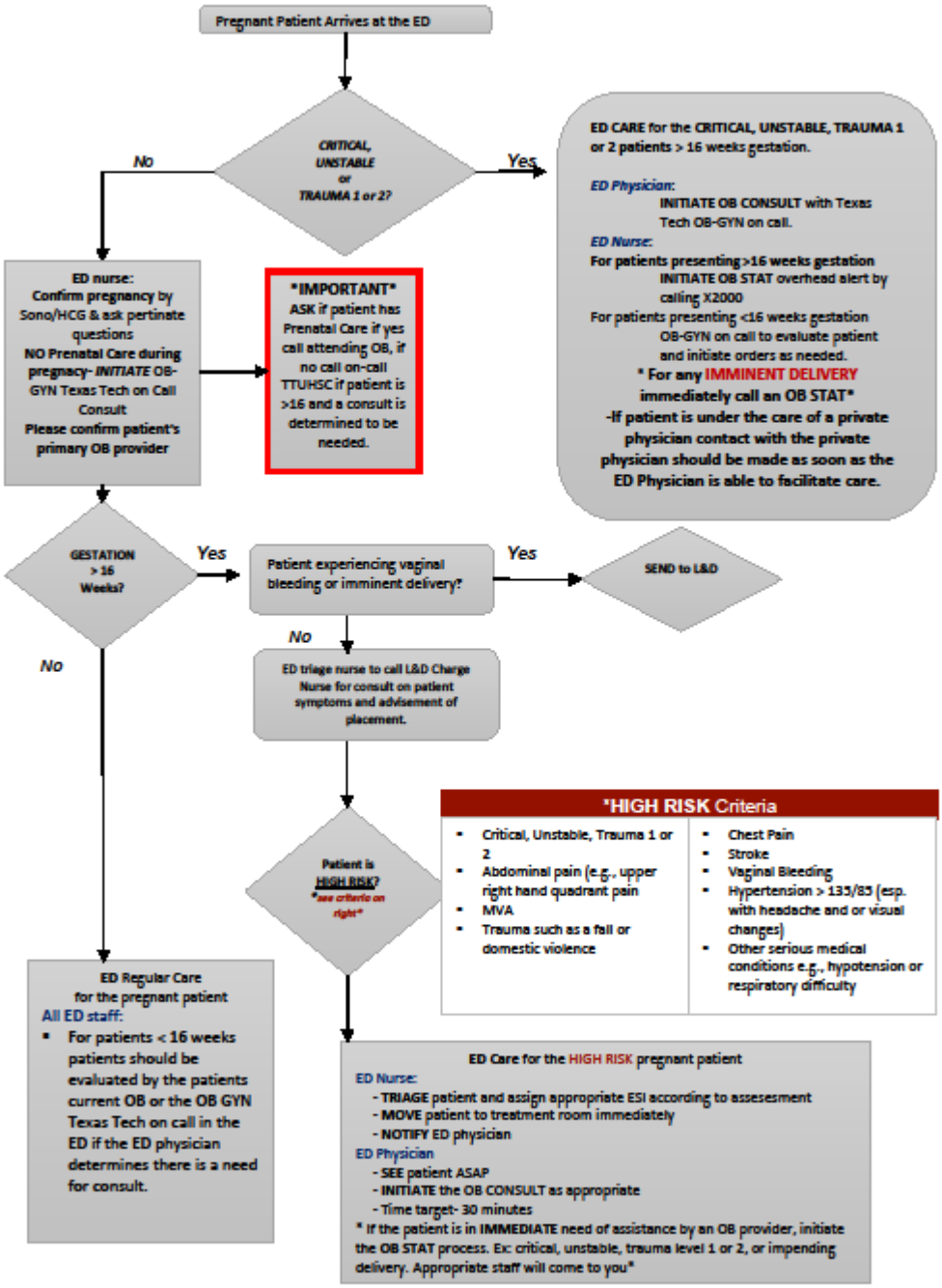
This guideline helps facilitate staff in triage, stabilization, and transfer of high-risk mothers admitted to the Center for Women and Infants.

GUIDELINE:

1. Maternal Triage, Stabilization, and Transfer:
    a. Women who are at risk for complications posing a significant risk for adverse outcomes and whose neonates are likely to require intensive support at a level IV facility should be considered candidates for referral during the antepartum period.
    b. Maternal transfer should be considered if necessary resources or personnel for optimal outcomes are not available.
    c. The attending obstetrician for each patient, in consultation with the Maternal Fetal Medicine provider and/or the neonatologist (as applicable), will triage and evaluate the need for transfer as appropriate.
    d. In the case of emergent cases presenting to the ED, the obstetrician and ED physician will coordinate care and transfer utilizing the OB STAT/ED Algorithm. *See algorithm below.*
    e. Transport may be undertaken if physician determines the well-being of either the woman or fetus would not be adversely affected or benefits of transfer outweigh foreseeable risks.
    f. The most common indications for maternal transfer may include, but are not restricted to:
        i. Potentially life-threatening maternal trauma and surgical complications as decided upon by the ED trauma team in coordination with the OB provider.
        ii. Severe maternal medical conditions which may include:
            1. Some cardiac conditions
            2. Some conditions of the liver
        iii. Fetal congenital anomaly requiring special newborn care
        iv. Fetal surgical procedure or intrauterine shunt placement
        v. Intrauterine transfusions

g. Maternal transfers to a more appropriate level of care are completed by the Charge Nurse and/or Care Coordinators on each unit in coordination with the accepting facilities transfer center.
h. Mode of transport is determined by patient acuity (e.g., ground transportation versus air transport)
i. Interventions necessary for stabilization will be performed before transport.
j. Under some circumstances, transport is either not desirable or not possible. Contraindications to maternal transport may include:
    i. Unstable maternal condition
    ii. Fetus's condition is unstable and threatening to deteriorate rapidly
    iii. Birth is imminent
    iv. Weather conditions are hazardous for travel, or present dilemmas for transport
k. Checklist for transports at MCHS include (forms can be located on eforms):
    ✓Physician order in Cerner for transport
    ✓Chart copy completed
    ✓Disc of all patient images made
    ✓MOT completed
    ✓Ambulance necessity form completed
    ✓Consent to transfer completed
    ✓Nurse to nurse report given to receiving facility
    ✓Transfer of documents form completed

ALGORITHM: MANAGEMENT OF PREGNANT PATIENTS ARRIVING TO THE ED



AUTHOR'S SIGNATURE	
	Clinical Coordinator
AUTHORIZING SIGNATURE(S)	
	Unit Director
	Associate Chief Nursing Officer Women's and Children's
	Maternal Medical Director
	Chief Nursing Officer
END OF POLICY	

Perinatal Behavioral Health Screening and Risk Assessment

Risk assessments aim to identify patients with behavioral health risks who may benefit from further evaluation and treatment.

PROCEDURE:

The screenings identify in this guideline aim to identify/assess all perinatal patients for the following behavioral risks:

- Substance abuse
- Domestic violence
- Depression and other mental health conditions

DEPRESSION SCREENING

1. A depression screen shall be administered to all perinatal patients
    a. Screening shall take place upon admission unless delivery is imminent and upon discharge. This screening can be done at any time the healthcare provider feels is appropriate in the
    b. Women with EDPH scores ≥ 10 should be evaluated by a provider and determination made whether further referral is needed.
    c. Patients with suicidal ideation, homicidal ideation, or active hallucinations should be referred immediately to either the psychiatric clinic or the psychiatric emergency department.
2. All patients shall be educated o the signs and symptoms of postpartum depression and postpartum psychosis:
    a. Feelings of sadness or hopelessness
    b. Loss of interest in normal activities
    c. Sleeping too little or too much
    d. Eating too little or too much
    e. Excessive crying
    f. Withdrawing from family or friends
    g. Thoughts of harming self or baby

3. Education in the form of handouts related to postpartum care and emotional changes will be given at discharge by the discharging nurse.

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

Scoring Guide

1. I have been able to laugh and see the funny side of things **0** As much as I always could **1** Not quite so much now **2** Definitely not so much now **3** Not at all	**2. I have looked forward with enjoyment to things** **0** As much as I ever did **1** Rather less than I used to **2** Definitely less than I used to **3** Hardly at all
3. I have blamed myself unnecessarily when things went wrong **3** Yes, most of the time **2** Yes, some of the time **1** Not very often **0** No, never	**4. I have been anxious or worried for no good reason** **0** No, not at all **1** Hardly ever **2** Yes, sometimes **3** Yes, very often
5. I have felt scared of panicky for no very good reason **3** Yes, quite a lot **2** Yes, sometimes **1** No, not much **0** No, not at all	**6. Things have been getting on top of me** **3** Yes, most of the time I haven't been able to cope **2** Yes, sometimes I haven't been coping as well as usual **1** Not very often **0** No, not at all
7. I have been so unhappy that I have had difficulty sleeping **3** Yes, most of the time **2** Yes, quite often **1** Not very often **0** No, not at all	**8. I have felt sad or miserable** **3** Yes, most of the time **2** Yes, quite often **1** Not very often **0** No, not at all
9. I have been so unhappy that I have been crying **3** Yes, most of the time **2** Yes, quite often **1** Only occasionally **0** No, never	**10. The thought of harming myself has occurred to me** **3** Yes, quite often **2** Sometimes **1** Hardly ever **0** Never

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

EPDS Score	Interpretation	Action
Less than 10	Depression not likely	Continue support
10 or greater Depression possible	Support, re-screen in 2-4 weeks with PCP	Refer to Social Work for evaluation while in-patient utilizing “maternal grief consult”
12-13 Fairly high possibility of depression	Fairly high possibility of depression	Refer to Social Worker for evaluation while in-patient utilizing “maternal grief consult”
14 and higher (positive screen)	Probable depression	Refer to Social Worker for evaluation while in-patient utilizing “maternal grief consult”
Positive score (1,2, or 3) on question 10 (suicide risk)		Immediate referral to Social Worker for suicidal ideation and arrange for psych sitter- urgency of referral will depend on several factors including whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, there is a psychotic disorder present, and/or there is concern about harm to the baby.

Additional risk assessment screenings are performed upon admission to the unit and can be found in the electronic medical record. These screenings include:

- Infectious disease risk
- Abuse and safety
- Substance use

REFERENCE:

Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Scale.

AUTHOR'S SIGNATURE	
	Clinical Coordinator
AUTHORIZING SIGNATURE(S)	
	Unit Director
	Associate Chief Nursing Officer Women's and Children's
	Maternal Medical Director
	Chief Nursing Officer
END OF POLICY	

Maternal Child

Venous Thromboembolism for Maternal populations

POLICY STATEMENT

Venous thromboembolism (VTE) is one of the leading causes of severe maternal morbidity and mortality. A complication of VTE, pulmonary embolism, accounts for approximately 15% of maternal deaths in developed countries according to the World Health Organization, while accounting for 9.3% of maternal deaths in the US (Venous Thromboembolism in Pregnancy and Postpartum Task Force, 2018).

Complications of Venous Thromboembolism:

- Deep vein thrombosis (DVT) - blood clot that forms in a deep vein.
- Pulmonary embolism (PE) - occurs when a blood clot in a vein breaks free and travels to the lungs blocking some or all of the blood supply.

Anticoagulation Medications:

1. Heparins- Heparins are considered safe in pregnancy as they do not cross the placenta, are not teratogenic and do not cause anticoagulation in the fetus.
2. Warfarin- Warfarin is a vitamin K antagonist that crosses the placenta, is teratogenic in early pregnancy resulting in “warfarin embryopathy” and causes anticoagulation in the fetus that may lead to hemorrhagic complications. Warfarin embryopathy is dose related and has been described with higher doses (> 5 mg qd); however, fetal complications have been reported at doses less than 5 mg a day. Warfarin use in pregnancy is primarily limited to select cases of mechanical heart valves only in consultation with cardiology and maternal fetal medicine and in the postpartum period. Warfarin is considered compatible with breastfeeding and therefore is a valid option for anticoagulation in the postpartum period.

PROCEDURE:

Risk assessment screening for venous thromboembolism is documented in the electronic metal record by the physician upon admission.

PREVENTION:

1. Apply sequential compression devices as ordered by the physician via the electronic medical record to the following patients:
    a. Patients undergoing cesarean delivery-should be fitted with SCDs prior to the beginning of surgery and continue SCD treatment into the postoperative period, until the patient is ambulatory, or by physician order.
    b. All patients with prolonged bedrest who do not routinely ambulate.
2. Promote early ambulation as ordered by the physician.
    a. In surgical patients, this should occur no later than postoperative day #1 unless extenuating circumstances.
3. Encourage adequate hydration.
4. Encourage positions to minimize venous stasis.
    a. These positions include elevation of extremities and discouraging prolonged sitting and/or crossing legs
5. Encourage active and passive leg exercises when ambulation is not possible.

DIAGNOSIS

1. Women displaying symptoms for VTE (including but not limited to: tachycardia, chest pain, shortness of breath, low oxygen saturation, unilateral leg swelling, and unilateral calf pain) should be immediately evaluated by a physician.
2. If concern for DVT after physician assessment, lower extremity Doppler ultrasound study should be ordered per physician.
3. If concern for PE after physician assessment the following tests may be ordered by the physician:
    a. Chest x-ray
    b. CT angiography
    c. V/Q scan

TREATMENT:

1. The physician may consider giving a therapeutic dose of enoxaparin (1 mg/kg subcutaneously) prior to imaging if high suspicion for VTE.
2. Women diagnosed with VTE should be started on therapeutic anticoagulation immediately. Treatment options may include:
    a. Lovenox (1mg/kg subcutaneously every 12 hours)
    b. Heparin (communication with hospital pharmacist to titrate to a therapeutic level)
3. Consideration of further consultation with Maternal Fetal Medicine for further work-up of etiology of thrombosis as well as duration of anticoagulation therapy.

MINIMIZING VTE COMPLICATIONS:

1. Ensure bedrest, as ordered by physician, until patient is stabilized.
2. Administer anticoagulants, as ordered by a physician.
    a. If unfractionated heparin is ordered administer on an infusion pump, coordination with pharmacist in regards to drip rates, and ensure coordination with lab in regards to timing of lab collection.
    b. Unfractionated heparin and low-molecular-weight heparin are considered safe for use during lactation.
3. Administer oxygen as necessary to maintain oxygen levels per physician order.
4. Administer pain relief medications for patient comfort, as ordered by physician. Consider consult to pharmacist for unrelieved pain.
5. Assess patient with DVT including peripheral pulses, measuring and comparing leg circumference and monitoring symptoms of pulmonary embolism:
    a. Shortness of breath: typically occurs suddenly and is worsened on exertion
    b. Chest pain, pain worsens on inspiration, cough, bending or stooping. Pain gets worse on exertion but does not reduce on rest.
    c. Cough
    d. Discolored skin
    e. Pain or swelling in the leg, usually the calf region
    f. Fever
    g. Excessive sweating
    h. Rapid or irregular heartbeat
    i. Dizziness or lightheadedness
6. Apply continuous, moist heat to relieve pain and promote circulation in the case of DVT.
7. Avoid pillows behind the knees or massaging of the affected area.
8. Elevate affected extremity on pillow for relief of venous aching and to increase venous return.
9. Educate patient as to condition, use of anticoagulants, and about the need to minimize venous stasis
10. Promote emotion support as necessary.

PERIPARTUM CONSIDERATIONS:

1. For planned induction of labor, wait 12 hours after prophylactic dose of lovenox (40 mg SC) or 24 hours after therapeutic dosing.

2. For patients presenting in spontaneous labor still on anticoagulation medications, obtain coagulation factors (PT, PTT, INR, fibrinogen, TEG) per physician's orders and alert the attending OB physician as well as anesthesia.
3. Protamine may be used for reversal of heparin, and fresh frozen plasma (FFP) may be used for reversal of enoxaparin in emergent cases.

POSTPARTUM CONSIDERATIONS:

1. Postpartum anticoagulation may be restarted 4-6 hours after vaginal delivery and 6-12 hours after cesarean delivery per physicians order.
2. Coordination for resuming anticoagulation postpartum should occur with anesthesia for removal of epidural catheter. For prophylactic dosing resumption should occur 12 hours after neuraxial blockade and at least 4 hours after catheter removal.
3. Women requiring anticoagulation therapy are recommended to continue anticoagulants for a minimum of 6 weeks postpartum.
4. Coumadin can be considered in the postpartum setting for women requiring long-term anticoagulation and who would like to avoid injections.
    a. Required bridging with therapeutic lovenox until INR is therapeutic.
    b. Requires coordination with outpatient INR evaluations.
5. Avoid new oral agents if patient is breastfeeding as there is limited information available about their safety breastfeeding profile.

REFERENCE:

American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2017). *Guidelines for perinatal care* (8 ed.). Elk Grove Village, IL.

American College of Obstetricians and Gynecologists. (2018). Thromboembolism in pregnancy. *American College of Obstetricians and Gynecolgoists*(196), 1-17.

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Maternal Child

TRIAL OF LABOR AFTER CESAREAN (TOLAC) VAGINAL BIRTH AFTER CESAREAN (VBAC)

STATEMENT:

This policy outlines the physician and nurse responsibilities in the management of patients who desire a trial of labor after cesarean section and/or delivery after previous cesarean section.

CONTRAINDICATIONS FOR TOLAC/VBAC

1. Patient refusal
2. Patient has a uterine incision other than low transverse
3. Patient has had a previous uterine rupture
4. Patient has had extensive transfundal uterine surgery
5. Any contraindication for vaginal delivery

PROCEDURE:

Prenatal Management:

1. Records of prior births will be reviewed by the provider if available, including type of cesarean birth.
2. Appropriate patient education will be provided to the patient by the provider including;
    a. Opportunity for patient and signification other/ support person to have questions answered.
    b. Risks and benefits of both TOLAC and elective repeat cesarean delivery; individual characteristics that effect the chance of complications associated with TOLAC and VBAC should be discussed.
    c. Provider and a witness will obtain consent and provider will document in the medical record that informed consent has been obtained and patient questions have been answered.
    d. Patients with a previous uterine scar will be informed regarding signs and symptoms of uterine rupture, signs of labor and when to go to the closest hospital for care.
3. Candidates for a planned TOLAC include the following:
    a. Two or fewer previous cesarean deliveries
    b. Low transverse or low vertical scare. If the type of incision is unknown the patient may be a candidate for TOLAC unless there is a high clinical suspicion of a previous classical uterine incision.

c. No history of prior uterine rupture or other uterine surgery such as hysterotomy or myomectomy entering the uterine cavity.
d. If twins, patient must be an otherwise appropriate candidate for twin vaginal delivery

Labor Management:

1. Determine that informed consent has been completed by the physician.
2. The provider will complete admission orders to include:
    a. CBC and Type and Screen, RPR, HIV labs as ordered by physician (this order may vary)
    b. All patients attempting TOLAC will have continuous electronic fetal monitoring
    c. Large bore IV (18 gauge or larger) will be started and maintained throughout labor and delivery
    d. Notify anesthesia and scrub tech staff of TOLAC patient
3. Medications
    a. Use of oxytocin will be at the discretion of the physician
    b. Prostaglandin agents (i.e. misoprostol) are not to be used in patients attempting TOLAC. Use may be considered in the case of fetal demise and for uterine atony after birth.
    c. Epidural analgesia may be used as part of TOLAC
4. Signs of Uterine Rupture may include:
    a. Fetal heart rate abnormality such as bradycardia
    b. Increased or decreased uterine contractions
    c. Vaginal bleeding
    d. Loss of fetal station
    e. New onset intense uterine pain
    f. Unstable maternal vital signs
    g. Signs of internal bleeding or shock
    h. Acute abdomen with peritoneal signs/guarding/shoulder pain

REFERENCE:

American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2012). Guidelines for Perinatal Care (6th ed.). Elk Grove Village, IL: Author.

American College of Obstetricians and Gynecologists (2010). Vaginal Birth after Previous Cesarean. (Practice Bulletin #115). Washington, DC.

American College of Obstetricians and Gynecologists (2012). Appropriateness of Trial of Labor after Previous Cesarean Delivery (Antepartum Period). Patient Safety Checklist

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END OF POLICY	

Medical Center Hospital
A Member of Medical Center Health System

4 East

POLICY MEMORANDUM

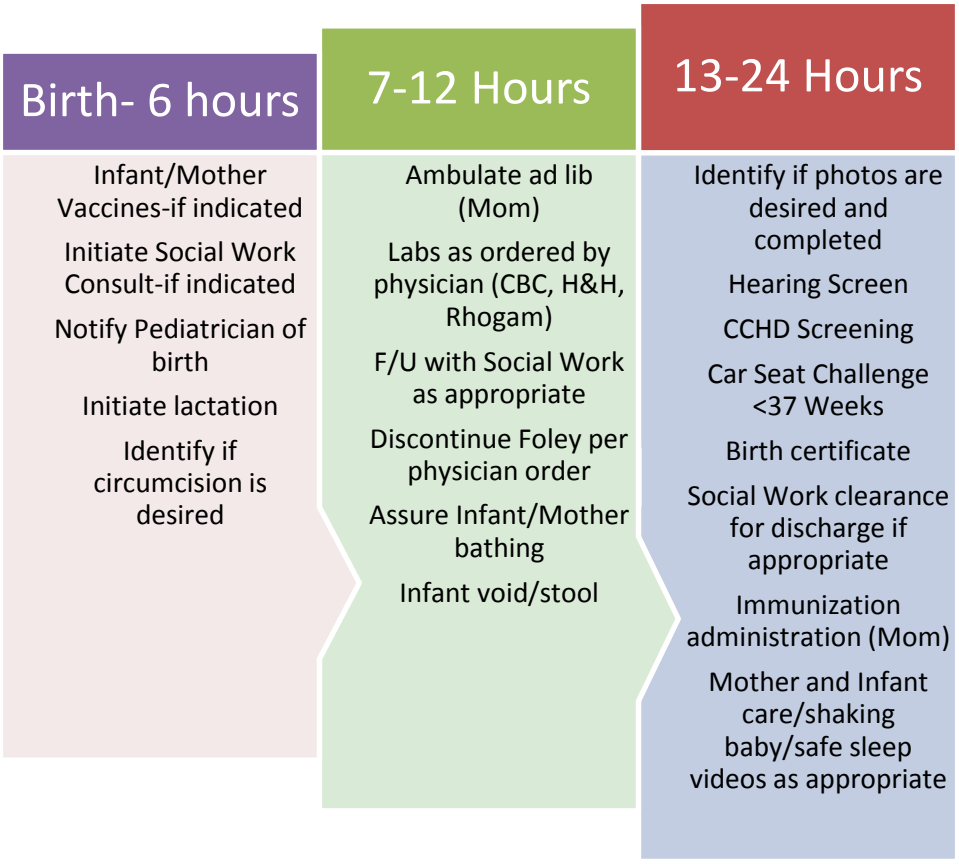
Discharge Planning of Mother and/or Baby from the Hospital

POLICY STATEMENT:

The purpose of this procedure is to give guidance to nursing staff in regards to preparing parents/guardians for discharge from the postpartum unit to home.

PROCEDURE:

1. Discharge planning should begin on admission to the unit or at the earliest possible time to meet the needs of the infant/patient and family, and will be based upon an assessment of individualized circumstances and needs of each family.
2. The discharge process for each patient should follow a discharge planning pathway that reflects an ultimate goal of discharge to home. While there are different circumstances that may cause variations, the following pathway would be appropriate in most cases:



3. Infants are generally discharged to their mothers. The infant may be discharged to the father or to a social service agency if the mother, for a justifiable reason, cannot be discharged with her infant, or if she is relinquishing the infant. These situations require:

    a. A physician's order, and
    b. Screening and approval by the Social Worker.
    c. Consent to discharge to person other than mother.

4. The Social Worker will ensure compliance with the following hospital policies:

    a. Discharge of children to be placed for adoption.
    b. Discharging children to other than parent or legal guardian.
    c. In-hospital rights of biological fathers not married to child's mother.

    Any situations with questionable circumstances involving the discharge of an infant should be referred to Social Services.

5. Facilitating appointment dates for follow-up with specialty provider may be done in coordination with the NICU Care Coordination. For regular scheduled follow-ups patients should be given their pediatrician/obstetricians phone numbers at discharge and instructions on desired follow-up timeframes.

Instructions:

1. If the parents want a "newborn" picture, ensure that this has been completed.
2. Assure that all newborn screenings were performed at 24 hours of age, these include:

Collecting Blood for Newborn Screening Test

The detection program in the state of Texas for Genetic and Metabolic Disorders that may result in brain damage if undetected requires the collection of newborn blood on cards specifically designed for this purpose.

PROCEDURE:

1. Explain procedure to parents before starting.
2. Form should be filled out completely.
    a. Initial screen to be done in hospital.
    b. Follow up in doctor's office or Department of Health.

3. At MCHS specimens are collected on healthy newborns after milk feeding or breast feeding for 24 hours. If hospital stay is short the specimen is collected at time of discharge.

4. Specimens are collected on premature babies at age of seven days, whether feeding or not. Second Newborn Screening is done at 1 month of age, 2500 gm, or discharge, whichever comes first.

Newborns of families with known PKU or other inherited disorders of metabolism should be tested daily during the newborn's hospital stay and at one week, two weeks and six weeks of age per physicians order.

Personnel:

Specially trained R.N.'s and L.V.N.'s or lab technicians.

Equipment:

1. Alcohol sponges or 70% ethyl alcohol
2. dry cotton balls
3. Band-Aids
4. Sterile lancet device
5. Filter papers (Newborn screening cards)
6. Gloves

Procedure:

1. Wash hands and wear gloves before start of procedure.
2. Site of choice in the infant is the lateral aspect of the heel. Make sure that infant's foot is warm and that the foot has been in a dependent position for several minutes prior to the test in order to assure an adequate blood supply.
3. Cleanse infant's heel with 70% alcohol. Wipe dry with 2x2 gauze sponge. Alcohol might alter test results.
4. Grasp the lancet device firmly and place correctly before releasing the lancet to puncture the skin.
5. Wipe away the first drop of blood. Allow another drop of blood to accumulate. Hold the infant's heel loosely, so as not to impede the flow of blood. If flow of blood does not

immediately appear, occasionally it may help to massage the lower portion of the extremity in a downward direction.

   a. Failure to collect large drops of blood can result in the collection of succession of small drops which tend to dry out and pile up on the filter paper and can give high reading on the test.

6. When a large drop of blood has accumulated touch the filter paper to the drop. Allow the blood to saturate the entire circle and watch to see that the blood soaks through to the opposite side.

   a. Do not handle the filter paper in the area of the circles, as organic substances may alter the growth of the bacterial organism in the laboratory.

7. Insure that all bleeding has stopped before the infant leaves if discharged.

8. Allow the blood specimen to fully dry for at least 3-4 hours. DO NOT stack. DO NOT allow specimen to touch any surface, heat, moisture, or direct sunlight.

   a. The use of capillary tubes and needles are NOT acceptable to obtain or transfer blood to filter.

9. Make sure all information on the blood collection form is completed. USE BLACK INK AND BLOCK CAPITAL LETTERS.

   a. Antibiotics and blood transfusion affect bio-assay by inhibition of growth. Laboratory is able to pick this up and request repeat testing while at the same time running tests that are not affected by antibiotic therapy.

10. Completed forms get sent daily to Texas Department of Health Laboratories.

Acceptable Specimen

Unacceptable Specimen

Do not collect specimens:

   a) Prior to 24 hrs. After protein intake.

   b) Infants of low birth weight, receiving antibiotics, or having transfusions.

11. Dry forms, completely filled out are to be placed in an appropriate envelope located in the Newborn Nursery and placed at the front nurse's station. Specimens MUST be mailed within 24 hours of collection. A courier will collect the Newborn Screening cards.

Critical Congenital Heart Disease (CCHD) Screening

This is a newborn screen and a passing or negative screen does not necessarily exclude CCHD. Approximately 18 out of every 10,000 babies are born with a critical congenital heart defect. CCHD is life threatening and requires intervention in infancy. Screening with pulse oximetry can identify a number of types of critical CHD, the most common:

- Coarctation of the aorta
- Double outlet right ventricle
- Epstein anomaly
- Hypoplastic left heart syndrome
- Interrupted aortic arch
- Pulmonary atresia
- Single ventricle
- Tetralogy of Fallot
- Total anomalous pulmonary venous return
- D-Transposition of the great arteries
- Tricuspid artresia
- Truncus ateriosus

Other conditions that are not critical CHDs

- Hemoglobinophathy
- Hypothermia
- Infection, including sepsis
- Lung disease (congenital or acquired)
- Non-critical congenital heart defect
- Persistent pulmonary hypertension
- Other hypoxic conditions not otherwise specified

SCREENING CONSIDERATIONS:

1. Pulse oximetry screening is done on healthy term newborns at least 24 hours of age or shortly before discharge if infant is <24 of age at discharge.
2. Pulse oximeter probe are attached to both the right hand and on either foot.

3. Infant should be warm, alert and calm and screen completed in a quiet environment. avoid screening infant during a period of deep sleep.

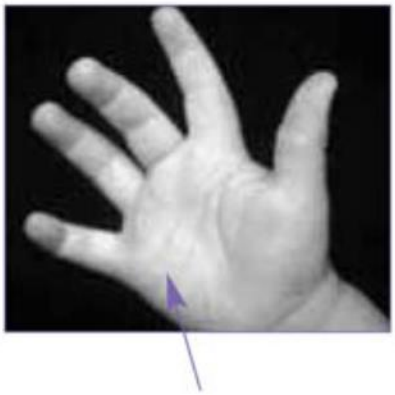
EQUIPMENT:

- Pulse oximeter with non-disposable probe
- Sanitizing wipes
- Tape
- Alcohol swab

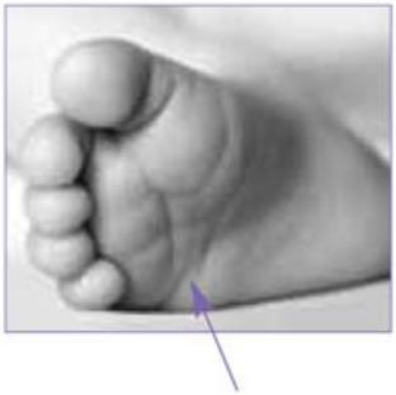
PROCEDURE:

1. Select application site on the outside, fleshy area of the infant's hand or foot. Clean sites with alcohol swab if needed. Make sure sites are dry.

2. Place the photodetector portion of the probe on the fleshy portion of the outside of the infant's hand or foot.



Right hand application site



Foot Application Site

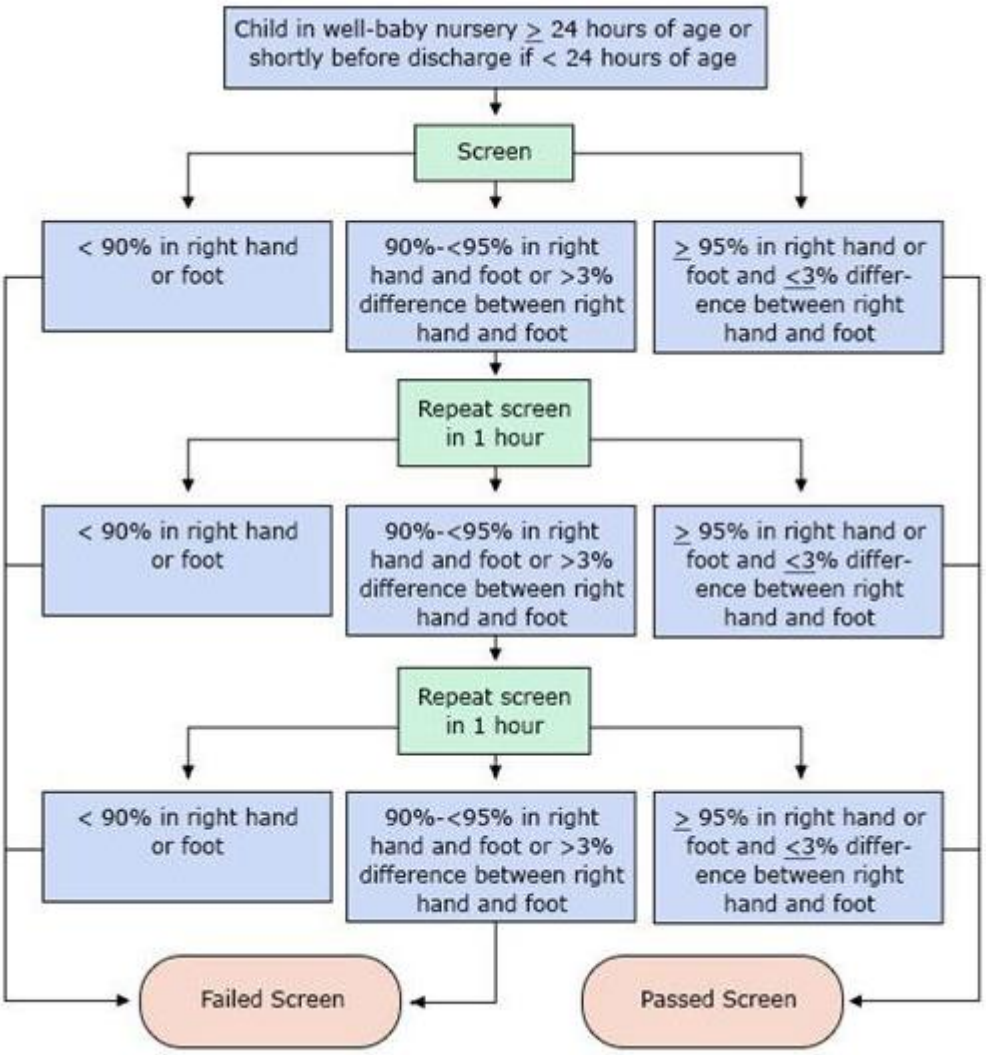
3. Place the light emitter portion of the probe on the top of the hand or foot. Place the photodetector directly opposite of light emitter, on the bottom of the hand or foot.

4. Remember: The photodetector and emitter must be directly opposite each other in order to obtain an accurate reading.

5. Secure the probe to the infant's hand or foot using the adhesive tape. Evaluate pulse ox reading for at least 30 seconds to ensure that the device is appropriately tracking the baby's pulse rate.

6. Record readings in CCHD Screening section of the EMR.

7. Practitioner will follow algorithm for next steps in the screening process.



AT DISCHARGE:

5. Check identification bracelets as follows:

   a. With the mother, ensure that the numbers printed on the infant's wristband correspond exactly to the numbers printed on the mother's wristband.

   b. Document that you witnessed the mother's identification of her newborn and her signature on the Identification Sheet by signing your name on the "Witness" line, and dating your signature.

   c. Escort, or ensure that a member of the nursing staff, escorts the infant to the hospital exit in a wheelchair.

6. Remove HUGS Tag as follows:

   a. The HUGS tag should only be removed if transport has arrived and the infant has met all discharge requirements.
   b. The nurse will discharge the tag from the HUGS system and immediately remove the tag from the infant's foot.

Documentation:

1. Time and date of discharge, with your signature
2. To whom baby was discharged

Ascertain/document that follow-up medical care for the infant has been arranged by the parents, or that teaching has been done in regards to them making this appointment. A two day follow up appointment for breastfeeding infants should be scheduled with a lactation consultant.

Reference:

Texas Department of State Health Services. Newborn Screening requirement. Oct. 2008

CDC. Screening for Critical Congenital Heart Disease. Http://www.cdc.gov/ncbddd/pediatricsgenetics/pulse.html.

Kemper AR, Mahle WT, Martin GR, et al. Strategies for Implementing Screening for Critical Congenital Heart Disease. Pediatrics.2011; 128(5).

Mahle WT, Martin GR, et al. Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease. Pediatrics. 2012; 129.

Pulse Oximetry Screening in Newborns: A policy Position from the American Heart Association. June, 2012. www. heart.org/advocacy.

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Maternal Child

ADMISSION OF NEWBORN TO 4E POSTPARTUM

PROCEDURE:

Upon admission to the unit routine assessment and care of the neonate should be provided in accordance with current Neonatal Resuscitation Program guidelines.

- If the status of the infant changes at any time, NICU nursing staff will be notified and/or rapid response will be called.
- Healthy newborns should remain with their mothers when possible.
- If breastfeeding, the infant should be placed to breast within the first hour of life.
- Involve the father or support person(s) with the infant as soon as possible.

Continue to facilitate thermoregulation by placing the infant:

a. Skin to skin with mother.

b. Under a radiant warmer.

c. Place a hat on the baby after thoroughly drying the infant's head and hair, and when taking the baby out from under the radiant warmer.

Initiate Newborn Admission Protocol:

1. Temperature, heart rate and respiratory rate on admission, Q1 hour X2, then every 4 hours, or per physician order.
2. Weigh on admission and daily.
3. Follow policy for screening and management of postnatal glucose: Appendix A
4. Vitamin K (Phytonadione) 1mg IM within six hours of life.
5. Erythomycin ophthalmic ointment to each eye by two hours of age.
6. Bacitracin 500 unit/gram topical ointment to cord and 1 inch around base on admission.
7. Recombivax HB 5mcg (0.5 mL) IM x1 dose on admission (irrespective of the mothers HBsAG status).
8. HBIG 0.5 mL IM x1 dose if mother is HBsAG positive or unknown.
9. For infants greater than 35 weeks of gestation Zidovudine 4 milligram/kilogram orally twice daily. Twice-daily dosing should be started as soon after birth as possible, preferably within 6 hours of delivery for HIV positive mothers.
10. Cord blood: Blood type, ABO/Rh (cord blood) ASAP once for infants born to mothers who have a clinically significant antibody, are Rh negative, or type "O"
11. Rapid plasma regain (RPR), qualitative (Cord blood CRPR) ASAP once.
12. *Follow GBS protocol*. See appendix A.
13. If coombs is positive, order Reticulocyte count, CBC, and bilirubin panel at six hours of life.
14. Aloe vista ointment to buttocks if red and sore PRN as needed.

15. Notify physician immediately if infant develops respiratory distress. Call NICU team to assess infant and place SPO2 monitor.
16. Urine and meconium drug screen if no prenatal care or mother's drug screen is positive.
17. Notify physician if no urine or meconium is passed by 24 hours of age.
18. Lactation consult order if breastfeeding.
19. Assess breast-feeding ability.
20. Measure head circumference on admission.
21. Measure length once on admission.
22. Document intake and output every 12 hours.
23. Perform Critical Congenital Heart Defect (CCHD) screening at 24 hours after birth.
24. Open crib continuously.
25. Neonatal metabolic screen routine once at 24 hours of age.
26. Transcutaneous Bilirubin once daily.
27. Ensure that a hearing screen order is in the system.
28. UOM consult for positive drug screen on mother, no PNC, or mother's age below 18.

Initial Assessment:

- Evaluate airway patency.
- Assess skin color.
- Auscultate lungs and heart.
- Assess muscle tone, LOC.
- Measurement of vital signs: axillary temperature, heart rate, respiratory rate, and temperature.
- Measurement of head circumference, body length, chest circumference.
- Additional evaluations if condition warrants: capillary refill, blood pressure (if anomaly or cardiac issue is present or suspected or per physician order), need for supplemental oxygen.
    - Acceptable axillary temperature is 36.5-37°C. (97.7-98.6°F.).
    - Axillary temperature 36.5-37°; infant may be wrapped in warm blankets and given to parent(s), or placed skin-to-skin with mother if she desires.
    - Axillary temperature (36-36.5°C.) 96.8-97.7°F.; place infant skin-to-skin with mother or support person with warm blanket, and/or radiant warmer over both. OR wrap in freshly warmed blankets.
    - Axillary temperature below (36°C.) 96.8°F. - place infant under radiant warmer and monitor temperature closely.
    - If initial axillary temperature is equal to or less than 36.5°C. (97.7°F) and warming initiated, recheck it at 15-30 minutes of age. If still equal to or less than 36.5°C. (97.7°F) check infant glucose level (capillary blood glucose). If less than 36°C. (96.8°F) place infant under radiant warmer.

- 6) Rectal temperatures should not be obtained unless otherwise specified by physician to avoid anal/bowel perforation.

Clinical care:

1) Eye Care- Gonococcal opthalmia prophylaxis is mandatory for all newborns, even those delivered by C-Section.

2) Antimicrobial ophthalmic prophylaxis administration is recommended soon after delivery, but may delayed until after the first breastfeeding.

3) Erythromycin should be administered per physician order. *For parent refusal forms please see Appendix C.*

Note: *HB 2886 provides an exception for certain health care providers who are unable to apply prophylaxis to a newborn due to the objection of a parent, managing conservator, or guardian of the newborn infant. Under this exception, the health care provider does not commit an offense and is not subject to criminal, civil, or administrative liability or any professional disciplinary action for failure to administer the prophylaxis.*

4) Vitamin K and Hep B administration.

5) All newborns should receive a one-time dose of parenteral Vitamin K (Phytonadione) 0.5-1 mg to prevent vitamin-k dependent hemorrhagic disease. *For parent refusal forms please see Appendix B.*

6) Vitamin K should be administered to the left leg to assist with congruity of care.

7) All stable babies should receive the Hep B vaccine regardless of maternal Hep B status, unless refused by parents. In such cases, parents should receive proper education about risks and advantages of refusing. Refusal of vaccine should be properly documented following CDC guidelines.

8) Hep B vaccine should be administered in the right leg to assist with congruity of care.

9) Skin care

- Exclusively bottle-fed Infants may be bathed after initial assessment is completed and vitals are stable with documented temperature ≥98° axillary for 2 hours. Breastfed infants should not be bathed until the infant has met the previously stated requirements, and has successfully latched and breastfed, 2 different feedings.
- Due to possible infectious diseases, use gloves when handling the infant after birth, until infant has been bathed with a mild soap.
- Thermoregulation will be maintained during and after the bath utilizing the Panda warmer.
- Bathing can be a source of significant heat loss and therefore should be postponed until stable temperature is reached (greater than or equal to 98°F axillary), unless necessary due to maternal infection risk factors.

13) During hospital stay, care of the newborns buttocks and perianal regions should be cleaned with warm water and cotton, mild soap and water, or baby wipes at each diaper change and when necessary.

14) Cord should be kept clean and dry.

15) Bacitracin 500 units/gm should be applied to cord and one inch of base per physician order on admission.

16) Complete admission assessment in electronic health record. Shift assessment should be completed every shift.

17) Document teaching done and response by parents.

18) Initiate Nursing Plan of Care in electronic health record.

16. Notify the infant's physician of birth and condition as soon as possible.

- Infants will be examined by a physician within 24 hours of birth.
- It is recommended that the admitting physician, or designee, be notified upon the birth of the infant.
    - If the infant is born after 2200 and there are no risk factors, the physician can be notified after 0600.
    - If the infant is born and has risk factors the physician should be notified upon birth so that orders are timely given for the infant.
    - It is the responsibility of the physician to provide adequate, appropriate, and uninterrupted 24 hour coverage for the newborn and the high risk infant.
    - Adequate and appropriate medical coverage will be defined as a 30 minute maximum response time by a physician for which the emergency and or concern has arisen. If a problem arises the Nursing Supervisor will be notified. The NICU staff will be asked for assistance in emergency cases where attending physician has not responded in 30 minutes, or rapid response may be called.

Notify Nursing Supervisor who will call:

- 1. Medical Director of Nursery or his designee
- 2. Pediatric Department - Chairman
- 3. Chief of Staff

17. If at any time, examination of the infant yields results that are not within normal limits, immediately notify the infant's physician.

18. Maintain communication with parents/family and encourage their participation in transitional care.

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Griese, M., & Prickett, S. (1992). Nursing Management of Umbilical Cord Prolapse. *JOGNN*, 311-315.

Sayed Ahmed, W., & Ahmed Hamdy, M. (2018). Optimal management of umbilical cord prolapse. *Internation Journal of Womens Health*, 451-463.

Evidence Based Practices In Fetal To Newborn Transitions, Journal Midwifery Women Health (2007); 52(3): 262-272, Guidelines to Perinatal Care, 5th Edition.

Guidelines for Perinatal Care (7th edition ed.). (2012). Elk Grove Village, IL.

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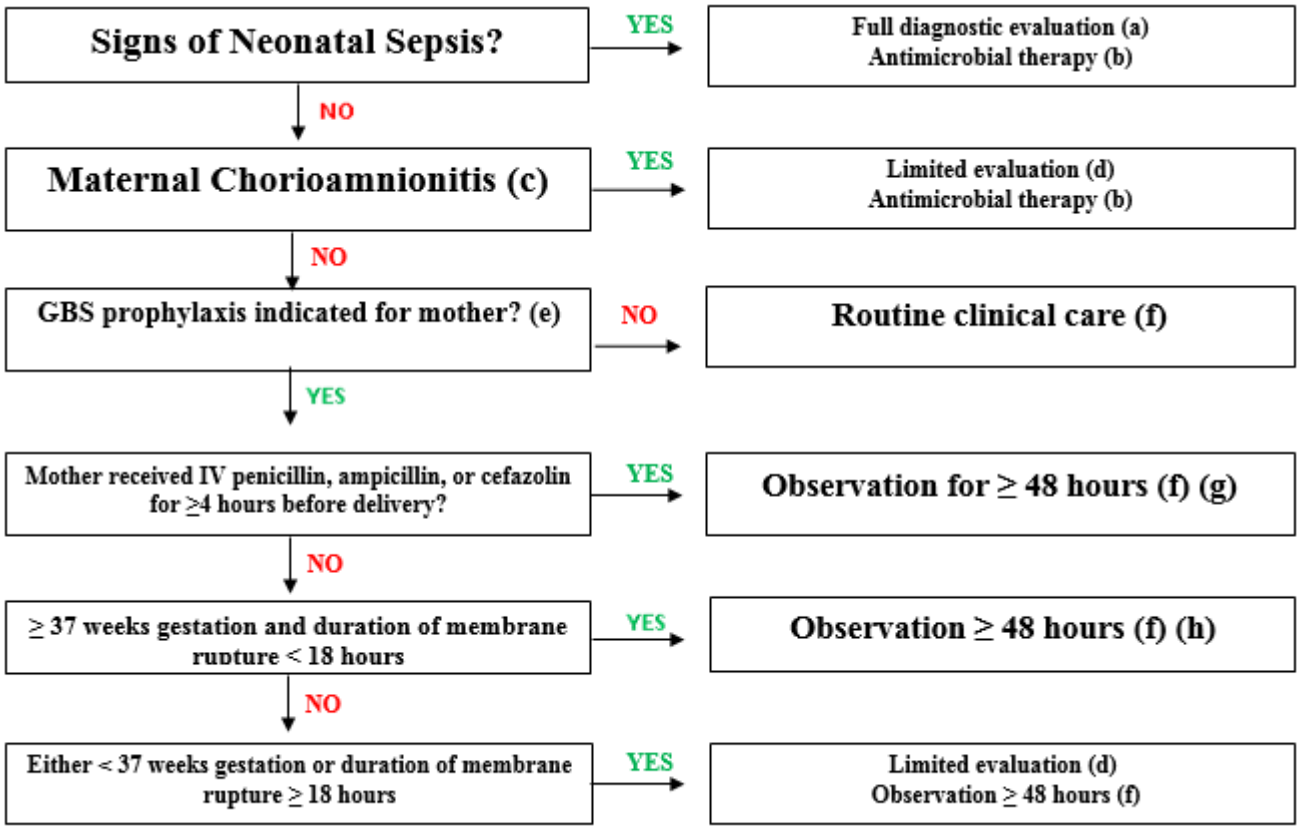
	Maternal Medical Director
END OF POLICY	

Appendix A



(a) Full diagnostic evaluation includes complete blood cell count with differential, platelets, blood culture, chest x-ray if chest abnormalities are present, and lumbar puncture (if patient is stable enough to tolerate procedure and sepsis is suspected).

(b) Antimicrobial therapy should be directed toward the most common causes of neonatal sepsis, including GBS, and other organisms (including gram negative pathogens), and should take into account local antimicrobial resistance patterns.

(c) Consultation with obstetric providers is important to determine the level of clinical suspicion for chorioamnionitis (now known as intra-amniotic infection). Intra-amniotic infection is diagnosed clinically, and some of these signs are non-specific.

(d) Limited evaluation includes blood culture (at birth), CBC, and CRP count with differential and platelets (at birth and or at 6-12 hours of life).

(e) GBS prophylaxis indicated if one or more of the following: (1) mother GBS + at 35 to 37 weeks gestation (2) GBS status unknown with one or more intrapartum risk factors, including; <37 weeks gestation, rupture of membranes ≥ 18 hours or temperature ≥ 100.4 (38.0C), or intrapartum nucleic acid amplification test results positive for GBS; (3) GBS bacteriuria during current pregnancy; (4) history of previous infant with GBS disease.

(f) If signs of sepsis develop, a full diagnostic evaluation should be performed and antimicrobial therapy should be initiated.

(g) If ≥ 37 weeks gestation, observation may occur at home after 24 hours if other discharge criteria have been met, if there is a knowledgeable observer and ready access to medical care.

(h) Some experts recommend a CBC with differential and platelets at 6-12 hours of age.

Vitamin K Informed Consent/Refusal Form

With the intent to reduce Vitamin K Deficiency Bleeding (VKDB) in infants, the American Academy of Pediatrics recommends an intramuscular injection of .5 – 1.0 milligrams of Vitamin K (phytonadione) into the thigh of every newborn within one hour of birth. VKDB was formerly known as Hemorrhagic Disease of the Newborn. All newborns normally have prolonged clotting times, but the abnormal condition of VKDB occurs in 0.01% - 1.5% of those who have not received a Vitamin K injection. VKDB is near confirmed when a bleeding infant has a prolonged prothrombin time (PT) together with a normal fibrinogen level and platelet count. Rapid correction of the PT and/or cessation of bleeding after Vitamin K administration confirm the diagnosis of VKDB. In national surveys researching millions of babies conducted from 1980 forward, almost all of the babies who had VKDB were breastfed. Most breastfed babies have an adequate Vitamin K supply and do not have bleeding episodes when they are NOT treated with Vitamin K. Most formulas have Vitamin K added.

An early warning sign of VKDB is visible bleeding evidenced by skin bruising or blood seepage from any body opening which can quickly lead to internal hemorrhage. In approximately 30-60% of cases, concealed internal bleeding is from fragile capillaries in the brain and can result in severely delayed development or death. If such bruising or bleeding occurs in an infant, it is imperative that a health professional be notified immediately. Medical intervention and Vitamin K administration are needed swiftly before seizures begin; internal bleeding may sometimes occur without visible outward signs.

If a baby is circumcised, he must be observed carefully afterwards for hemorrhage. It is normal for a baby girl to have an occasional spot of vaginal bleeding caused by hormones transferred from the mother. A few drops of blood from the umbilicus are also normal, but it should not continue.

Vitamin K Deficiency Bleeding can occur as early as within 24 hours of birth. A Vitamin K injection may be particularly warranted if the birth has been unusually traumatic or if certain maternal drugs have been used during the pregnancy (these may include anticonvulsants, cephalosporin antibiotics, tuberculostatic agents and Vitamin K antagonists). A reported link between intramuscular Vitamin K and childhood cancer prompted a number of studies that have yielded inconsistent results. The possibility of a small risk may exist, but we currently have inadequate information.

I/we, _____ and _____ are the parents of _____, born at home on _____. We have read this form and understand the medical recommendations to administer a Vitamin K injection to this baby.

_____ *I/We give permission for this newborn to receive a Vitamin K injection. We release Medical Center Hospital and agents from any and all liability that may be result from administration of Vitamin K to this infant.*

_____ *I/We give permission for this newborn to receive an* ***Initial Dose*** *of Oral Vitamin K. We release Medical Center Hospital and agents from any and all liability that may be result from administration of Vitamin K to this infant.*

_____ *I/We understand the risks and refuse a Vitamin K injection for our baby. We release Medical Center Hospital and agents from any and all liability that may result from our decision to refuse a Vitamin K injection.*

_____	_____	_____
Mother's Signature	Partner's Signature	Date
_____	_____	_____
Witness's Signature	Midwife's Signature	Date

Refusal of Newborn Eye Prophylaxis

I, _____ (name),
_____ (address), am the parent of an expected newborn infant. I know that my physician or the professional in charge of the care of my baby is required by Texas law to treat my newborn infant's eyes with prophylaxis approved by the Texas Department of State Health Services. The method would be to use erythromycin eye ointment generally within one hour after the infant's birth.

I understand that the eye drops are designed to prevent harm to the newborn's eyes from the consequences of exposure to Sexually Transmitted Infections. The state law requires the treatment to protect the eyes of newborns because their parents may not know for certain that they do not have an infection. Sexually Transmitted Infections may be present in a person but not show symptoms. Even testing at an earlier point during the pregnancy does not always prevent newborn disease because the infection could have happened after the test was obtained.

If the treatment is not provided the following injuries could occur to your child: severe eye infection with significant complications up to and including impaired vision or blindness. If the eye infection is left untreated, or if treatment is delayed, your child could develop a systemic infection.

I have read and I understand the above material. I have had all of my questions answered. Knowing the risk to my child I refuse to allow the treatment of my newborn infant on the grounds that the treatment violates my personal religious beliefs.

I hereby release, indemnify and hold harmless Medical Center Hospital its agents and employees including but not limited to anyone involved in my care and the delivery and care of my child for any and all liability for any injury resulting from my refusal to allow treatment. I have made this decision of my own free will with full understanding and knowledge of the harm that may result to my child. I understand that by signing this document I am agreeing not to have the treatment for my child and to assume full responsibility for the consequences including but not limited to assuming the defense and paying for any claim made against the University its faculty and staff by me, my family or my child arising out of my decision.

Signature of mother: _____
Date: _____

Witness: _____
Date: _____

Family Health Clinic
May 2020
ECHD Board Packet

Medical Center Health System
Your One Source for Health

Date: May 1, 2020

To: Board of Directors-Family Health Clinic

From: Grant Trollope, Assistant Chief Financial Officer

Subject: Combined Financial Report for the Month Ended March 31, 2020

Visits

Combined Medical visits for March were 1,350 comparing unfavorably to the budgeted total of 1,630 and unfavorably to the prior year's 1,438 by 17.2% and 6.1% respectively. Year-to-date medical visits were 9,018 comparing unfavorably to budget by 8.1% and unfavorable to prior year by 20.7%.

Revenues and Revenue Deductions

Combined patient revenue for March totaled $438,794 comparing unfavorably to the combined budget of $601,485 by 27.0% and unfavorably to prior year's total of $516,427 by 15.0%. Year-to-date patient revenue was $3,231,067 comparing unfavorably to budget by 10.7% and unfavorable to prior year by 19.7%

Combined revenue deductions for March were $357,566 comparing favorably to the combined budgeted amount of $407,956 and unfavorably to prior year's total of $285,143. Year-to-date deductions were $2,041,030 comparing favorably to budget and to unfavorably to prior year by 18.9% and 0.4% respectively.

Combined net operating revenue for March was $100,494 comparing unfavorably to the combined budget amount of $201,375 and unfavorably to the prior year amount of $245,875. On a year-to-date basis, net operating revenue was $1,344,146 comparing favorably to budget by 16.8 % and unfavorably to prior year by 34.6 %.

Operating Expenses

Combined salaries and wages expense for March were $105,620, comparing favorably to a combined budget of $125,336 and favorably to prior year's $121,853. Trends in salaries, wages, and benefits resulted from operations, which are now running with 26.2, Full Time Equivalents (FTEs) for March, compared to a budget of 32.7 FTEs and prior year's 30.5 FTEs.

Combined physician services (Provider salaries) for March totaled $117,242, comparing favorably to a budgeted amount of $174,037 and unfavorably to prior year's amount of $139,798.

Total operating expenses for March were $258,944 comparing favorably to budgeted expenses of $364,090 and favorably to prior year expenses of $341,468. On a year-to date basis total operating expenses were $1,717,908 comparing favorably to budget by 21.3% and favorable to prior year by 12.3%.

Operating Results

Combined operating results for the month of March resulted in a net loss of $192,394, comparing favorably to the combined budgeted deficit of $208,557, and unfavorably to prior year loss of

$140,831. Year-to-date the net loss from operations is $580,768 comparing favorably to budget by 55.4% and unfavorably to prior year by 231.7%

Revenue and Payments by Payor

For the month of March, Medicaid patients represented the largest revenue financial class, followed by Self-Pay, and Medicare. Clinics combined, Medicaid revenue accounted for 35.7%, Self-Pay 27.0%, Commercial 16.8%, Medicare 20.3%, 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 $1,166,156 compared to the prior year YTD amount of $885,769.

ECTOR COUNTY HOSPITAL DISTRICT
CENTERS FOR PRIMARY CARE COMBINED - OPERATIONS SUMMARY
MARCH 2020

	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	$ 438,794	$ 601,485	-27.0%	$ 516,427	-15.0%	$ 3,231,067	$ 3,619,844	-10.7%	$ 4,024,029	-19.7%
TOTAL PATIENT REVENUE	$ 438,794	$ 601,485	-27.0%	$ 516,427	-15.0%	$ 3,231,067	$ 3,619,844	-10.7%	$ 4,024,029	-19.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 285,594	$ (15,167)	-1983.0%	$ (47,018)	-707.4%	$ 844,944	$ (93,530)	-1003.4%	$ 71,230	1086.2%
Self Pay Adjustments	(29,442)	(825)	3468.8%	(10,926)	169.5%	155,417	(5,086)	-3155.8%	1,107	13944.3%
Bad Debts	101,414	423,948	-76.1%	343,087	-70.4%	1,040,670	2,614,382	-60.2%	1,977,315	-47.4%
TOTAL REVENUE DEDUCTIONS	$ 357,566	$ 407,956	-12.4%	$ 285,143	25.4%	$ 2,041,030	$ 2,515,766	-18.9%	$ 2,049,652	-0.4%
	81.49%	67.82%		55.21%		63.17%	69.50%		50.94%	
NET PATIENT REVENUE	$ 81,228	$ 193,529	-58.0%	$ 231,284	-64.9%	$ 1,190,037	$ 1,104,078	7.8%	$ 1,974,377	-39.7%
OTHER REVENUE										
FHC Other Revenue	$ 19,266	$ 7,846	145.5%	$ 14,591	32.0%	$ 154,109	$ 47,076	227.4%	$ 81,410	89.3%
TOTAL OTHER REVENUE	$ 19,266	$ 7,846	145.5%	$ 14,591	32.0%	$ 154,109	$ 47,076	227.4%	$ 81,410	89.3%
NET OPERATING REVENUE	$ 100,494	$ 201,375	-50.1%	$ 245,875	-59.1%	$ 1,344,146	$ 1,151,154	16.8%	$ 2,055,787	-34.6%
OPERATING EXPENSE										
Salaries and Wages	$ 105,620	$ 125,336	-15.7%	$ 121,853	-13.3%	$ 644,096	$ 754,297	-14.6%	$ 709,428	-9.2%
Benefits	14,791	34,839	-57.5%	32,902	-55.0%	159,868	200,307	-20.2%	195,623	-18.3%
Physician Services	117,242	174,037	-32.6%	139,798	-16.1%	770,335	1,047,420	-26.5%	873,919	-11.9%
Cost of Drugs Sold	3,010	10,528	-71.4%	23,942	-87.4%	55,679	63,354	-12.1%	61,118	-8.9%
Supplies	10,548	9,508	10.9%	17,157	-38.5%	37,434	57,168	-34.5%	70,732	-47.1%
Utilities	5,642	5,704	-1.1%	2,983	89.2%	34,919	34,669	0.7%	31,053	12.4%
Repairs and Maintenance	600	1,892	-68.3%	575	4.3%	3,650	11,352	-67.8%	4,736	-22.9%
Leases and Rentals	490	391	25.4%	378	29.9%	2,835	2,346	20.8%	2,553	11.0%
Other Expense	1,000	1,855	-46.1%	1,880	-46.8%	9,092	11,130	-18.3%	10,278	-11.5%
TOTAL OPERATING EXPENSES	$ 258,944	$ 364,090	-28.9%	$ 341,468	-24.2%	$ 1,717,908	$ 2,182,043	-21.3%	$ 1,959,441	-12.3%
Depreciation/Amortization	$ 33,944	$ 45,842	-26.0%	$ 45,238	-25.0%	$ 207,006	$ 270,612	-23.5%	$ 271,429	-23.7%
TOTAL OPERATING COSTS	$ 292,888	$ 409,932	-28.6%	$ 386,706	-24.3%	$ 1,924,914	$ 2,452,655	-21.5%	$ 2,230,870	-13.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (192,394)**	**$ (208,557)**	**-7.7%**	**$ (140,831)**	**36.6%**	**$ (580,768)**	**$ (1,301,501)**	**-55.4%**	**$ (175,083)**	**231.7%**
Operating Margin	-191.45%	-103.57%	84.9%	-57.28%	234.2%	-43.21%	-113.06%	-61.8%	-8.52%	407.3%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	1,350	1,630	-17.2%	1,438	-6.1%	9,018	9,809	-8.1%	11,367	-20.7%
Optometry Visits	-	-	0.0%	-	0.0%	-	-	0.0%	1,115	-100.0%
Total Visits	1,350	1,630	-17.2%	1,438	-6.1%	9,018	9,809	-8.1%	12,482	-27.8%
Average Revenue per Office Visit	325.03	369.01	-11.9%	359.13	-9.5%	358.29	369.03	-2.9%	322.39	11.1%
Hospital FTE's (Salaries and Wages)	26.2	32.7	-20.1%	30.5	-14.2%	26.8	33.4	-19.6%	31.4	-14.5%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE CLEMENTS - OPERATIONS SUMMARY
MARCH 2020

	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	$ 268,030	$ 448,818	-40.3%	$ 412,459	-35.0%	$ 2,058,772	$ 2,700,816	-23.8%	$ 2,673,932	-23.0%
TOTAL PATIENT REVENUE	$ 268,030	$ 448,818	-40.3%	$ 412,459	-35.0%	$ 2,058,772	$ 2,700,816	-23.8%	$ 2,673,932	-23.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 195,217	$ 31,643	516.9%	$ (5,817)	-3455.8%	$ 524,653	$ 195,133	168.9%	$ 196,717	166.7%
Self Pay Adjustments	(48,201)	6,603	-830.0%	(1,181)	3980.0%	65,855	40,721	61.7%	37,042	77.8%
Bad Debts	75,159	200,734	-62.6%	225,602	-66.7%	606,676	1,237,876	-51.0%	1,001,419	-39.4%
TOTAL REVENUE DEDUCTIONS	$ 222,175	$ 238,980	-7.0%	$ 218,603	1.6%	$ 1,197,184	$ 1,473,730	-18.8%	$ 1,235,178	-3.1%
	82.9%	53.2%		53.0%		58.2%	54.6%		46.2%	
NET PATIENT REVENUE	$ 45,855	$ 209,838	-78.1%	$ 193,856	-76.3%	$ 861,588	$ 1,227,086	-29.8%	$ 1,438,754	-40.1%
OTHER REVENUE										
FHC Other Revenue	$ 19,266	$ 7,846	0.0%	$ 14,591	32.0%	$ 154,109	$ 47,076	0.0%	$ 81,410	89.3%
TOTAL OTHER REVENUE	$ 19,266	$ 7,846	145.5%	$ 14,591	32.0%	$ 154,109	$ 47,076	227.4%	$ 81,410	89.3%
NET OPERATING REVENUE	$ 65,121	$ 217,684	-70.1%	$ 208,447	-68.8%	$ 1,015,697	$ 1,274,162	-20.3%	$ 1,520,164	-33.2%
OPERATING EXPENSE										
Salaries and Wages	$ 74,521	$ 92,710	-19.6%	$ 88,418	-15.7%	$ 448,309	$ 557,894	-19.6%	$ 517,991	-13.5%
Benefits	10,436	25,770	-59.5%	23,874	-56.3%	111,273	148,151	-24.9%	142,835	-22.1%
Physician Services	70,396	112,881	-37.6%	112,259	-37.3%	457,898	679,273	-32.6%	598,342	-23.5%
Cost of Drugs Sold	460	8,882	-94.8%	25,894	-98.2%	37,483	53,446	-29.9%	49,873	-24.8%
Supplies	5,311	5,909	-10.1%	6,792	-21.8%	29,531	35,518	-16.9%	30,208	-2.2%
Utilities	2,637	2,992	-11.9%	602	338.1%	16,453	17,343	-5.1%	16,209	1.5%
Repairs and Maintenance	600	1,892	-68.3%	575	4.3%	3,650	11,352	-67.8%	4,736	-22.9%
Leases and Rentals	490	391	25.4%	378	29.9%	2,835	2,346	20.8%	2,553	11.0%
Other Expense	1,000	1,848	-45.9%	1,880	-46.8%	9,092	11,088	-18.0%	10,278	-11.5%
TOTAL OPERATING EXPENSES	$ 165,850	$ 253,275	-34.5%	$ 260,672	-36.4%	$ 1,116,524	$ 1,516,411	-26.4%	$ 1,373,025	-18.7%
Depreciation/Amortization	$ 4,620	$ 5,203	-11.2%	$ 5,121	-9.8%	$ 28,266	$ 30,712	-8.0%	$ 30,726	-8.0%
TOTAL OPERATING COSTS	$ 170,470	$ 258,478	-34.0%	$ 265,793	-35.9%	$ 1,144,789	$ 1,547,123	-26.0%	$ 1,403,751	-18.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ (105,349)**	**$ (40,794)**	**-158.2%**	**$ (57,346)**	**-83.7%**	**$ (129,092)**	**$ (272,961)**	**52.7%**	**$ 116,413**	**-210.9%**
Operating Margin	-161.77%	-18.74%	763.3%	-27.51%	488.0%	-12.71%	-21.42%	-40.7%	7.66%	-266.0%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	784	1,176	-33.3%	1,145	-31.5%	5,792	7,076	-18.1%		0.0%
Average Revenue per Office Visit	341.88	381.65	-10.4%	360.23	-5.1%	355.45	381.69	-6.9%	371.17	-4.2%
Hospital FTE's (Salaries and Wages)	17.6	23.8	-25.9%	21.5	-17.9%	17.9	24.3	-26.2%	22.2	-19.4%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE WEST UNIVERSITY - OPERATIONS SUMMARY
MARCH 2020

	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	$ 170,764	$ 152,667	11.9%	$ 103,968	64.2%	$ 1,172,296	$ 919,028	27.6%	$ 1,350,097	-13.2%
TOTAL PATIENT REVENUE	$ 170,764	$ 152,667	11.9%	$ 103,968	64.2%	$ 1,172,296	$ 919,028	27.6%	$ 1,350,097	-13.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 90,378	$ (46,810)	-293.1%	$ (41,201)	-319.4%	$ 320,291	$ (288,663)	-211.0%	$ (125,487)	-355.2%
Self Pay Adjustments	18,759	(7,428)	-352.5%	(9,744)	-292.5%	89,562	(45,807)	-295.5%	(35,935)	-349.2%
Bad Debts	26,255	223,214	-88.2%	117,485	-77.7%	433,994	1,376,506	-68.5%	975,896	-55.5%
TOTAL REVENUE DEDUCTIONS	$ 135,391	$ 168,976	-19.9%	$ 66,540	103.5%	$ 843,846	$ 1,042,036	-19.0%	$ 814,474	3.6%
	79.29%	110.68%		64.00%		71.98%	113.38%		60.33%	
NET PATIENT REVENUE	$ 35,373	$ (16,309)	-316.9%	$ 37,428	-5.5%	$ 328,449	$ (123,008)	-367.0%	$ 535,623	-38.7%
OTHER REVENUE										
FHC Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 35,373	$ (16,309)	-316.9%	$ 37,428	-5.5%	$ 328,449	$ (123,008)	-367.0%	$ 535,623	-38.7%
OPERATING EXPENSE										
Salaries and Wages	$ 31,099	$ 32,626	-4.7%	$ 33,435	-7.0%	$ 195,787	$ 196,403	-0.3%	$ 191,437	2.3%
Benefits	4,355	9,069	-52.0%	9,028	-51.8%	48,595	52,156	-6.8%	52,788	-7.9%
Physician Services	46,846	61,156	-23.4%	27,539	70.1%	312,437	368,147	-15.1%	275,577	13.4%
Cost of Drugs Sold	2,550	1,646	54.9%	(1,952)	-230.6%	18,196	9,908	83.7%	11,245	61.8%
Supplies	5,237	3,599	45.5%	10,365	-49.5%	7,903	21,650	-63.5%	40,525	-80.5%
Utilities	3,006	2,712	10.8%	2,381	26.2%	18,466	17,326	6.6%	14,844	24.4%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Other Expense	-	7	-100.0%	-	0.0%	-	42	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 93,094	$ 110,815	-16.0%	$ 80,796	15.2%	$ 601,384	$ 665,632	-9.7%	$ 586,415	2.6%
Depreciation/Amortization	$ 29,324	$ 40,639	-27.8%	$ 40,117	-26.9%	$ 178,741	$ 239,900	-25.5%	$ 240,703	-25.7%
TOTAL OPERATING COSTS	$ 122,418	$ 151,454	-19.2%	$ 120,913	1.2%	$ 780,125	$ 905,532	-13.8%	$ 827,118	-5.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (87,045)**	**$ (167,763)**	**-48.1%**	**$ (83,485)**	**4.3%**	**$ (451,676)**	**$(1,028,540)**	**-56.1%**	**$ (291,496)**	**55.0%**
Operating Margin	-246.08%	1028.65%	-123.9%	-223.06%	10.3%	-137.52%	836.16%	-116.4%	-54.42%	152.7%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	566	454	24.7%	293	93.2%	3,226	2,733	18.0%	4,163	-22.5%
Optometry Visits	-	-	0.0%	-	0.0%	-	-	0.0%	1,115	-100.0%
Total Visits	566	454	24.7%	293	93.2%	3,226	2,733	18.0%		0.0%
Average Revenue per Office Visit	301.70	336.27	-10.3%	354.84	-15.0%	363.39	336.27	8.1%	255.80	42.1%
Hospital FTE's (Salaries and Wages)	8.5	8.9	-4.5%	9.0	-5.3%	8.9	9.1	-1.9%	9.2	-2.6%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC COMBINED
MARCH 2020

	MONTHLY REVENUE				YTD REVENUE			
	Clements	West	Total	%	Clements	West	Total	%
Medicare	$ 54,402	$ 34,660	$ 89,062	20.3%	$ 338,987	$ 266,906	$ 605,893	18.8%
Medicaid	95,694	60,967	156,661	35.7%	832,526	335,269	1,167,795	36.1%
FAP	-	-	-	0.0%	-	-	-	0.0%
Commercial	45,014	28,679	73,693	16.8%	353,992	237,001	590,993	18.3%
Self Pay	72,472	46,173	118,645	27.0%	528,529	330,034	858,563	26.6%
Other	448	285	733	0.2%	4,738	3,086	7,824	0.2%
Total	**$ 268,030**	**$ 170,764**	**$ 438,794**	**100.0%**	**$ 2,058,772**	**$ 1,172,296**	**$ 3,231,067**	**100.0%**

	MONTHLY PAYMENTS				YEAR TO DATE PAYMENTS			
	Clements	West	Total	%	Clements	West	Total	%
Medicare	$ 18,225	$ 10,819	$ 29,043	19.4%	$ 347,250	$ 76,159	$ 423,409	36.3%
Medicaid	46,782	27,772	74,554	49.7%	290,515	107,209	397,724	34.1%
FAP	-	-	-	0.0%	-	-	-	0.0%
Commercial	10,314	6,123	16,437	11.0%	91,530	60,395	151,925	13.0%
Self Pay	18,270	10,846	29,116	19.4%	124,403	64,703	189,106	16.2%
Other	590	351	941	0.6%	2,404	1,587	3,991	0.3%
Total	**$ 94,181**	**$ 55,910**	**$ 150,091**	**100.0%**	**$ 856,103**	**$ 310,053**	**$ 1,166,156**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
MARCH 2020

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	$ 54,402	20.3%	$ 59,267	14.4%	$ 338,987	16.5%	$ 376,053	14.1%
Medicaid	95,694	35.7%	178,897	43.4%	832,526	40.4%	1,145,803	42.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	45,014	16.8%	79,310	19.2%	353,992	17.2%	519,387	19.4%
Self Pay	72,472	27.0%	94,141	22.8%	528,529	25.7%	626,309	23.4%
Other	448	0.2%	844	0.2%	4,738	0.2%	6,380	0.2%
TOTAL	**$ 268,030**	**100.0%**	**$ 412,459**	**100.0%**	**$ 2,058,772**	**100.0%**	**$ 2,673,932**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 18,225	19.4%	$ 6,166	5.7%	$ 347,250	40.6%	$ 39,271	6.9%
Medicaid	46,782	49.6%	53,979	49.7%	290,515	33.9%	254,719	44.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	10,314	11.0%	32,023	29.5%	91,530	10.7%	159,653	28.2%
Self Pay	18,270	19.4%	16,455	15.1%	124,403	14.5%	113,058	19.9%
Other	590	0.6%	-	0.0%	2,404	0.3%	305	0.1%
TOTAL	**$ 94,181**	**100.0%**	**$ 108,624**	**100.0%**	**$ 856,103**	**100.0%**	**$ 567,006**	**100.0%**
TOTAL NET REVENUE	45,855		193,856		861,588		1,438,754	
% OF GROSS REVENUE	17.1%		47.0%		41.8%		53.8%	
VARIANCE	48,325		(85,233)		(5,485)		(871,748)	
% VARIANCE TO CASH COLLECTIONS	105.4%		-44.0%		-0.6%		-60.6%	

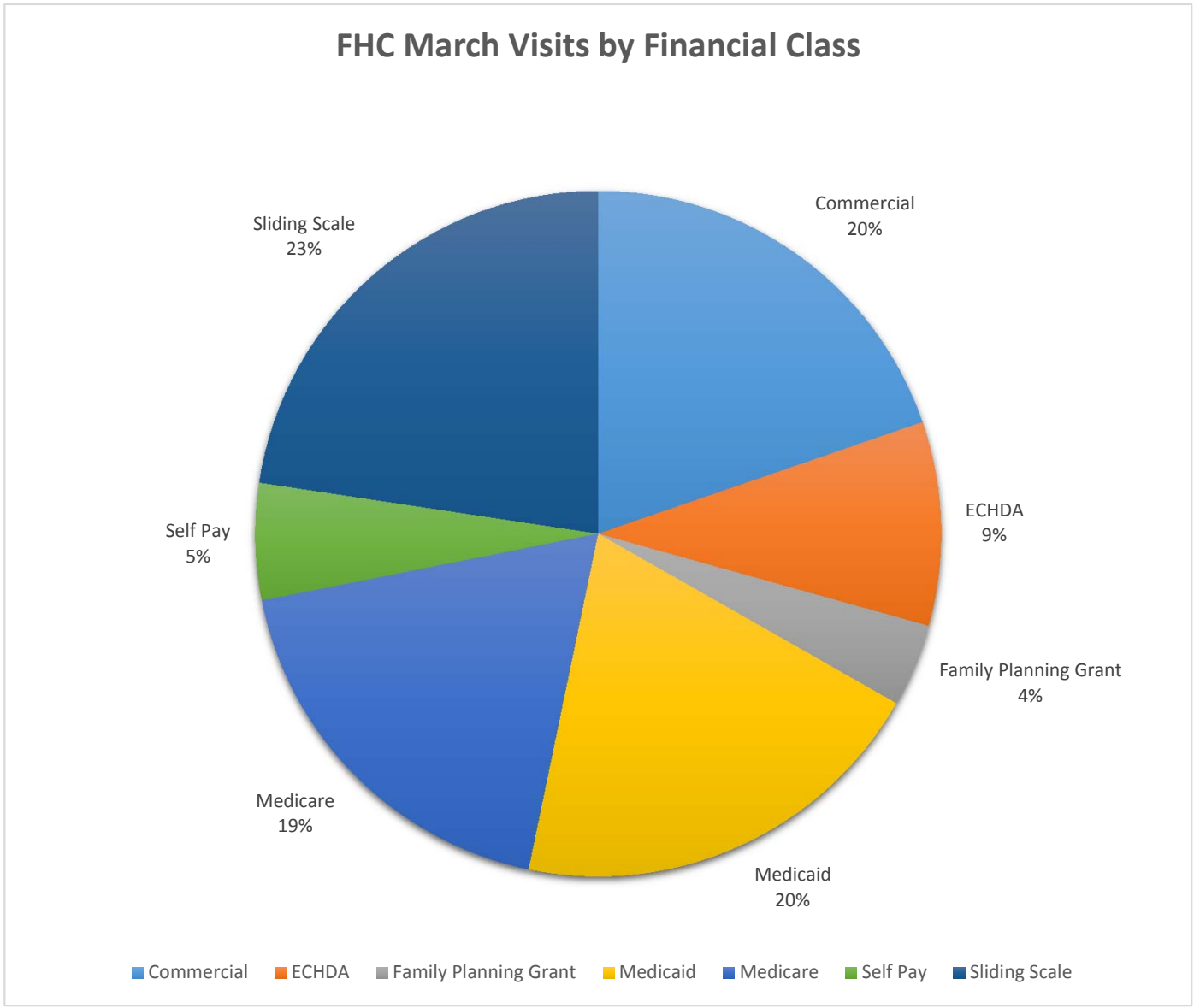
ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
MARCH 2020

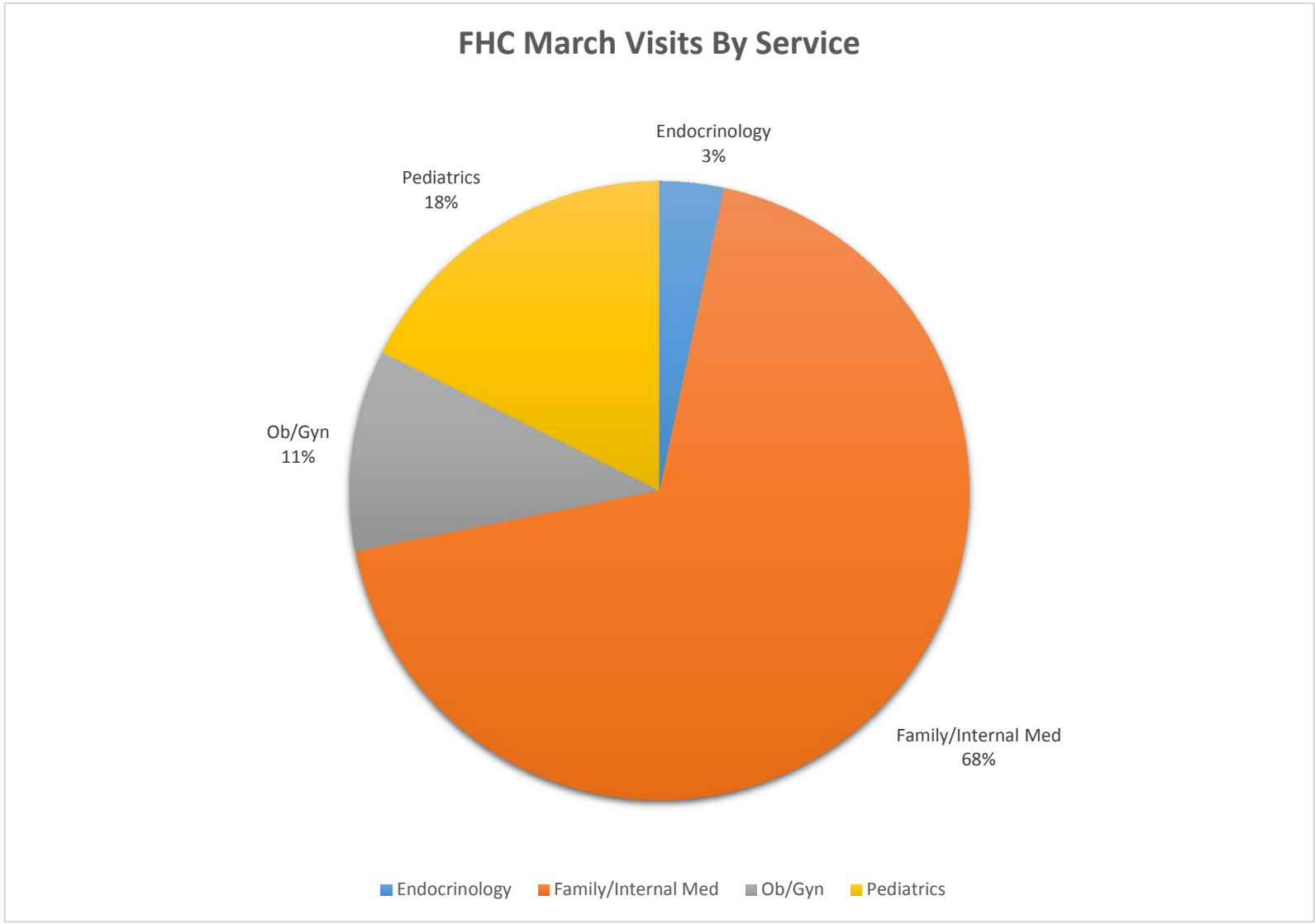
REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 34,660	20.3%	$ 23,431	22.5%	$ 266,906	22.8%	$ 224,602	16.6%
Medicaid	60,967	35.7%	$ 23,494	22.6%	335,269	28.5%	534,760	39.6%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	28,679	16.8%	$ 16,254	15.6%	237,001	20.2%	263,919	19.5%
Self Pay	46,173	27.0%	$ 40,788	39.2%	330,034	28.2%	326,521	24.2%
Other	285	0.2%	$ -	0.0%	3,086	0.3%	294	0.0%
TOTAL	**$ 170,764**	**100.0%**	**$ 103,968**	**100.0%**	**$ 1,172,296**	**100.0%**	**$ 1,350,097**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 10,819	19.4%	$ 8,501	24.8%	$ 76,159	24.6%	$ 55,404	17.4%
Medicaid	27,772	49.6%	9,016	26.3%	107,209	34.5%	127,909	40.1%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	6,123	11.0%	12,090	35.2%	60,395	19.5%	92,905	29.1%
Self Pay	10,846	19.4%	4,695	13.7%	64,703	20.9%	42,528	13.3%
Other	351	0.6%	16	0.0%	1,587	0.5%	16	0.0%
TOTAL	**$ 55,910**	**100.0%**	**$ 34,317**	**100.0%**	**$ 310,054**	**100.0%**	**$ 318,763**	**100.0%**
TOTAL NET REVENUE	35,373		37,428		328,449		535,623	
% OF GROSS REVENUE	20.7%		36.0%		28.0%		39.7%	
VARIANCE	20,537		(3,111)		(18,395)		(216,860)	
% VARIANCE TO CASH COLLECTIONS	58.1%		-8.3%		-5.6%		-40.5%	


FHC March Visits by Financial Class
Commercial 20%
ECHDA 9%
Family Planning Grant 4%
Medicaid 20%
Medicare 19%
Self Pay 5%
Sliding Scale 23%
Commercial
ECHDA
Family Planning Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC March Visits By Service
Endocrinology
3%
Pediatrics
18%
Ob/Gyn
11%
Family/Internal Med
68%
Endocrinology
Family/Internal Med
Ob/Gyn
Pediatrics

FHC Executive Director's Report-May 2020

- **Provider Update**: Dr. Poudel, Pediatrician, has signed his Letter of Intent. We are in search of a Pediatrician to fill the vacancy at our Clements location. Given the current COVID 19 crisis, Edak Akan, NP has agreed to postpone her start date to June or until we have a better idea of how future volumes will be affected by the current crisis.
- **Staffing Update**: The Family Health Clinic has the following open staff positions: 3 LVNs, 1 Front Desk, and 1 Eligibility Coordinator.
- **2020 FQHC Recertification:** The Family Health Clinic's FQHC recertification application has been reviewed and approved by HRSA. The Family Health Clinic's new designation period ends 3/31/2023.
- **COVID 19 Update:** Due to the COVID 19 crisis, the Family Health Clinic has implemented the following temporary operational changes: no walk-in patients, patients will be scheduled with same day appointments; temporary hold on our public walk-in vaccine clinic; implemented telehealth options for remote health services; decreased operating hours to Monday thru Thursday 8am-3pm and Friday 8am to noon; implemented visitor restrictions, and employee and patient screening processes at both FHC locations.

POLICY MEMORANDUM

POLICY TITLE:	Organizational Risk Management Plan
POLICY NUMBER:	MCH-5001
TJC FUNCTION AREA:	Performance Improvement
POLICY APPLICABLE TO:	This is an organization-wide policy; as such, it applies to all settings providing care, treatment and services.
POLICY EFFECTIVE DATE:	06/2019
POLICY REVIEWED:	6/2019, 02/2020
POLICY REVISED:	6/2019, 02/2020

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.

Medical Center Health System is committed to providing a safe environment by assuring a high quality patient centered experience for our patients by maintaining acceptable standards of care, minimizing the risk of injury to patients and visitors and minimizing financial loss to the institution as a result of patient and/or visitor injury.

The Patient Safety and Risk Management Programs support the Medical Center Health System philosophy that patient safety and risk management is everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.

Purpose

The Medical Center Heath System (MCHS) Risk Management Program's function is to maintain an organized program of loss prevention and loss control. The purpose is also to establish a framework for addressing a broad range of integrated administrative and clinical functions to reduce losses associated with patients, employees, visitors, property loss or damage or other potential sources of liability.

The Risk Management Plan supports this function by:

- Identifying areas of risk in the clinical aspect of patient care and safety and/or visitor safety.
- Establishing the investigative and evaluation process applied to cases with identified or reported risk potential.
- Assuring timely investigation and intervention (as appropriate) into occurrences that are considered not meeting the standards of care and/or have resulted or could have resulted in patient harm.
- Developing policies and programs to reduce risk in clinical aspects of patient care and safety.
- Endorsing the National Patient Safety Goals as outlined by regulatory, licensing, and/or accrediting organizations and facilitates adoption of programs and protocols designed to achieve those goals.
- Establishing mechanisms to report risk management activities to the appropriate regulatory, licensing, and/or accrediting organizations as mandated by law.
- Promoting collaboration between risk management and performance improvement functions throughout the organization to decrease risk and identify opportunities for improvement.
- Participating in staff education programs focusing on topics relevant to patient safety, compliance, and other loss prevention areas.

Policy

To meet its commitment to provide quality health care and to assure the continuing human, physical and financial integrity, the facility shall maintain a comprehensive Risk Management Program in accordance with the provisions of applicable federal regulations, state standards, and The Joint Commission and other regulatory agencies. The Risk Management Program operates with the support and under the authority of the Board of Directors through its approval of this plan.

Obligation to Report

All employees and health care providers of MCHS directly or indirectly involved in the delivery of health care services are required to report any occurrence, act, or condition whether actual or a "near miss" that they believe:

- Is an actual error or holds potential for error
- May not meet the applicable standard of care
- Caused actual harm or injury to a patient
- Has reasonable probability of causing injury to a patient
- May be grounds for disciplinary action by the appropriate licensing agency
- Anything not normally expected to occur.

All occurrences must be reported prior to the end of the reporter's workday/shift but at a minimum within 24 hours of the discovery of the occurrence. The person with direct knowledge of the occurrence or the person discovering the occurrence must report the occurrence by completing and submitting the Occurrence Reporting and Trending System (ORTS) report form or via the physician patient safety hotline. "Knowledge of the Occurrence" means familiarity because of direct involvement *or* observation of the occurrence. After hours the occurrence must be reported to the Administrative Coordinator. *See policy # MCH-4012.*

A willful and knowing failure to make a required report may be subject to disciplinary action. All individuals reporting occurrences will be considered to be acting appropriately and in the interest of safety. The system will not discharge or otherwise discriminate against an employee for making a required report in good faith. All investigations and corrective actions will be handled discreetly and in a just and equitable manner for all parties concerned.

All interested parties also have the right to report directly to the Department of State Health Services at 1-888-963-7111 or The Joint Commission 1-800-994-6610 or www.jointcommission.org.

Leadership, Authority, and Scope

In alignment with the top strategic organizational goal to provide a High Quality Evidence Based Practice MCHS follows the 5 essential principles of a High Reliability Organization:

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

Hospital, Clinic and Medical Staff leaders have an integral role in promoting and fostering risk management activities and controls. These leaders include the Ector County Hospital District Board of Directors, MCHS Executive Staff, Elected Medical Staff Officers and Chairpersons, Quality & Patient Safety Leadership, and all MCHS Department Directors/Managers. The leaders foster and promote risk management through planning, educating, prioritizing challenges and solutions, analyzing resources, defining accountability, empowering staff, celebrating achievements and securing and safe-guarding protected information. The Risk Management Program shall include all departments, services and health care professionals. It shall be ongoing and include effective mechanisms to monitor patient care as well as identify, evaluate and resolve problems that impact the quality of services offered.

Roles and Responsibilities:

The Ector County Hospital District Board of Directors:

The ECHD Board of Directors has the ultimate responsibility and authority for the Risk Management Program of Medical Center Health System. Responsibility for implementation of the plan is delegated to the President/CEO, Chief Medical Officer, Chief Legal Counsel, and Director of Risk Management.

The Director of Risk Management is charged with the responsibility for the implementation and coordination of the Risk Management Program and is empowered with the authority and responsibility from the Board, Medical Staff, and Executive Staff that is necessary to carry out the functions and activities of the Risk Management Program.

The Director of Risk Management is qualified by education, training and/or experience to coordinate the functions and activities of the Risk Management Program.

In order to carry out the functions and activities and meet the responsibilities of the program, the Director of Risk Management shall have access to all necessary and relevant hospital and medical staff data, including but not limited to committee minutes, medical records, and medical staff and personnel files.

Executive Leadership and the Board of Directors' commitment to the Risk Management Program, including allocation of human and financial resources necessary to implement and maintain the daily functions of the program, is evidenced in writing by its approval of the Risk Management Plan.

In the absence of the Director of Risk Management, these functions may be performed/implemented by Chief Legal Counsel, Chief Executive Officer, Chief Operating Officer, or designee.

The Risk Management Program involves the interaction of the Board of Directors, the Medical Staff, Executive Leadership, and professional, technical and support services.

Board of Directors:

A. Review report findings, actions, and results of the risk management program activities and approves the actions taken and recommends further action and/or follow up.

B. Reviews the results of the annual evaluation and effectiveness of the risk management program.
C. Reviews and approves the Risk Management Plan annually.

Executive Leadership:

The Chief Executive Officer and Chief Legal Counsel are responsible for providing qualified personnel and adequate funding to support the proper functioning and operation of the risk management program. Executive Leadership will participate in assignment of priorities for the investigation of problems, and, as appropriate, shall study and act upon problems that are identified through risk management activities.

Medical Staff:

The Medical Staff is responsible for the review and evaluation of patient care. The Medical Staff reviews and acts upon, as necessary, reports relating to risk management activities. The Medical Staff participates in the identification and resolution of problems affecting the delivery of quality patient care. The Chief Medical Officer will be notified of all risk management activities involving Medical Staff members.

Management/Leadership:

The department managers/directors are responsible for loss control and safety activities within their area and may designate other individuals within their area to perform specific exposure identification and evaluation activities, maintaining communication with the Director of Risk Management so that activities may be coordinated within the facility-wide program. Findings of risk management activities shall be used, as appropriate, in departmental educational program policy and procedure development, and in the evaluation of individual staff performance.

Staff:

All health care providers, employees, and volunteers for the facility are responsible for:

A. Reporting incidences, adverse or unusual occurrences, with or without injuries, to the Director of Risk Management.
B. Complying with safety and health standards and with the policies and procedures that apply to their job responsibilities in an effort to provide quality patient care and maintain a safe environment.

Director of Risk Management:

The Director of Risk Management has the authority and the responsibility to administer the facility Risk Management Program. The Director of Risk Management is responsible for developing and implementing appropriate measures to minimize the risk of injuries to patients, visitors, and staff, and management with the ability to cross lines of accountability and to influence and/or change behavior or all individuals within the facility. The Director of Risk Management's responsibilities include (but not limited to):

A. Review all occurrence and investigative reports, investigation of serious incidences, trending of data, recommending corrective action and continued monitoring to evaluate the effectives of actions taken.
B. Report specific occurrences with all federal, state, and other appropriate facility committee, departments and individuals.
C. Coordinate an ongoing program to educate Board members, Medical Staff, employees, and volunteers in risk management, safety and loss control matters at their initial orientation and at least annually thereafter.
D. Co-Manage with the Patient Experience/Service Excellence Director the patient/visitor complaint/grievance process to ensure that complaints and/or grievances are referred to the appropriate individual or committee for action, and that they are resolved in a timely manner. To work with the Director of Patient Experience/Service Excellence and/or Patient Advocate or designee(s) accordingly relating to all patient experience concerns therein.

E. Assist Executive Leadership as requested.
F. Participate in the process to review ethical issues.
G. Participate in the process for planning new services.
H. Act in an advisory capacity to all facility departments identifying and correcting unsafe conditions and/or practices.
I. Monitor the facility's risk financing program and report unprotected/under protected assets and new exposures to insurance carrier/provider and Chief Legal Counsel.
J. Maintain professional relationships necessary to stay knowledgeable in current regulations and standards to keep the Risk Management Program up-to-date.
K. Serve as liaison with the insurance carriers/provider for the purpose of reporting potential claims (including but not limited to professional liability, general liability, property and auto damage, etc.) and participate in the management of claims with Chief Legal Counsel and in accordance with current insurance carrier/provider guidelines.
L. The Director of Risk Management has authority to settle patient claims up to $2,500/per claim. Claims greater than $2,500 and less than $50,000 require Chief Legal Counsel, and/or CFO and President/CEO approval. Claims greater than $50,000 require Chief Legal Counsel, President/CEO and ECHD Board of Directors approval.

Key Elements of the Risk Management Program

A. Claims Management

1. Claims management involves management of both actual or potential losses and litigation situations. It includes reporting serious occurrences and probable claims, general and professional liability losses, automobile and property losses and other types of losses, according to the procedures defined by Chief Legal Counsel and by the insurance carrier.
2. The claims management processes include investigation of potential and/or actual claims and the defense of claims and lawsuits in an effective manner as expeditiously and cost efficiently as possible.
3. Activities included, but are not limited to, interviewing and scheduling staff or witnesses, security medical records and/or imaging films, sequestering equipment, attending depositions and representing the facility at trial.

B. Risk Control and Risk Identification

Risk control, identification and reduction consists of developing, eliminating, minimizing or reducing exposures through education, pattern and trending occurrences, implementing projects to counteract high risk issues. The Director of Risk Management is responsible for identifying property, human and financial risk to the facility as well as implementing mechanisms to control and reduce risk.

C. Risk Analysis

Risk analysis consists of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur.

D. Occurrence/Incident Reporting

The occurrence reporting system is part of the overall risk management program. The occurrence reporting system is a mechanism utilized to assist in risk reduction, risk identification and risk analysis. An ongoing evaluation and analysis of the reported occurrences is conducted and appropriate action instituted when opportunities for improvement are identified.

1. Any occurrence with results in a potential for an actual injury to a patient, visitor, or employee or damage to the facility property or reputation will be reported through completion of appropriate occurrence reporting system.
2. Employees, volunteers, and medical staff members have an affirmative duty to report occurrences/incidents to the Director of Risk Management. The individual most directly involved or finding the occurrence/incident will be responsible for initiating and completing the report.
3. The report must be completed and submitted to the Director of Risk Management as soon after the occurrence as possible and must be completed and submitted during the shift that the occurrence is discovered.

4. The report is a factual description of the occurrence. Conclusions and subjective information should not be entered in the report.
5. The Director of Risk Management will be responsible for regular and systematic review of all occurrence/incident reports for the purpose of identifying exposures, trends and/or patterns. If an exposure trend or pattern is identified, the Director of Risk Management will develop recommendations for corrective actions or make a referral to the appropriate committee, department chairman, and/or manager/director.
6. The Director of Risk Management will prepare and submit occurrence trending reports to the Board of Directors, Executive Leadership, Medical Executive Committee, Environment of Care Committee, and the facility's designated Performance Improvement and/or Patient Safety Committee(s) at least twice annually but more frequently as directed or as information becomes available. Serious occurrences will be reported to the appropriate bodies immediately.

E. Education

Risk Management education/orientation for the Medical Staff, employees and volunteers is aimed toward methods of decreasing risk and controlling liability. It includes education resulting from evaluation of risk findings. Education can occur both formally and informally, at department or facility-wide levels.

Topics for education in risk education should include, but is not limited to, the following:

1. Patient safety
2. Risk Management notification and investigation processes
3. Legal aspects of medical care such as informed consent, confidentiality, EMTALA, etc.
4. Effective documentation and provider responsibilities
5. Professional liability and accountability
6. Any topic relating to findings from risk analysis which may help eliminate and reduce risk

F. Product Recall

The product recall program consists of implementing and tracking product recalls that occur that effect the facility. The Materials Management Director is responsible for oversight of the product recall program. The Director of Clinical Engineering will manage any recalled patient care equipment per policy. The Director of Risk Management will coordinate the Director of Materials Management and Director of Clinical Engineering and will as the liaison for physicians when circumstances are required.

G. Contract Review

All contracts involving clinical care will be reviewed by Chief Legal Counsel or designee to ensure adequate liability coverage from contracting parties, as well as any other issues which might place the facility at risk. The Director of Risk Management will act as directed by Chief Legal Counsel.

H. External Reporting

Incidents involving medical devices and other "reportable" occurrences are required to be reported to bodies outside of the facility, to comply with state and federal statutes and regulatory requirements. The Director of Clinical Engineering and the Director of Risk Management will be jointly responsible for ensuring that these incidents are reported in a timely and appropriate manner, and when appropriate, after consultation with Chief Legal Counsel and other Executive Leadership. The require external report includes the following (but is not limited to):

1. Safe Medical Device Action of 1990
   The Medical Device Reporting (MDR) regulation requires that device user facilities report to the device manufacturer when the facility determines that the device has or may have cause or contributed to the patient death or serious injury.

   There are three (3) types of serious injuries and they are not mutually exclusive: 1) Life threatening injuries; 2) Injuries that result in permanent damage or impairment, and 3) Injuries that require medical intervention to prevent permanent damage or impairment.

In the case of death, the facility must also send a copy of the report to the FDA. All reports of death or serious injury are to be submitted on FDA form 3500A within 10 working days from the time that any medical personnel employed by or affiliated with the facility becomes aware that the device may have cause or contributed to the death or injury.

Device user facilities include hospitals, outpatient diagnostic or treatment facilities, nursing homes and ambulatory surgical facilities. Outpatient treatment facilities include ambulance providers, rescue services, and home health groups. Nursing homes include hospice care for the terminally ill and services for the rehabilitation of the injured, disabled, or sick. Private physician offices and private office of other health care professionals are not considered to be device user facilities.

It is the joint responsibility of the Director of Clinical Engineering and Director of Risk Management to report any incident in which there is information that reasonably suggest that a device has or "may have" caused or contributed to a death or serious injury of a patient.

(Follow/See Policy – Safe Medical Device Act)

I. Patient Grievances

A patient grievance is a written or verbal complaint by a patient, relative, or other representative relating to patient care or the quality of medical services provided. All efforts are undertaken to resolve each concern as quickly and effectively as possible (see Patient Grievance policy). An ongoing analysis of the reported occurrences is conducted and appropriate action instituted when opportunities for improvement are identified.

J. Additional Elements of the Risk Management Program

Additional elements of the Risk Management Program includes the Patient Satisfaction Program, Employee Health Program, Patient Safety Program, and the Environmental Health and Safety Program, which are governed by policies and procedures, and the Medical Staff credentialing activities, which are governed by the Medical Staff Bylaws.

K. Operational Linkages

The operational linkage between Risk Management, Safety, Resource/Case Management, and Infection Prevention/Control is accomplished through the following mechanisms:

1. Referral from concurrent review will be made to the appropriate department and/or committee.
2. Any identified occurrences related to clinical aspects of patient care and safety will be referred to the appropriate committee or department for investigation, analysis and process improvement.
3. Sentinel events, near miss evaluations and/or identified trends will be referred to the appropriate committee for evaluation and action.
4. If an opportunity to improve care is identified, the appropriate staff/department/committee will be notified and appropriate action developed, initiated, and monitored for effectiveness.

L. Record Retention

1. Copies of minutes of the Medical Staff committee meetings will be permanently maintained in the Medical Staff Office. Risk Management reports submitted to committees will be kept permanently with those committee minutes.
2. Probable claim reports and claim files will be secured in the Risk Management Department and/or Chief Legal Counsel offices until statute of limitations has expired and/or the claim is closed. Closed claims files will be kept permanently.

M. Confidentiality

1. Occurrence reports are prepared in good faith for the purpose of improving patient safety through thorough and credible evaluation of systems, processes and human factors involved in adverse occurrences.
2. Peer Review is conducted to improve care and services, provide oversight of caregivers and establish credible preventative programs. All those participating in Risk Management and/or

Peer Review activities are bound to confidentiality of information both for the protection of patient privacy and to promote open and honest dialogue in an effort to prevent future occurrences. All reports, statements, memoranda, proceedings, findings and records of such proceedings shall be confidential and privileged, and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and shall not be admissible in any civil or administrative action.

3. Data collected for the purposes of risk management and performance improvement shall be considered confidential information and not discoverable in a court of law.
4. Committee members recognize that any and all data reviewed by them shall be held in strict confidence. Any breach of this confidence will result in disciplinary action, including, if applicable, termination.
5. All requests and/or subpoenas from attorneys or regulatory agencies for information pertaining to Risk Management and/or Performance Improvement activities or copies of related patient records therein must be reviewed by the Director of Risk Management and Chief Legal Counsel prior to release and/or response as directed therein.
6. Any photographic or videotaped recording, other than that deemed necessary for patient care or educational purposes must first be approved by the Director of Risk Management (who will validate appropriateness of release through Chief Legal Counsel) to ensure that the rights of patients and employees to confidentiality and privacy will not be breached.
7. Risk Management reports will be copied only for the purpose of communicating with appropriate committees, individuals or leadership, to evaluate the effectiveness of the facility's Risk Management Program.

Preliminary Investigation of Occurrences

As soon as practical after receiving an occurrence report, the Director of Risk Management will notify the appropriate Department Director. The Department Director and/or supervisor/manager will conduct a preliminary investigation and complete a written summary of findings in accordance with *policy MCH-4012.* The Director of Risk Management will ensure that all affected Department Directors and/or supervisors/managers are made aware of the occurrence. *See policy MCH 4012.*

A statistical summary of occurrences shall be compiled by the Director of Risk Management, and reported at least quarterly to the Quality and Patient Safety Council which is designated as the Patient Safety Committee of the hospital. Occurrences involving individual members of the Medical Staff will be forwarded to the Chief Medical Officer, the Medical Staff Peer Review Coordinator, and (as applicable) the appropriate Medical Staff Department Chairperson for executive session peer review. Occurrences involving individual members of the nursing staff will be forwarded to the Vice President/CNO, Nursing Peer Review for executive session peer review.

Root Cause Analysis (RCA)

In response to all Sentinel Events or near miss events, a Root Cause Analysis and resulting Performance Improvement Action Plan will be completed. *See policy #MCH-4024.* The Director of Risk Management will be responsible for ensuring compliance and ensuring monitoring of the improvement actions is occurring using the PDSA/PDCA methodology.

Failure Mode and Effect Analysis (FMEA) or Process Hazard Analysis

FMEA or Process Hazard Analysis are the methodology for proactive risk assessment. A FMEA or Process Hazard Analysis shall be conducted at least every 18 months on an organization-wide high risk activity facilitated by the Risk, Quality and Patient Safety Leadership under the direction of the Quality and Patient Safety Council. Outcome measures will be included in all FMEA or Hazard analysis processes and monitored for at least one year to validate improvements. Results of the organization-wide FMEAs or Hazard analysis processes will be reviewed by the Quality and Patient Safety Council and reported to the hospital's Governing Board. See FMEA policy.

Patient Safety

The ECHD Board of Directors has ultimate responsibility for the adequacy of the Patient Safety Plan. Responsibility for implementation and maintenance of the plan is delegated to the President/CEO. As part of that delegation, the Director of Risk Management are responsible for facilitating, directing and monitoring patient safety initiatives in compliance with the National Patient Safety Goals and as outlined by the MCHS Patient Safety Program. *See Medical Center Health System Patient Safety Program.*

Resource Allocation

Medical Center Health System shall provide for a Director of Risk Management, clerical and staff support and such other resources as are necessary to fulfill the provisions of this plan.

Occurrence Reporting and Trending System (ORTS)

See Policy # MCH-4012

Legal Claim Processing-Notice of Claim/Lawsuit

See policy # PI-1017

Depositions/Briefing Scheduling

See policy # PI-1018

Replacement/Reimbursement of Lost/Broken Personal Patient Items

See policy # MCH 4031

Product Recall Procedure

See policy # MCH -4041

Personal Injury Occurrence and Emergency Care (Non-patient, non-employee)

See policy # MCH-4029

Patient Complaints/Grievances

See policy # MCH-2049

Sentinel Event/Patient Safety Event

See Policy # MCH-4024

Annual Program Evaluation

The purpose, scope, organization, and effectiveness of the Organizational Risk Management Plan will be reviewed and evaluated annually and revised if necessary.

Status of Risk Management

The Risk Management function of Medical Center Health System provided for in this plan and related policies, is intended to be and is a Professional Review Body (See Section 151.002(8), Texas Occupations Code) and an integral part of the Hospital's peer review process. The Director of Risk Management and all employees of or working with the Department are authorized by the Board of Directors of the Ector County

Hospital District to evaluate and assist in the evaluation of the quality of medical and health care services provided by MCHS including but not limited to those services included in an occurrence report.

AUTHOR'S SIGNATURE	Mary Gallegos, MBA/HCM Risk Manager
This will be authorized electronically	
AUTHORIZING SIGNATURE(S)	Antonionette Land, MBA, BSN, RN, CPXP Chief Patient Experience & Quality Officer
This will be authorized electronically	
	Sari Nabulsi, MD Sr Vice President CMO CMIO
	Steve Steen Vice President Chief Legal Counsel
	Russell Tippin President/CEO
	Don Hallmark President/ECHD Board of Directors
END OF POLICY	

ECTOR COUNTY HOSPITAL DISTRICT
Investment Portfolio
Charles Brown, Hilltop Securities Independent Network Inc.

March 31, 2020

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

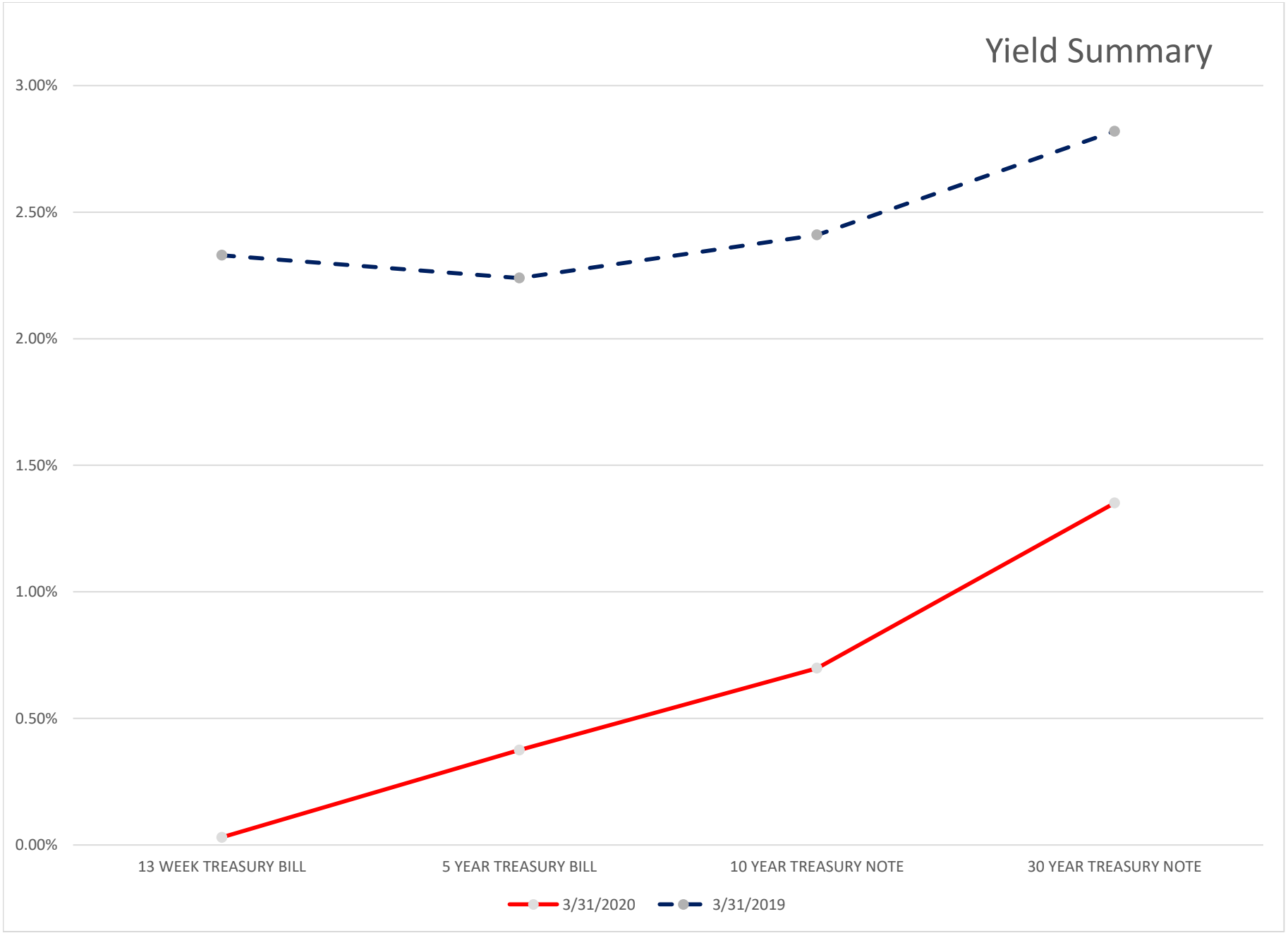
"This report is given as a courtesy to our clients. Hilltop Securities makes no warranties as to the completeness or accuracy of this information and specifically disclaims any liability arising from your use or reliance on this information. Hilltop Securities does not offer tax advice. You are solely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

ECTOR COUNTY HOSPITAL DISTRICT
March 31, 2020

Yield Summary

SECTOR	PAR VALUE	Weighted Avg Yield	Market Value	Gain/Loss
SHORT-TERM INVESTMENTS	$ 51,622,744.49	0.998%	$ 51,680,728.24	$ 57,983.75
TOTAL	**$ 51,622,744.49**	**0.998%**	**$ 51,680,728.24**	**$ 57,983.75**

	3/31/2020	3/31/2019
13 WEEK TREASURY BILL	0.03%	2.33%
5 YEAR TREASURY BILL	0.375%	2.24%
10 YEAR TREASURY NOTE	0.698%	2.41%
30 YEAR TREASURY NOTE	1.351%	2.82%


Yield Summary
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
13 WEEK TREASURY BILL
5 YEAR TREASURY BILL
10 YEAR TREASURY NOTE
30 YEAR TREASURY NOTE
3/31/2020
3/31/2019

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2020

Safekeeping

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Dispro 4 (339788818)					
912828VV9	DP4-US Treasury	8/31/2020	2.125%	$ 900,000.00	$ 907,488.00
3135G0D75	DP4-FNMA	6/22/2020	1.500%	$ 750,000.00	$ 752,107.50
912796TP4	DP4-T-Bill	11/5/2020	1.469%	$ 750,000.00	$ 749,640.00
Money Market	DP4-Dreyfus	-	0.010%	$ 2,986,271.68	$ 2,986,271.68
TOTAL				**$ 5,386,271.68**	**$ 5,395,507.18**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Funded Depreciation (339814498)					
C108452T1	FND CDARS	8/20/2020	1.800%	$ 5,000,000.00	$ 4,999,000.00
3135G0T60	FND-FNMA	7/30/2020	1.500%	$ 5,000,000.00	$ 5,021,700.00
912796TP4	FND-T-Bill	11/5/2020	1.469%	$ 5,000,000.00	$ 4,997,600.00
3133ELNK6	FND-FFCB	2/18/2021	1.530%	$ 5,000,000.00	$ 5,007,450.00
Money Market	FND-Dep Dreyfus	-	0.010%	$ 14,644,620.99	$ 14,644,620.99
TOTAL				**$ 34,644,620.99**	**$ 34,670,370.99**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Funded Workers Comp (339818296)					
912828VV9	FWC-US Treasury	8/31/2020	2.125%	$ 500,000.00	$ 504,160.00
C108452T1	FWC CDARS	8/20/2020	1.790%	$ 600,000.00	$ 599,880.00
3133ELNK6	FWC-FFCB	2/18/2021	1.530%	$ 600,000.00	$ 600,894.00
Money Market	FWC-Dreyfus	-	0.010%	$ 573,684.11	$ 573,684.11
TOTAL				**$ 2,273,684.11**	**$ 2,278,618.11**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Professional Liability (339767185)					
3133ELNK6	ProfLiab-FFCB	2/18/2021	1.530%	$ 500,000.00	$ 500,745.00
C108452T1	Prof Liab-CDARS	8/20/2020	1.806%	$ 500,000.00	$ 499,900.00
3135G0D75	ProfLiab-FNMA	6/22/2020	1.806%	$ 475,000.00	$ 476,334.75
3135G0T60	ProfLiab-FNMA	7/30/2020	1.500%	$ 525,000.00	$ 527,278.50
912796TP4	ProfLiab-T-Bill	11/5/2020	1.470%	$ 1,000,000.00	$ 999,520.00
Money Market	Prof Liab-Dreyfus	-	0.010%	$ 95,607.87	$ 95,607.87
TOTAL				**$ 3,095,607.87**	**$ 3,099,386.12**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location Designated Funds (339801057)					
912828VV9	DES-US Treasury	8/31/2020	2.125%	$ 1,000,000.00	$ 1,008,320.00
3133ELNK6	DES-FFCB	2/18/2021	1.530%	$ 500,000.00	$ 500,745.00
C108452T1	DES-CDARS	8/20/2020	1.806%	$ 500,000.00	$ 499,900.00
Money Market	DES-Dreyfus	-	0.010%	$ 1,232,111.13	$ 1,232,111.13
TOTAL				**$ 3,232,111.13**	**$ 3,241,076.13**

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	PAR VALUE	MARKET VALUE
Safekeeping Location General Operating (339809022)					
912828VV9	GenOp-US Treasury	8/31/2020	2.125%	$ 500,000.00	$ 504,160.00
3133ELNK6	GenOp-FFCB	2/18/2021	1.530%	$ 900,000.00	$ 901,341.00
C108452T1	GenOp-CDARS	8/20/2020	1.806%	$ 900,000.00	$ 899,820.00
Money Market	GEN Op-Dreyfus	-	0.010%	$ 690,448.71	$ 690,448.71
TOTAL				**$ 2,990,448.71**	**$ 2,995,769.71**

GRAND TOTAL	**$ 51,622,744.49**	**$ 51,680,728.24**

ECTOR COUNTY HOSPITAL DISTRICT

March 31, 2020

Short Term Invesments

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	YIELD (%)	ORIGINAL FACE	PAR VALUE	BOOK VALUE	MARKET VALUE	ANNUAL INCOME	GAIN (LOSS)
912828VV9	DP4-US Treasury	8/31/2020	2.125%	2.125%	$900,000.00	$900,000.00	$900,000.00	$907,488.00	$19,125.00	$7,488.00
3135G0D75	DP4-FNMA	6/22/2020	1.500%	1.500%	$750,000.00	$750,000.00	$750,000.00	$752,107.50	$11,250.00	$2,107.50
912796TP4	DP4-T-Bill	11/5/2020	1.469%	1.469%	$750,000.00	$750,000.00	$750,000.00	$749,640.00	$11,017.50	($360.00)
C108452T1	FND CDARS	8/20/2020	1.800%	1.800%	$5,000,000.00	$5,000,000.00	$5,000,000.00	$4,999,000.00	$90,000.00	($1,000.00)
3135G0T60	FND-FNMA	7/30/2020	1.500%	1.500%	$5,000,000.00	$5,000,000.00	$5,000,000.00	$5,021,700.00	$75,000.00	$21,700.00
912796TP4	FND-T-Bill	11/5/2020	1.469%	1.469%	$5,000,000.00	$5,000,000.00	$5,000,000.00	$4,997,600.00	$73,450.00	($2,400.00)
3133ELNK6	FND-FFCB	2/18/2021	1.530%	1.530%	$5,000,000.00	$5,000,000.00	$5,000,000.00	$5,007,450.00	$76,500.00	$7,450.00
912828VV9	FWC-US Treasury	8/31/2020	2.125%	2.125%	$500,000.00	$500,000.00	$500,000.00	$504,160.00	$10,625.00	$4,160.00
C108452T1	FWC CDARS	8/20/2020	1.790%	1.790%	$600,000.00	$600,000.00	$600,000.00	$599,880.00	$10,740.00	($120.00)
3133ELNK6	FWC-FFCB	2/18/2021	1.530%	1.530%	$600,000.00	$600,000.00	$600,000.00	$600,894.00	$9,180.00	$894.00
3133ELNK6	ProfLiab-FFCB	2/18/2021	1.530%	1.530%	$500,000.00	$500,000.00	$500,000.00	$500,745.00	$7,650.00	$745.00
C108452T1	Prof Liab-CDARS	8/20/2020	1.806%	1.806%	$500,000.00	$500,000.00	$500,000.00	$499,900.00	$9,030.00	($100.00)
3135G0D75	ProfLiab-FNMA	6/22/2020	1.806%	1.806%	$475,000.00	$475,000.00	$475,000.00	$476,334.75	$8,578.50	$1,334.75
3135G0T60	ProfLiab-FNMA	7/30/2020	1.500%	1.500%	$525,000.00	$525,000.00	$525,000.00	$527,278.50	$7,875.00	$2,278.50
912796TP4	ProfLiab-T-Bill	11/5/2020	1.470%	1.469%	$1,000,000.00	$1,000,000.00	$1,000,000.00	$999,520.00	$14,690.00	($480.00)
912828VV9	DES-US Treasury	8/31/2020	2.125%	2.125%	$1,000,000.00	$1,000,000.00	$1,000,000.00	$1,008,320.00	$21,250.00	$8,320.00
3133ELNK6	DES-FFCB	2/18/2021	1.530%	1.530%	$500,000.00	$500,000.00	$500,000.00	$500,745.00	$7,650.00	$745.00
C108452T1	DES-CDARS	8/20/2020	1.806%	1.806%	$500,000.00	$500,000.00	$500,000.00	$499,900.00	$9,030.00	($100.00)
912828VV9	GenOp-US Treasury	8/31/2020	2.125%	2.125%	$500,000.00	$500,000.00	$500,000.00	$504,160.00	$10,625.00	$4,160.00
3133ELNK6	GenOp-FFCB	2/18/2021	1.530%	1.530%	$900,000.00	$900,000.00	$900,000.00	$901,341.00	$13,770.00	$1,341.00
C108452T1	GenOp-CDARS	8/20/2020	1.806%	1.806%	$900,000.00	$900,000.00	$900,000.00	$899,820.00	$16,254.00	($180.00)
	Weighted Avg Life	0.52			**$31,400,000.00**	**$31,400,000.00**	**$31,400,000.00**	**$31,457,983.75**	**$513,290.00**	**57,983.75**
	Weighted Avg Yield	1.635%								

ECTOR COUNTY HOSPITAL DISTRICT

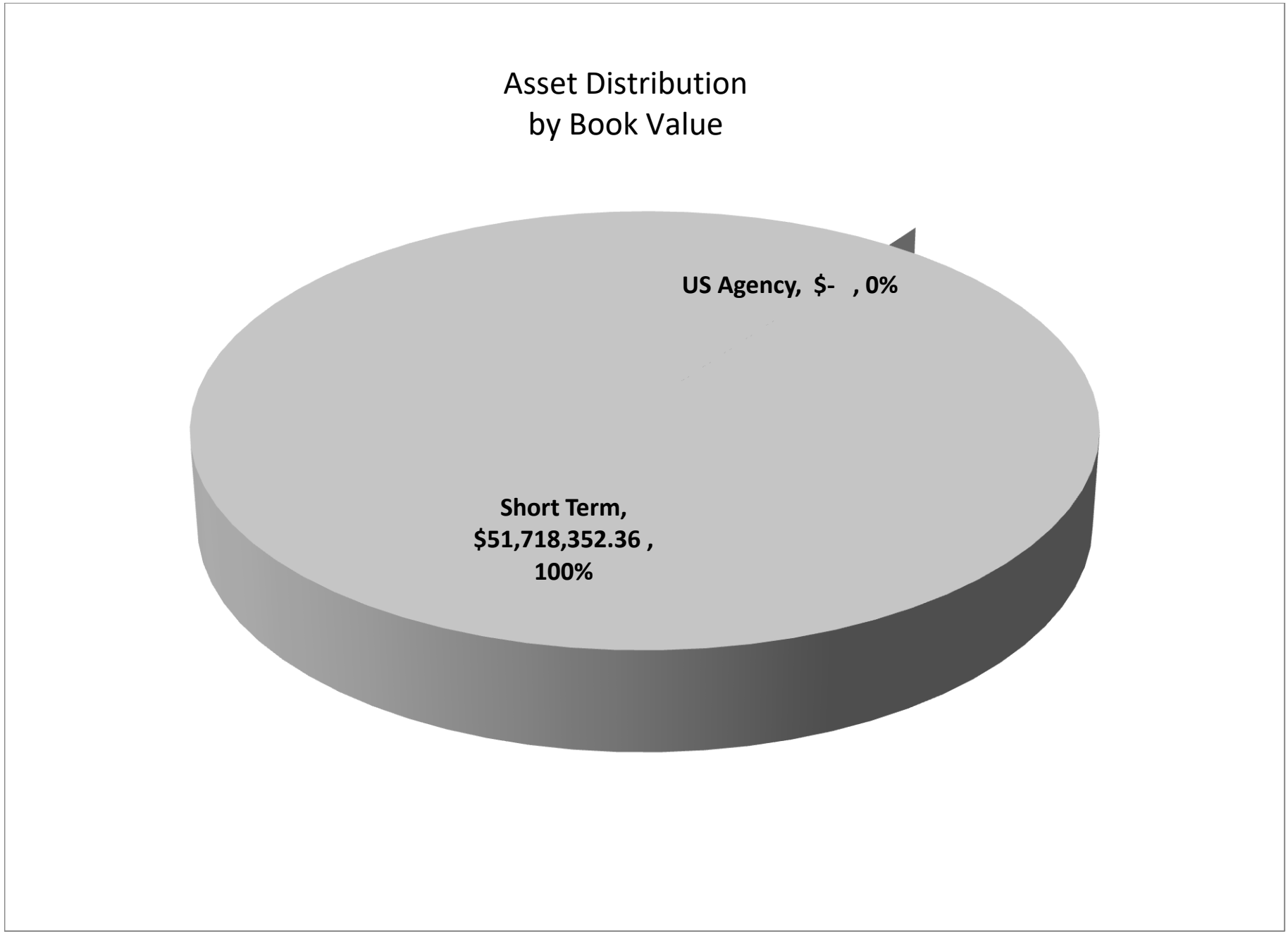
March 31, 2020

Short Term Investments: Money Market

CUSIP	DESCRIPTION	MATURITY	COUPON (%)	YIELD (%)	ORIGINAL FACE	PAR VALUE	BOOK VALUE	MARKET VALUE	ANNUAL INCOME
Money Market	DP4-Dreyfus		0.01%	0.01%	$2,986,271.68	$2,986,271.68	$2,986,271.68	$2,986,271.68	$298.63
Money Market	FND-Dep Dreyfus		0.01%	0.01%	$14,644,620.99	$14,644,620.99	$14,644,620.99	$14,644,620.99	$1,464.46
Money Market	FWC-Dreyfus		0.01%	0.01%	$573,684.11	$573,684.11	$573,684.11	$573,684.11	$57.37
Money Market	Prof Liab-Dreyfus		0.01%	0.01%	$95,607.87	$95,607.87	$95,607.87	$95,607.87	$9.56
Money Market	DES-Dreyfus		0.01%	0.01%	$1,232,111.13	$1,232,111.13	$1,232,111.13	$1,232,111.13	$123.21
Money Market	GEN Op-Dreyfus		0.01%	0.01%	$690,448.71	$690,448.71	$690,448.71	$690,448.71	$69.04

Weighted Avg Life	0.000
Weighted Avg Yield	0.010%

$ 20,222,744.49	**$ 20,222,744.49**	**20,222,744.49**	**20,222,744.49**	**$2,022.27**


Asset Distribution
by Book Value
US Agency, $- , 0%
Short Term,
$51,718,352.36 ,
100%

ECTOR COUNTY HOSPITAL DISTRICT
March 31, 2020

Outstanding Bonded Debt

2010-B Build America Bonds

Amount	MAT/Call		
$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 Health System
Your One Source for Health

MEMORANDUM

TO: Russell Tippin, President and Chief Executive Officer

FROM: Steve Ewing, Chief Financial Officer

RE: **Quarterly Investment Report – Second Quarter 2020**

DATE: May 5, 2020

The Investment Report of Ector County Hospital District for the second quarter ended March 31, 2020 will be presented at the Finance Committee meeting May 5, 2020. 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. No investments were purchased during the second quarter of fiscal 2020.

To the best of my knowledge, as of March 31, 2020 the investment portfolio is in compliance with the Public Funds Investment Act and with the District's Investment Policy.

Steve Ewing
Investment Officer

Medical Center Health System
Your One Source for Health

DATE: May 1, 2020

TO: Board of Directors
Ector County Hospital District

FROM: Steve Ewing
Senior Vice President / Chief Financial Officer

Subject: Financial Report for the month ended March 31, 2020

Attached are the Financial Statements for the month ended March 31, 2020 and a high level summary of the months activity.

Operating Results - Hospital Operations:
For the month ended March, the change in net position was a loss of $904,211 comparing unfavorably to the budgeted loss of $682,429 by 32.5% and favorably to the prior year loss of $2,743,156 by 67.0%. Inpatient (I/P) revenue was below budget by $4,716,691 or 8.6% driven primarily by decreased admissions. Outpatient (O/P) revenue was below budget by $4,904,094 or 10.7% due to decreased Emergency Department visits, observation days, surgical procedures and cath lab procedures caused by increased safety measures due to the COVID-19 outbreak. Net patient revenue was $822,481 or 3.7% above the budget of $22,355,648 due to a year-to-date adjustment in Disproportinate Share (DSH) and Uncompensated Care (UC) receivables from the State of Texas. Net operating revenue was $29,001,834 or 0.9% below budget due to decreased sales tax receipts estimates by $1,030,903.

Operating expenses for the month were above budget by $218,723 due primarily to unfavorable labor costs (salaries and wages, and temporary labor), physician fees, purchased services, and ECHDA expenses. Unfavorable labor costs were driven by decreased census and OP volumes without a corresponding decrease in staffing. FTEs per adjusted occupied bed in the month of March were 5.2 comparing unfavorably to the budget of 4.8 and prior year of 4.7. Physician fees unfavorable expense was caused by the unbudgeted addition of Teladoc telemedicine ($248,000) that is offset by $248,000 in donations from the MCHS Foundation, $167,170 in telemedicine fees from Eagle Telemedicine, and $222,904 in additional trauma services coverage. The unfavorable purchased services expenses were caused by $123,840 in additional inmate health costs for Ector County, $67,046 in additional coding in HIM, and $63,651 in additional physician recruitment costs. ECHDA expenses were unfavorable due to increased assistance

approved in March. Notable favorable expenses include benefits, repairs and maintenance, and other expenses. Favorable benefits expenses were driven by receipt of $456,223 in stop loss for prior month medical claims, and decreased medical and pharmacy claims by $506,921. Repairs and maintenance favorable expense was driven by numerous departments. Other expenses were favorable due to $203,007 in Administration other expense that was not used and a credit of $100,173 in CMN dues that were incorrectly expensed in a prior month.

Operating Results - ProCare (501a) Operations:
For the month of March the net loss from operations before capital contributions was $2,198,549 compared to a budgeted loss of $2,111,761. Net operating revenue was under budget by $704,721 due to decreased office, procedure, and surgical volumes due to the COVID-19 virus. Total operating expenses were under budget by $617,983. The favorable expense variance was due to decreased staffing expenses caused by 28.0 fewer than budgeted FTEs.

Operating Results - Family Health Center Operations:
For the month of March the net gain or loss from operations by location:

- Clements: $105,349 loss compared to a budgeted loss of $40,794. Net revenue was unfavorable by $152,563 due to decreased visits. Operating expenses were $87,425 favorable to budget due primarily to a decreased physician salary allocation from ProCare as well as decreased salary, wages, and benefits expenses.
- West University: $87,045 loss compared to a budgeted loss of $167,763. Net revenue was favorable by $51,682. Operating costs were favorable by $17,721.

Blended Operating Results - Ector County Hospital District:
The Change in Net Position for the month of January was a deficit of $904,211 comparing unfavorably to a budgeted deficit of $682,429 and favorably to the prior year deficit of $2,743,156. On a year-to-date basis the Change in Net Postion is a deficit of $12,846,556 comparing unfavorably to a budgeted surplus of $208,573, and unfavorably to the prior year surplus of $1,604,221.

Volume:
Total admissions for the month were 1,064 or 10.4% below budget and 10.5% below last year. Year-to-date admissions were 7,069 comparing unfavorably to budget by 3.3% and favorable to prior year by 0.5%. Patient days for the month were were 5,258 or 6.5% below budget and 10.5% below last year. Year-to-date patient days were 32,757 or 7.5% below budget and 3.8% below last year. Due to the preceding, total average length of stay (ALOS) was 4.94 for the month and 4.63 year-to-date. Observation days were below budget by 6.5% and below prior year by 12.2%.

Emergency room visits for the month were 4,046 resulting in a decrease compared to budget of 13.0% and a decrease compared to last year of 9.8%. On a year-to-date basis, emergency room visits were 27,892 or 1.1% below budget and 0.4% above prior year. Total O/P occasions of service for the month were 9.1% below budget for the month and 6.1% below last year. Year-to-date O/P occasions of service were 150,739 or 2.3% above budget and 1.6% above last year.

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
MARCH 2020

	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	1,042	1,157	-9.9%	1,165	-10.6%	6,896	7,136	-3.4%	6,856	0.6%
Neonatal ICU (NICU)	22	30	-26.7%	24	-8.3%	173	174	-0.6%	179	-3.4%
Total Admissions	1,064	1,187	-10.4%	1,189	-10.5%	7,069	7,310	-3.3%	7,035	0.5%
Patient Days										
Adult & Pediatric	3,911	4,237	-7.7%	4,477	-12.6%	25,080	26,957	-7.0%	25,723	-2.5%
ICU	386	418	-7.7%	463	-16.6%	2,272	2,631	-13.6%	2,557	-11.1%
CCU	349	418	-16.5%	476	-26.7%	2,274	2,632	-13.6%	2,573	-11.6%
NICU	612	552	10.9%	457	33.9%	3,131	3,203	-2.2%	3,215	-2.6%
Total Patient Days	5,258	5,625	-6.5%	5,873	-10.5%	32,757	35,423	-7.5%	34,068	-3.8%
Observation (Obs) Days	687	796	-13.7%	782	-12.2%	5,048	4,643	8.7%	4,635	8.9%
Nursery Days	297	279	6.5%	246	20.7%	1,772	1,608	10.2%	1,517	16.8%
Total Occupied Beds / Bassinets	6,242	6,700	-6.8%	6,901	-9.6%	39,577	41,674	-5.0%	40,220	-1.6%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.46	4.38	1.7%	4.65	-4.1%	4.30	4.52	-4.9%	4.50	-4.5%
NICU	27.82	18.40	51.2%	19.04	46.1%	18.10	18.41	-1.7%	17.96	0.8%
Total ALOS	4.94	4.74	4.3%	4.94	0.0%	4.63	4.85	-4.4%	4.84	-4.3%
Acute / Adult & Pediatric w/o OB	5.56			5.44	2.2%	5.13			5.33	-3.8%
Average Daily Census	169.6	181.5	-6.5%	189.5	-10.5%	179.0	193.6	-7.5%	187.2	-4.4%
Hospital Case Mix Index (CMI)	1.6408	1.5510	5.8%	1.6194	1.3%	1.5770	1.5712	0.4%	1.5604	1.1%
Medicare										
Admissions	399	456	-12.5%	460	-13.3%	2,552	2,827	-9.7%	2,711	-5.9%
Patient Days	1,981	2,270	-12.7%	2,485	-20.3%	12,300	14,443	-14.8%	13,844	-11.2%
Average Length of Stay	4.96	4.98	-0.3%	5.40	-8.1%	4.82	5.11	-5.7%	5.11	-5.6%
Case Mix Index	1.9093			1.8086	5.6%	1.8211			1.7235	5.7%
Medicaid										
Admissions	111	150	-26.0%	135	-17.8%	843	921	-8.5%	906	-7.0%
Patient Days	606	818	-25.9%	735	-17.6%	4,255	5,022	-15.3%	4,948	-14.0%
Average Length of Stay	5.46	5.45	0.1%	5.44	0.3%	5.05	5.45	-7.4%	5.46	-7.6%
Case Mix Index	1.2718			1.3044	-2.5%	1.1277			1.1963	-5.7%
Commercial										
Admissions	315	331	-4.8%	330	-4.5%	1,954	2,029	-3.7%	1,961	-0.4%
Patient Days	1,395	1,368	2.0%	1,391	0.3%	8,403	8,604	-2.3%	8,356	0.6%
Average Length of Stay	4.43	4.13	7.2%	4.22	5.1%	4.30	4.24	1.4%	4.26	0.9%
Case Mix Index	1.4210			1.5587	-8.8%	1.4675			1.5165	-3.2%
Self Pay										
Admissions	212	228	-7.0%	249	-14.9%	1,548	1,399	10.7%	1,334	16.0%
Patient Days	1,175	1,043	12.7%	1,178	-0.3%	6,898	6,566	5.1%	6,283	9.8%
Average Length of Stay	5.54	4.57	21.2%	4.73	17.2%	4.46	4.69	-5.1%	4.71	-5.4%
Case Mix Index	1.5085			1.4424	4.6%	1.4550			1.4639	-0.6%
All Other										
Admissions	27	22	22.7%	15	80.0%	172	134	28.4%	123	39.8%
Patient Days	101	107	-5.6%	84	20.2%	901	669	34.7%	637	41.4%
Average Length of Stay	3.74	4.86	-23.1%	5.60	-33.2%	5.24	4.99	4.9%	5.18	1.1%
Case Mix Index	2.0329			2.3928	-15.0%	2.0614			2.0165	2.2%
Radiology										
InPatient	3,938	4,456	-11.6%	4,621	-14.8%	25,875	28,056	-7.8%	27,092	-4.5%
OutPatient	6,933	7,697	-9.9%	7,596	-8.7%	48,093		0.0%	46,073	4.4%
Cath Lab										
InPatient	513	529	-3.0%	492	4.3%	3,004	3,331	-9.8%	3,307	-9.2%
OutPatient	327	610	-46.4%	535	-38.9%	3,091	3,670	-15.8%	3,606	-14.3%
Laboratory										
InPatient	66,008	71,673	-7.9%	75,218	-12.2%	420,051	451,355	-6.9%	432,214	-2.8%
OutPatient	55,295	58,965	-6.2%	59,623	-7.3%	372,075	354,880	4.8%	352,111	5.7%
Other										
Deliveries	175	172	1.7%	147	19.0%	1,057	991	6.7%	941	12.3%
Surgical Cases										
InPatient	221	291	-24.1%	320	-30.9%	1,623	1,793	-9.5%	1,765	-8.0%
OutPatient	395	539	-26.7%	486	-18.7%	3,083	3,242	-4.9%	3,249	-5.1%
Total Surgical Cases	616	830	-25.8%	806	-23.6%	4,706	5,035	-6.5%	5,014	-6.1%
GI Procedures (Endo)										
InPatient	144	149	-3.4%	177	-18.6%	977	941	3.8%	898	8.8%
OutPatient	189	226	-16.4%	311	-39.2%	1,503	1,362	10.4%	1,398	7.5%
Total GI Procedures	333	375	-11.2%	488	-31.8%	2,480	2,303	7.7%	2,296	8.0%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
MARCH 2020

	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	4,046	4,648	-13.0%	4,487	-9.8%	27,892	28,192	-1.1%	27,772	0.4%
Observation Days	687	796	-13.7%	782	-12.2%	5,048	4,643	8.7%	4,635	8.9%
Other O/P Occasions of Service	17,533	19,053	-8.0%	18,674	-6.1%	117,799	114,526	2.9%	115,947	1.6%
Total O/P Occasions of Svc.	22,266	24,497	-9.1%	23,943	-7.0%	150,739	147,361	2.3%	148,354	1.6%
Hospital Operations										
Manhours Paid	286,511	290,809	-1.5%	280,807	2.0%	1,692,522	1,799,594	-5.9%	1,628,569	3.9%
FTE's	1,617.4	1,641.7	-1.5%	1,585.2	2.0%	1,618.5	1,720.9	-5.9%	1,565.9	3.4%
Adjusted Patient Days	9,546	10,440	-8.6%	10,465	-8.8%	61,618	64,751	-4.8%	62,666	-1.7%
Hours / Adjusted Patient Day	30.01	27.86	7.7%	26.83	11.9%	27.47	27.79	-1.2%	25.99	5.7%
Occupancy - Actual Beds	48.6%	52.0%	-6.5%	54.3%	-10.5%	51.3%	55.5%	-7.5%	53.6%	-4.4%
FTE's / Adjusted Occupied Bed	5.3	4.9	7.7%	4.7	11.9%	4.8	4.9	-1.2%	4.5	5.7%
InPatient Rehab Unit										
Admissions	35	46	-23.9%	45	-22.2%	204	269	-24.2%	269	-24.2%
Patient Days	484	561	-13.7%	590	-18.0%	2,680	3,280	-18.3%	3,262	-17.8%
Average Length of Stay	13.8	12.2	13.4%	13.1	5.5%	13.1	12.2	7.7%	12.1	8.3%
Manhours Paid	8,357	8,549	-2.2%	7,493	11.5%	47,213	51,193	-7.8%	33,660	40.3%
FTE's	47.2	48.3	-2.2%	42.3	11.5%	45.1	49.0	-7.8%	32.4	39.5%
Center for Primary Care - Clements										
Total Medical Visits	784	1,176	-33.3%	1,145	-31.5%	5,792	7,076	-18.1%	7,204	-19.6%
Total Dental Visits	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Manhours Paid	3,126	4,217	-25.9%	3,806	-17.9%	18,732	25,375	-26.2%	23,117	-19.0%
FTE's	17.6	23.8	-25.9%	21.5	-17.9%	17.9	24.3	-26.2%	22.2	-19.4%
Center for Primary Care - West University										
Total Medical Visits	566	454	24.7%	293	93.2%	3,226	2,733	18.0%	4,163	-22.5%
Total Optometry	-	-	0.0%	-	0.0%	-	-	0.0%	1,115	-100.0%
Manhours Paid	1,510	1,581	-4.5%	1,595	-5.3%	9,332	9,516	-1.9%	9,525	-2.0%
FTE's	8.5	8.9	-4.5%	9.0	-5.3%	8.9	9.1	-1.9%	9.2	-2.6%
Total ECHD Operations										
Total Admissions	1,099	1,233	-10.9%	1,234	-10.9%	7,273	7,579	-4.0%	7,304	-0.4%
Total Patient Days	5,742	6,186	-7.2%	6,463	-11.2%	35,437	38,703	-8.4%	37,330	-5.1%
Total Patient and Obs Days	6,429	6,982	-7.9%	7,245	-11.3%	40,485	43,346	-6.6%	41,965	-3.5%
Total FTE's	1,691.3	1,722.7	-1.8%	1,658.0	2.0%	1,690.6	1,803.2	-6.2%	1,629.7	3.7%
FTE's / Adjusted Occupied Bed	5.0	4.7	8.1%	4.5	12.7%	4.6	4.7	-1.9%	4.3	7.4%
Total Adjusted Patient Days	10,425	11,481	-9.2%	11,517	-9.5%	66,660	69,779	-4.5%	68,666	-2.9%
Hours / Adjusted Patient Day	28.74	26.58	8.1%	25.50	12.7%	26.52	27.02	-1.9%	24.68	7.4%
Outpatient Factor	1.8155	1.8560	-2.2%	1.7819	1.9%	1.8815	1.8250	3.1%	1.8394	2.3%
Blended O/P Factor	2.0099	2.0966	-4.1%	1.9868	1.2%	2.0876	2.0281	2.9%	2.0466	2.0%
Total Adjusted Admissions	1,995	2,288	-12.8%	2,199	-9.3%	13,695	13,859	-1.2%	13,435	1.9%
Hours / Adjusted Admisssion	150.15	133.35	12.6%	133.57	12.4%	129.09	136.06	-5.1%	126.15	2.3%
FTE's - Hospital Contract	44.2	16.0	176.8%	43.4	1.8%	41.2	16.9	143.8%	46.8	-12.1%
FTE's - Mgmt Services	25.0	50.1	-50.2%	53.9	-53.7%	63.6	50.1	26.8%	65.0	-2.3%
Total FTE's (including Contract)	1,760.4	1,788.7	-1.6%	1,755.3	0.3%	1,795.3	1,870.3	-4.0%	1,741.5	3.1%
Total FTE'S per Adjusted Occupied Bed (including Contract)	5.2	4.8	8.4%	4.7	10.8%	4.9	4.9	0.5%	4.6	6.8%
ProCare FTEs	212.7	240.7	-11.6%	216.5	-1.8%	208.4	240.7	-13.4%	216.2	-3.6%
Total System FTEs	1,973.1	2,029.4	-2.8%	1,971.8	0.1%	2,003.7	2,111.0	-5.1%	1,957.7	2.3%
Urgent Care Visits										
JBS Clinic	926	1,011	-8.4%	1,051	-11.9%	6,293	6,367	-1.2%	6,405	-1.7%
West University	618	636	-2.8%	609	1.5%	3,963	4,005	-1.0%	4,123	-3.9%
42nd Street	739	694	6.5%	631	17.1%	4,635	4,370	6.1%	4,511	2.7%
Total Urgent Care Visits	2,283	2,341	-2.5%	2,291	-0.3%	14,891	14,742	1.0%	15,039	-1.0%
Wal-Mart Clinic Visits										
East Clinic	229	484	-52.7%	441	-48.1%	2,455	3,253	-24.5%	3,072	-20.1%
West Clinic	266	337	-21.1%	337	-21.1%	2,381	2,379	0.1%	2,323	2.5%
Total Wal-Mart Visits	495	821	-39.7%	778	-36.4%	4,836	5,632	-14.1%	5,395	-10.4%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
MARCH 2020

	HOSPITAL	PRO CARE	ECTOR COUNTY HOSPITAL DISTRICT
ASSETS			
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 29,119,207	$ 4,750	$ 29,123,957
Investments	31,488,786	-	31,488,786
Patient Accounts Receivable - Gross	219,301,589	28,715,652	248,017,241
Less: 3rd Party Allowances	(116,814,814)	(6,672,352)	(123,487,166)
Bad Debt Allowance	(68,007,614)	(14,967,162)	(82,974,776)
Net Patient Accounts Receivable	34,479,161	7,076,137	41,555,299
Taxes Receivable	8,414,648	-	8,414,648
Accounts Receivable - Other	21,663,676	32,388	21,696,064
Inventories	6,876,525	392,358	7,268,883
Prepaid Expenses	3,392,606	204,947	3,597,553
Total Current Assets	135,434,610	7,710,580	143,145,190
CAPITAL ASSETS:			
Property and Equipment	473,731,879	467,364	474,199,243
Construction in Progress	1,660,278	-	1,660,278
	475,392,157	467,364	475,859,521
Less: Accumulated Depreciation and Amortization	(299,859,087)	(318,431)	(300,177,518)
Total Capital Assets	175,533,070	148,933	175,682,003
INTANGIBLE ASSETS / GOODWILL - NET	0	4,105	4,105
RESTRICTED ASSETS:			
Restricted Assets Held by Trustee	4,787,855	-	4,787,855
Restricted Assets Held in Endowment	6,375,547	-	6,375,547
Restricted TPC, LLC	522,753	-	522,753
Restricted MCH West Texas Services	2,289,090	-	2,289,090
Pension, Deferred Outflows of Resources	32,844,671	-	32,844,671
Assets whose use is Limited	-	45,813	45,813
TOTAL ASSETS	$ 357,787,596	$ 7,909,431	$ 365,697,027
LIABILITIES AND FUND BALANCE			
CURRENT LIABILITIES:			
Current Maturities of Long-Term Debt	$ 3,116,559	$ -	$ 3,116,559
Self-Insurance Liability - Current Portion	3,179,304	-	3,179,304
Accounts Payable	27,182,736	1,680,469	28,863,205
A/R Credit Balances	4,954,830	-	4,954,830
Accrued Interest	91,551	-	91,551
Accrued Salaries and Wages	7,869,880	5,812,852	13,682,732
Accrued Compensated Absences	4,038,286	-	4,038,286
Due to Third Party Payors	2,461,536	-	2,461,536
Deferred Revenue	8,317,979	448,941	8,766,920
Total Current Liabilities	61,212,662	7,942,262	69,154,924
ACCRUED POST RETIREMENT BENEFITS	85,662,701	-	85,662,701
SELF-INSURANCE LIABILITIES - Less Current Portion	2,037,980	-	2,037,980
LONG-TERM DEBT - Less Current Maturities	39,740,636	-	39,740,636
Total Liabilities	188,653,979	7,942,262	196,596,241
FUND BALANCE	169,133,617	(32,831)	169,100,787
TOTAL LIABILITIES AND FUND BALANCE	$ 357,787,596	$ 7,909,431	$ 365,697,027

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
MARCH 2020

	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	$ 29,123,957	$ 21,730,607	$ 4,700	$ 7,388,650
Investments	31,488,786	44,279,715	-	(12,790,929)
Patient Accounts Receivable - Gross	248,017,241	212,208,742	24,246,718	11,561,781
Less: 3rd Party Allowances	(123,487,166)	(94,255,751)	(4,149,301)	(25,082,114)
Bad Debt Allowance	(82,974,776)	(83,274,566)	(14,155,859)	14,455,649
Net Patient Accounts Receivable	41,555,299	34,678,425	5,941,558	935,316
Taxes Receivable	8,414,648	9,069,806	-	(655,158)
Accounts Receivable - Other	21,696,064	12,414,472	45,727	9,235,865
Inventories	7,268,883	6,802,054	356,733	110,096
Prepaid Expenses	3,597,553	3,227,470	211,520	158,563
Total Current Assets	143,145,190	132,202,550	6,560,237	4,382,403
CAPITAL ASSETS:				
Property and Equipment	474,199,243	469,803,260	467,364	3,928,620
Construction in Progress	1,660,278	870,112	-	790,166
	475,859,521	470,673,371	467,364	4,718,786
Less: Accumulated Depreciation and Amortization	(300,177,518)	(290,984,763)	(304,223)	(8,888,532)
Total Capital Assets	175,682,003	179,688,608	163,141	(4,169,746)
INTANGIBLE ASSETS / GOODWILL - NET	4,105	5,174	66,358	(67,426)
RESTRICTED ASSETS:				
Restricted Assets Held by Trustee	4,787,855	3,849,297	-	938,559
Restricted Assets Held in Endowment	6,375,547	6,285,946	-	89,601
Restricted TPC, LLC	522,753	522,753	-	-
Restricted MCH West Texas Services	2,289,090	2,232,525	-	56,565
Pension, Deferred Outflows of Resources	32,844,671	33,175,595	-	(330,924)
Assets whose use is Limited	45,813	-	29,000	16,813
TOTAL ASSETS	$ 365,697,027	$ 357,962,448	$ 6,818,736	$ 915,844
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES:				
Current Maturities of Long-Term Debt	$ 3,116,559	$ 4,655,041	$ -	$ (1,538,483)
Self-Insurance Liability - Current Portion	3,179,304	3,179,304	-	-
Accounts Payable	28,863,205	24,068,706	435,734	4,358,764
A/R Credit Balances	4,954,830	4,964,667	-	(9,836)
Accrued Interest	91,551	41,791	-	49,761
Accrued Salaries and Wages	13,682,732	7,972,237	5,882,159	(171,664)
Accrued Compensated Absences	4,038,286	3,848,446	-	189,841
Due to Third Party Payors	2,461,536	2,717,814	-	(256,277)
Deferred Revenue	8,766,920	348,543	533,674	7,884,703
Total Current Liabilities	69,154,923.92	51,796,549.11	6,851,567	10,506,807
ACCRUED POST RETIREMENT BENEFITS	85,662,701	82,062,701	-	3,600,000
SELF-INSURANCE LIABILITIES - Less Current Portion	2,037,980	2,037,980	-	-
LONG-TERM DEBT - Less Current Maturities	39,740,636	40,085,043	-	(344,407)
Total Liabilities	196,596,241	175,982,273	6,851,567	13,762,400
FUND BALANCE	169,100,787	181,980,174	(32,831)	(12,846,557)
TOTAL LIABILITIES AND FUND BALANCE	$ 365,697,027	$ 357,962,448	$ 6,818,736	$ 915,844

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
MARCH 2020

	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	$ 50,193,465	$ 54,910,156	-8.6%	$ 57,313,437	-12.4%	$ 315,513,634	$ 340,430,175	-7.3%	$ 326,550,953	-3.4%
Outpatient Revenue	50,691,523	57,369,553	-11.6%	56,559,690	-10.4%	343,146,656	349,988,788	-2.0%	341,783,123	0.4%
TOTAL PATIENT REVENUE	$ 100,884,988	$ 112,279,709	-10.1%	$ 113,873,127	-11.4%	$ 658,660,289	$ 690,418,963	-4.6%	$ 668,334,076	-1.4%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 78,253,816	$ 66,173,650	18.3%	$ 69,632,042	12.4%	$ 390,881,597	$ 407,015,535	-4.0%	$ 412,072,334	-5.1%
Policy Adjustments	885,986	1,527,327	-42.0%	709,037	25.0%	7,056,408	9,207,948	-23.4%	12,903,240	-45.3%
Uninsured Discount	34,527,011	8,679,164	297.8%	12,283,558	181.1%	89,150,451	48,911,618	82.3%	56,241,615	58.5%
Indigent	1,451,180	1,515,943	-4.3%	627,137	131.4%	8,775,847	9,337,904	-6.0%	8,993,279	-2.4%
Provision for Bad Debts	(33,351,500)	9,623,377	-446.6%	8,119,034	-510.8%	26,443,802	59,303,499	-55.4%	34,248,409	-22.8%
TOTAL REVENUE DEDUCTIONS	$ 81,766,493	$ 87,519,461	-6.6%	$ 91,370,808	-10.5%	$ 522,308,106	$ 533,776,504	-2.1%	$ 524,458,876	-0.4%
	81.05%	77.95%		80.24%		79.30%	77.31%		78.47%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 6,730,012	$ 960,141	600.9%	$ 429,208	1468.0%	$ 12,686,963	5,760,846	120.2%	$ 4,756,171	166.7%
DSRIP	479,459	479,459	0.0%	971,658	-50.7%	2,876,754	2,876,754	0.0%	5,829,948	-50.7%
Medicaid Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	$ 7,209,471	$ 1,439,600	400.8%	$ 1,400,866	414.6%	$ 15,563,717	$ 8,637,600	80.2%	$ 10,586,119	47.0%
NET PATIENT REVENUE	$ 26,327,966	$ 26,199,848	0.5%	$ 23,903,185	10.1%	$ 151,915,901	$ 165,280,059	-8.1%	$ 154,461,319	-1.6%
OTHER REVENUE										
Tax Revenue	$ 5,117,733	$ 6,148,636	-16.8%	$ 5,797,268	-11.7%	$ 32,550,072	$ 34,832,304	-6.6%	$ 35,944,376	-9.4%
Other Revenue	887,372	961,606	-7.7%	928,257	-4.4%	5,131,721	5,587,845	-8.2%	5,082,595	1.0%
TOTAL OTHER REVENUE	$ 6,005,105	$ 7,110,242	-15.5%	$ 6,725,525	-10.7%	$ 37,681,793	$ 40,420,149	-6.8%	$ 41,026,971	-8.2%
NET OPERATING REVENUE	$ 32,333,071	$ 33,310,090	-2.9%	$ 30,628,711	5.6%	$ 189,597,693	$ 205,700,208	-7.8%	$ 195,488,290	-3.0%
OPERATING EXPENSES										
Salaries and Wages	$ 13,852,067	$ 13,685,394	1.2%	$ 13,808,471	0.3%	$ 82,480,050	$ 83,423,448	-1.1%	$ 79,025,079	4.4%
Benefits	1,795,118	3,064,543	-41.4%	3,081,123	-41.7%	17,211,518	18,216,507	-5.5%	18,029,093	-4.5%
Temporary Labor	1,215,275	952,583	27.6%	1,111,674	9.3%	6,891,146	5,762,539	19.6%	6,321,649	9.0%
Physician Fees	1,848,039	1,206,833	53.1%	1,348,372	37.1%	9,096,859	7,122,264	27.7%	6,904,417	31.8%
Texas Tech Support	1,015,989	1,083,333	-6.2%	1,002,621	1.3%	6,075,014	6,499,998	-6.5%	5,962,280	1.9%
Purchased Services	5,219,789	5,046,598	3.4%	4,562,475	14.4%	30,774,046	30,773,010	0.0%	27,173,692	13.2%
Supplies	5,184,018	5,225,488	-0.8%	5,055,504	2.5%	29,416,461	31,850,492	-7.6%	29,778,150	-1.2%
Utilities	364,018	372,363	-2.2%	317,710	14.6%	1,997,168	2,209,047	-9.6%	1,922,169	3.9%
Repairs and Maintenance	644,871	752,589	-14.3%	762,487	-15.4%	4,298,216	4,517,324	-4.9%	4,991,653	-13.9%
Leases and Rent	111,126	117,869	-5.7%	128,461	-13.5%	861,081	705,924	22.0%	739,759	16.4%
Insurance	142,284	183,913	-22.6%	146,353	-2.8%	894,849	1,102,420	-18.8%	778,993	14.9%
Interest Expense	252,009	247,445	1.8%	259,550	-2.9%	1,489,754	1,493,842	-0.3%	1,553,489	-4.1%
ECHDA	516,046	279,009	85.0%	326,585	58.0%	1,994,924	1,674,054	19.2%	1,803,492	10.6%
Other Expense	64,046	405,995	-84.2%	318,900	-79.9%	1,148,120	2,498,733	-54.1%	1,068,779	7.4%
TOTAL OPERATING EXPENSES	$ 32,224,695	$ 32,623,955	-1.2%	$ 32,230,287	0.0%	$ 194,629,207	$ 197,849,602	-1.6%	$ 186,052,695	4.6%
Depreciation/Amortization	$ 1,539,091	$ 1,606,630	-4.2%	$ 1,396,628	10.2%	$ 9,234,153	$ 9,487,575	-2.7%	$ 9,477,679	-2.6%
(Gain) Loss on Sale of Assets	-	-	0.0%	-	0.0%	7,009	-	0.0%	7,935	-11.7%
TOTAL OPERATING COSTS	$ 33,763,786	$ 34,230,585	-1.4%	$ 33,626,915	0.4%	$ 203,870,369	$ 207,337,177	-1.7%	$ 195,538,308	4.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (1,430,715)**	**$ (920,495)**	**-55.4%**	**$ (2,998,205)**	**52.3%**	**$ (14,272,676)**	**$ (1,636,969)**	**771.9%**	**$ (50,019)**	**28434.7%**
Operating Margin	-4.42%	-2.76%	60.1%	-9.79%	-54.8%	-7.53%	-0.80%	845.9%	-0.03%	29321.2%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 59,767	$ 84,831	-29.5%	$ 114,587	-47.8%	$ 460,931	$ 508,986	-9.4%	$ 707,672	-34.9%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	248,000	20,833	1090.4%	-		248,000	124,998	98.4%	300,260	-17.4%
Build America Bonds Subsidy	84,094	79,277	6.1%	82,117	2.4%	474,594	475,662	-0.2%	490,407	-3.2%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (1,038,854)	$ (735,554)	41.2%	$ (2,801,501)	-62.9%	$ (13,089,151)	$ (527,323)	2382.2%	$ 1,448,321	-1003.7%
Unrealized Gain/(Loss) on Investments	$ 134,212	$ (6,622)	0.0%	$ 61,517	118.2%	$ 186,025	$ (39,732)	0.0%	$ 91,674	102.9%
Investment in Subsidiaries	431	59,747	-99.3%	(3,172)	-113.6%	56,570	358,482	-84.2%	64,226	-11.9%
CHANGE IN NET POSITION	**$ (904,211)**	**$ (682,429)**	**-32.5%**	**$ (2,743,156)**	**67.0%**	**$ (12,846,556)**	**$ (208,573)**	**-6059.3%**	**$ 1,604,221**	**-900.8%**

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
MARCH 2020

	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	50,193,465	$ 54,910,156	-8.6%	$ 57,313,437	-12.4%	$ 315,513,634	$ 340,430,175	-7.3%	$ 326,550,953	-3.4%
Outpatient Revenue	40,935,243	45,839,337	-10.7%	44,815,450	-8.7%	278,131,183	280,866,053	-1.0%	274,121,707	1.5%
TOTAL PATIENT REVENUE	91,128,708	$ 100,749,493	-9.5%	$ 102,128,886	-10.8%	$ 593,644,817	$ 621,296,228	-4.5%	$ 600,672,660	-1.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	74,636,052	$ 60,440,129	23.5%	$ 62,708,377	19.0%	$ 362,878,046	$ 372,766,996	-2.7%	$ 377,984,908	-4.0%
Policy Adjustments	249,958	213,801	16.9%	103,907	140.6%	797,763	1,341,424	-40.5%	1,591,262	-49.9%
Uninsured Discount	33,944,106	8,348,681	306.6%	11,633,517	191.8%	84,341,917	46,907,272	79.8%	53,202,012	58.5%
Indigent Care	1,416,548	1,503,244	-5.8%	645,411	119.5%	8,522,607	9,270,119	-8.1%	8,939,143	-4.7%
Provision for Bad Debts	(35,086,614)	9,327,590	-476.2%	7,633,186	-559.7%	20,442,287	57,520,854	-64.5%	34,805,652	-41.3%
TOTAL REVENUE DEDUCTIONS	75,160,050	$ 79,833,445	-5.9%	$ 82,724,398	-9.1%	$ 476,982,619	$ 487,806,665	-2.2%	$ 476,522,977	0.1%
	82.48%	79.24%		81.00%		80.35%	78.51%		79.33%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	6,730,012	$ 960,141	600.9%	$ 429,208	1468.0%	$ 12,686,963	$ 5,760,846	120.2%	$ 381,171	3228.4%
DSRIP	479,459	479,459	0.0%	971,658	-50.7%	2,876,754	2,876,754	0.0%	5,829,948	-50.7%
Medicaid Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	7,209,471	$ 1,439,600	400.8%	$ 1,400,866	414.6%	$ 15,563,717	$ 8,637,600	80.2%	$ 6,211,119	150.6%
NET PATIENT REVENUE	23,178,129	$ 22,355,648	3.7%	$ 20,805,354	11.4%	$ 132,225,916	$ 142,127,163	-7.0%	$ 130,360,802	1.4%
OTHER REVENUE										
Tax Revenue	5,117,733	$ 6,148,636	-16.8%	$ 5,797,268	-11.7%	$ 32,550,072	$ 34,832,304	-6.6%	$ 35,944,376	-9.4%
Other Revenue	705,971	769,848	-8.3%	793,303	-11.0%	3,977,875	4,452,650	-10.7%	4,133,201	-3.8%
TOTAL OTHER REVENUE	5,823,704	$ 6,918,484	-15.8%	$ 6,590,571	-11.6%	$ 36,527,947	$ 39,284,954	-7.0%	$ 40,077,577	-8.9%
NET OPERATING REVENUE	29,001,834	$ 29,274,132	-0.9%	$ 27,395,925	5.9%	$ 168,753,862	$ 181,412,117	-7.0%	$ 170,438,379	-1.0%
OPERATING EXPENSE										
Salaries and Wages	10,029,786	$ 9,563,663	4.9%	$ 9,969,084	0.6%	$ 59,638,717	$ 59,247,212	0.7%	$ 56,443,451	5.7%
Benefits	1,404,523	2,658,398	-47.2%	2,691,790	-47.8%	14,802,671	15,733,321	-5.9%	15,564,143	-4.9%
Temporary Labor	651,376	187,372	247.6%	475,284	37.0%	3,470,605	1,171,273	196.3%	3,087,238	12.4%
Physician Fees	1,674,207	1,023,021	63.7%	1,169,226	43.2%	7,848,010	6,083,916	29.0%	5,944,680	32.0%
Texas Tech Support	1,015,989	1,083,333	-6.2%	1,002,621	1.3%	6,075,014	6,499,998	-6.5%	5,962,280	1.9%
Purchased Services	5,079,513	4,819,352	5.4%	4,329,534	17.3%	29,703,798	29,116,691	2.0%	25,824,363	15.0%
Supplies	5,040,647	5,085,327	-0.9%	4,928,417	2.3%	28,592,211	30,978,234	-7.7%	28,890,272	-1.0%
Utilities	362,529	369,028	-1.8%	314,500	15.3%	1,979,146	2,190,762	-9.7%	1,900,031	4.2%
Repairs and Maintenance	644,871	751,683	-14.2%	762,326	-15.4%	4,296,803	4,511,888	-4.8%	4,989,858	-13.9%
Leases and Rentals	(57,467)	(51,246)	12.1%	(45,819)	25.4%	(146,951)	(307,476)	-52.2%	(305,899)	-52.0%
Insurance	94,075	134,783	-30.2%	97,778	-3.8%	607,391	808,698	-24.9%	487,291	24.6%
Interest Expense	252,009	247,445	1.8%	259,550	-2.9%	1,489,754	1,493,842	-0.3%	1,553,489	-4.1%
ECHDA	516,046	279,009	85.0%	326,585	58.0%	1,994,924	1,674,054	19.2%	1,803,492	10.6%
Other Expense	4,940	343,152	-98.6%	270,931	-98.2%	795,413	2,057,612	-61.3%	699,904	13.6%
TOTAL OPERATING EXPENSES	26,713,043	$ 26,494,320	0.8%	$ 26,551,807	0.6%	$ 161,147,506	$ 161,260,025	-0.1%	$ 152,844,593	5.4%
Depreciation/Amortization	1,520,957	$ 1,588,546	-4.3%	$ 1,377,056	10.4%	$ 9,125,166	$ 9,377,621	-2.7%	$ 9,357,874	-2.5%
(Gain)/Loss on Disposal of Assets	-	-	0.0%	-	0.0%	877	-	100.0%	7,935	-89.0%
TOTAL OPERATING COSTS	28,234,000	$ 28,082,866	0.5%	$ 27,928,862	1.1%	$ 170,273,549	$ 170,637,646	-0.2%	$ 162,210,402	5.0%
NET GAIN (LOSS) FROM OPERATIONS	**767,834**	**$ 1,191,266**	**-35.5%**	**$ (532,938)**	**244.1%**	**$ (1,519,686)**	**$ 10,774,471**	**-114.1%**	**$ 8,227,978**	**-118.5%**
Operating Margin	2.65%	4.07%	-34.9%	-1.95%	-236.1%	-0.90%	5.94%	-115.2%	4.83%	-118.7%
NONOPERATING REVENUE/EXPENSE										
Interest Income	59,767	$ 84,831	-29.5%	$ 114,587	-47.8%	$ 460,931	$ 508,986	-9.4%	$ 707,672	-34.9%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	0.0%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	248,000	20,833	1090.4%	-	0.0%	248,000	124,998	98.4%	300,260	-17.4%
Build America Bonds Subsidy	84,094	79,277	6.1%	82,117	2.4%	474,594	475,662	-0.2%	490,407	-3.2%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	1,159,695	$ 1,376,207	-15.7%	$ (336,234)	-444.9%	$ (336,161)	$ 11,884,117	-102.8%	$ 9,726,317	-103.5%
Procare Capital Contribution	(2,198,549)	(2,111,761)	4.1%	(2,465,268)	-10.8%	(12,752,989)	(12,411,440)	2.8%	(8,277,997)	54.1%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	(1,038,854)	$ (735,554)	41.2%	$ (2,801,501)	-62.9%	$ (13,089,150)	$ (527,323)	2382.2%	$ 1,448,321	-1003.7%
Unrealized Gain/(Loss) on Investments	134,212	$ (6,622)	-2126.8%	$ 61,517	118.2%	$ 186,025	$ (39,732)	-568.2%	$ 91,674	102.9%
Investment in Subsidiaries	431	59,747	-99.3%	(3,172)	-113.6%	56,570	358,482	-84.2%	64,226	-11.9%
CHANGE IN NET POSITION	**(904,211)**	**$ (682,429)**	**-32.5%**	**$ (2,743,156)**	**67.0%**	**$ (12,846,556)**	**$ (208,573)**	**-6059.3%**	**$ 1,604,221**	**-900.8%**

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
MARCH 2020

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 9,756,280	$ 11,530,216	-15.4%	$ 11,744,241	-16.9%	$ 65,015,472	$ 69,122,735	-5.9%	$ 67,661,416	-3.9%
TOTAL PATIENT REVENUE	$ 9,756,280	$ 11,530,216	-15.4%	$ 11,744,241	-16.9%	$ 65,015,472	$ 69,122,735	-5.9%	$ 67,661,416	-3.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 3,617,764	$ 5,733,521	-36.9%	$ 6,923,665	-47.7%	$ 28,003,551	$ 34,248,539	-18.2%	$ 34,087,426	-17.8%
Policy Adjustments	636,029	1,313,526	-51.6%	605,130	5.1%	6,258,645	7,866,524	-20.4%	11,311,978	-44.7%
Uninsured Discount	582,905	330,483	76.4%	650,040	-10.3%	4,808,534	2,004,346	139.9%	3,039,603	58.2%
Indigent	34,632	12,699	172.7%	(18,274)	-289.5%	253,241	67,785	273.6%	54,136	367.8%
Provision for Bad Debts	1,735,114	295,787	486.6%	485,848	257.1%	6,001,516	1,782,645	236.7%	(557,243)	-1177.0%
TOTAL REVENUE DEDUCTIONS	$ 6,606,443	$ 7,686,016	-14.0%	$ 8,646,410	-23.6%	$ 45,325,487	$ 45,969,839	-1.4%	$ 47,935,900	-5.4%
	67.71%	66.66%		73.62%		69.71%	66.50%		70.85%	
Medicaid Supplemental Payments	$ -	$ -		$ -		-	-		$ 4,375,000	-100.0%
NET PATIENT REVENUE	$ 3,149,836	$ 3,844,200	-18.1%	$ 3,097,831	1.7%	$ 19,689,985	$ 23,152,896	-15.0%	$ 24,100,516	-18.3%
						30.3%				
OTHER REVENUE										
Other Income	$ 181,401	$ 191,758	-5.4%	$ 134,954	34.4%	$ 1,153,846	$ 1,135,195	1.6%	$ 949,394	21.5%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,331,237	$ 4,035,958	-17.5%	$ 3,232,786	3.0%	$ 20,843,831	$ 24,288,091	-14.2%	$ 25,049,910	-16.8%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 3,822,281	$ 4,121,731	-7.3%	$ 3,839,387	-0.4%	$ 22,841,333	$ 24,176,236	-5.5%	$ 22,581,628	1.2%
Benefits	390,595	406,145	-3.8%	389,333	0.3%	2,408,847	2,483,186	-3.0%	2,464,950	-2.3%
Temporary Labor	563,899	765,211	-26.3%	636,390	-11.4%	3,420,542	4,591,266	-25.5%	3,234,412	5.8%
Physician Fees	173,832	183,812	-5.4%	179,147	-3.0%	1,248,850	1,038,348	20.3%	959,737	30.1%
Purchased Services	140,276	227,246	-38.3%	232,941	-39.8%	1,070,247	1,656,319	-35.4%	1,349,329	-20.7%
Supplies	143,371	140,161	2.3%	127,087	12.8%	824,250	872,258	-5.5%	887,878	-7.2%
Utilities	1,489	3,335	-55.4%	3,210	-53.6%	18,022	18,285	-1.4%	22,138	-18.6%
Repairs and Maintenance	-	906	-100.0%	161	-100.0%	1,413	5,436	-74.0%	1,795	-21.3%
Leases and Rentals	168,594	169,115	-0.3%	174,280	-3.3%	1,008,032	1,013,400	-0.5%	1,045,659	-3.6%
Insurance	48,209	49,130	-1.9%	48,575	-0.8%	287,458	293,722	-2.1%	291,702	-1.5%
Other Expense	59,106	62,843	-5.9%	47,969	23.2%	352,707	441,121	-20.0%	368,875	-4.4%
TOTAL OPERATING EXPENSES	$ 5,511,652	$ 6,129,635	-10.1%	$ 5,678,481	-2.9%	$ 33,481,701	$ 36,589,577	-8.5%	$ 33,208,102	0.8%
Depreciation/Amortization	$ 18,134	$ 18,084	0.3%	$ 19,573	-7.3%	$ 108,988	$ 109,954	-0.9%	$ 119,805	-9.0%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	6,132	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 5,529,786	$ 6,147,719	-10.1%	$ 5,698,053	-3.0%	$ 33,596,821	$ 36,699,531	-8.5%	$ 33,327,907	0.8%
NET GAIN (LOSS) FROM OPERATIONS	**$ (2,198,549)**	**$ (2,111,761)**	**-4.1%**	**$ (2,465,268)**	**-10.8%**	**$ (12,752,990)**	**$ (12,411,440)**	**-2.8%**	**$ (8,277,997)**	**-54.1%**
Operating Margin	-66.00%	-52.32%	26.1%	-76.26%	-13.5%	-61.18%	-51.10%	19.7%	-33.05%	85.1%
MCH Contribution	$ 2,198,549	$ 2,111,761	4.1%	$ 2,465,268	-10.8%	$ 12,752,990	$ 12,411,440	2.8%	$ 8,277,997	54.1%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	8,234	9,602	-14.25%	9,809	-16.06%	57,240	59,069	-3.10%	59,942	-4.51%
Total Hospital Visits	5,200	5,074	2.48%	5,864	-11.32%	32,861	29,331	12.04%	31,969	2.79%
Total Procedures	9,634	11,424	-15.67%	11,973	-19.54%	68,580	66,220	3.56%	72,227	-5.05%
Total Surgeries	734	844	-13.03%	863	-14.95%	5,158	4,846	6.44%	5,210	-1.00%
Total Provider FTE's	83.7	91.4	-8.42%	84.4	-0.83%	79.9	91.4	-12.58%	84.5	-5.48%
Total Staff FTE's	115.4	136.3	-15.33%	121.4	-4.94%	116.2	136.3	-14.73%	119.4	-2.69%
Total Administrative FTE's	13.6	13.0	4.62%	10.7	27.10%	12.3	13.0	-5.38%	12.2	0.82%
Total FTE's	212.7	240.7	-11.63%	216.5	-1.76%	208.4	240.7	-13.41%	216.2	-3.59%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE CLEMENTS - OPERATIONS SUMMARY
MARCH 2020

	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	$ 268,030	$ 448,818	-40.3%	$ 412,459	-35.0%	$ 2,058,772	$ 2,700,816	-23.8%	$ 2,673,932	-23.0%
TOTAL PATIENT REVENUE	$ 268,030	$ 448,818	-40.3%	$ 412,459	-35.0%	$ 2,058,772	$ 2,700,816	-23.8%	$ 2,673,932	-23.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 195,217	$ 31,643	516.9%	$ (5,817)	-3455.8%	$ 524,653	$ 195,133	168.9%	$ 196,717	166.7%
Self Pay Adjustments	(48,201)	6,603	-830.0%	(1,181)	3980.0%	65,855	40,721	61.7%	37,042	77.8%
Bad Debts	75,159	200,734	-62.6%	225,602	-66.7%	606,676	1,237,876	-51.0%	1,001,419	-39.4%
TOTAL REVENUE DEDUCTIONS	$ 222,175	$ 238,980	-7.0%	$ 218,603	1.6%	$ 1,197,184	$ 1,473,730	-18.8%	$ 1,235,178	-3.1%
	82.9%	53.2%		53.0%		58.2%	54.6%		46.2%	
NET PATIENT REVENUE	$ 45,855	$ 209,838	-78.1%	$ 193,856	-76.3%	$ 861,588	$ 1,227,086	-29.8%	$ 1,438,754	-40.1%
OTHER REVENUE										
FHC Other Revenue	$ 19,266	$ 7,846	0.0%	$ 14,591	32.0%	$ 154,109	$ 47,076	0.0%	$ 81,410	89.3%
TOTAL OTHER REVENUE	$ 19,266	$ 7,846	145.5%	$ 14,591	32.0%	$ 154,109	$ 47,076	227.4%	$ 81,410	89.3%
NET OPERATING REVENUE	$ 65,121	$ 217,684	-70.1%	$ 208,447	-68.8%	$ 1,015,697	$ 1,274,162	-20.3%	$ 1,520,164	-33.2%
OPERATING EXPENSE										
Salaries and Wages	$ 74,521	$ 92,710	-19.6%	$ 88,418	-15.7%	$ 448,309	$ 557,894	-19.6%	$ 517,991	-13.5%
Benefits	10,436	25,770	-59.5%	23,874	-56.3%	111,273	148,151	-24.9%	142,835	-22.1%
Physician Services	70,396	112,881	-37.6%	112,259	-37.3%	457,898	679,273	-32.6%	598,342	-23.5%
Cost of Drugs Sold	460	8,882	-94.8%	25,894	-98.2%	37,483	53,446	-29.9%	49,873	-24.8%
Supplies	5,311	5,909	-10.1%	6,792	-21.8%	29,531	35,518	-16.9%	30,208	-2.2%
Utilities	2,637	2,992	-11.9%	602	338.1%	16,453	17,343	-5.1%	16,209	1.5%
Repairs and Maintenance	600	1,892	-68.3%	575	4.3%	3,650	11,352	-67.8%	4,736	-22.9%
Leases and Rentals	490	391	25.4%	378	29.9%	2,835	2,346	20.8%	2,553	11.0%
Other Expense	1,000	1,848	-45.9%	1,880	-46.8%	9,092	11,088	-18.0%	10,278	-11.5%
TOTAL OPERATING EXPENSES	$ 165,850	$ 253,275	-34.5%	$ 260,672	-36.4%	$ 1,116,524	$ 1,516,411	-26.4%	$ 1,373,025	-18.7%
Depreciation/Amortization	$ 4,620	$ 5,203	-11.2%	$ 5,121	-9.8%	$ 28,266	$ 30,712	-8.0%	$ 30,726	-8.0%
TOTAL OPERATING COSTS	$ 170,470	$ 258,478	-34.0%	$ 265,793	-35.9%	$ 1,144,789	$ 1,547,123	-26.0%	$ 1,403,751	-18.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ (105,349)**	**$ (40,794)**	**-158.2%**	**$ (57,346)**	**-83.7%**	**$ (129,092)**	**$ (272,961)**	**52.7%**	**$ 116,413**	**-210.9%**
Operating Margin	-161.77%	-18.74%	763.3%	-27.51%	488.0%	-12.71%	-21.42%	-40.7%	7.66%	-266.0%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	784	1,176	-33.3%	1,145	-31.5%	5,792	7,076	-18.1%		0.0%
Average Revenue per Office Visit	341.88	381.65	-10.4%	360.23	-5.1%	355.45	381.69	-6.9%	371.17	-4.2%
Hospital FTE's (Salaries and Wages)	17.6	23.8	-25.9%	21.5	-17.9%	17.9	24.3	-26.2%	22.2	-19.4%

ECTOR COUNTY HOSPITAL DISTRICT
CENTER FOR PRIMARY CARE WEST UNIVERSITY - OPERATIONS SUMMARY
MARCH 2020

	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	$ 170,764	$ 152,667	11.9%	$ 103,968	64.2%	$ 1,172,296	$ 919,028	27.6%	$ 1,350,097	-13.2%
TOTAL PATIENT REVENUE	$ 170,764	$ 152,667	11.9%	$ 103,968	64.2%	$ 1,172,296	$ 919,028	27.6%	$ 1,350,097	-13.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 90,378	$ (46,810)	-293.1%	$ (41,201)	-319.4%	$ 320,291	$ (288,663)	-211.0%	$ (125,487)	-355.2%
Self Pay Adjustments	18,759	(7,428)	-352.5%	(9,744)	-292.5%	89,562	(45,807)	-295.5%	(35,935)	-349.2%
Bad Debts	26,255	223,214	-88.2%	117,485	-77.7%	433,994	1,376,506	-68.5%	975,896	-55.5%
TOTAL REVENUE DEDUCTIONS	$ 135,391	$ 168,976	-19.9%	$ 66,540	103.5%	$ 843,846	$ 1,042,036	-19.0%	$ 814,474	3.6%
	79.29%	110.68%		64.00%		71.98%	113.38%		60.33%	
NET PATIENT REVENUE	$ 35,373	$ (16,309)	-316.9%	$ 37,428	-5.5%	$ 328,449	$ (123,008)	-367.0%	$ 535,623	-38.7%
OTHER REVENUE										
FHC Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 35,373	$ (16,309)	-316.9%	$ 37,428	-5.5%	$ 328,449	$ (123,008)	-367.0%	$ 535,623	-38.7%
OPERATING EXPENSE										
Salaries and Wages	$ 31,099	$ 32,626	-4.7%	$ 33,435	-7.0%	$ 195,787	$ 196,403	-0.3%	$ 191,437	2.3%
Benefits	4,355	9,069	-52.0%	9,028	-51.8%	48,595	52,156	-6.8%	52,788	-7.9%
Physician Services	46,846	61,156	-23.4%	27,539	70.1%	312,437	368,147	-15.1%	275,577	13.4%
Cost of Drugs Sold	2,550	1,646	54.9%	(1,952)	-230.6%	18,196	9,908	83.7%	11,245	61.8%
Supplies	5,237	3,599	45.5%	10,365	-49.5%	7,903	21,650	-63.5%	40,525	-80.5%
Utilities	3,006	2,712	10.8%	2,381	26.2%	18,466	17,326	6.6%	14,844	24.4%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Other Expense	-	7	-100.0%	-	0.0%	-	42	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 93,094	$ 110,815	-16.0%	$ 80,796	15.2%	$ 601,384	$ 665,632	-9.7%	$ 586,415	2.6%
Depreciation/Amortization	$ 29,324	$ 40,639	-27.8%	$ 40,117	-26.9%	$ 178,741	$ 239,900	-25.5%	$ 240,703	-25.7%
TOTAL OPERATING COSTS	$ 122,418	$ 151,454	-19.2%	$ 120,913	1.2%	$ 780,125	$ 905,532	-13.8%	$ 827,118	-5.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (87,045)**	**$ (167,763)**	**-48.1%**	**$ (83,485)**	**4.3%**	**$ (451,676)**	**$(1,028,540)**	**-56.1%**	**$ (291,496)**	**55.0%**
Operating Margin	-246.08%	1028.65%	-123.9%	-223.06%	10.3%	-137.52%	836.16%	-116.4%	-54.42%	152.7%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	566	454	24.7%	293	93.2%	3,226	2,733	18.0%	4,163	-22.5%
Optometry Visits	-	-	0.0%	-	0.0%	-	-	0.0%	1,115	-100.0%
Total Visits	566	454	24.7%	293	93.2%	3,226	2,733	18.0%		0.0%
Average Revenue per Office Visit	301.70	336.27	-10.3%	354.84	-15.0%	363.39	336.27	8.1%	255.80	42.1%
Hospital FTE's (Salaries and Wages)	8.5	8.9	-4.5%	9.0	-5.3%	8.9	9.1	-1.9%	9.2	-2.6%

ECTOR COUNTY HOSPITAL DISTRICT
MARCH 2020

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	$ 36,112,332	39.6%	$ 39,470,418	38.7%	$ 226,230,521	38.2%	$ 236,561,740	39.3%
Medicaid	9,589,133	10.5%	10,444,025	10.2%	69,711,287	11.7%	62,490,365	10.4%
Commercial	26,497,065	29.1%	29,221,101	28.6%	176,578,635	29.7%	171,788,902	28.6%
Self Pay	16,049,843	17.6%	19,056,200	18.7%	98,606,598	16.6%	106,670,749	17.8%
Other	2,880,336	3.2%	3,937,142	3.9%	22,517,777	3.8%	23,160,903	3.9%
TOTAL	**$ 91,128,708**	**100.0%**	**$ 102,128,886**	**100.1%**	**$ 593,644,817**	**100.0%**	**$ 600,672,660**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 7,832,050	39.3%	$ 9,249,508	45.0%	$ 44,004,161	38.1%	$ 45,703,201	39.2%
Medicaid	2,018,141	10.1%	2,103,627	10.3%	14,347,023	12.4%	13,179,606	11.3%
Commercial	7,515,458	37.7%	6,877,422	33.5%	44,507,055	38.5%	44,876,649	38.6%
Self Pay	1,758,338	8.8%	1,693,498	8.3%	7,634,106	6.6%	8,331,786	7.2%
Other	822,357	4.1%	589,661	2.9%	5,125,500	4.4%	4,360,986	3.7%
TOTAL	**$ 19,946,344**	**100.0%**	**$ 20,513,716**	**100.0%**	**$ 115,617,845**	**100.0%**	**$ 116,452,226**	**100.0%**
TOTAL NET REVENUE	15,968,659		19,404,488		116,662,198		124,149,684	
% OF GROSS REVENUE	17.5%		19.0%		19.7%		20.7%	
VARIANCE	3,977,686		1,109,228		(1,044,353)		(7,697,458)	
% VARIANCE TO CASH COLLECTIONS	24.9%		5.7%		-0.9%		-6.2%	

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
MARCH 2020

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	$ 54,402	20.3%	$ 59,267	14.4%	$ 338,987	16.5%	$ 376,053	14.1%
Medicaid	95,694	35.7%	178,897	43.4%	832,526	40.4%	1,145,803	42.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	45,014	16.8%	79,310	19.2%	353,992	17.2%	519,387	19.4%
Self Pay	72,472	27.0%	94,141	22.8%	528,529	25.7%	626,309	23.4%
Other	448	0.2%	844	0.2%	4,738	0.2%	6,380	0.2%
TOTAL	**$ 268,030**	**100.0%**	**$ 412,459**	**100.0%**	**$ 2,058,772**	**100.0%**	**$ 2,673,932**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 18,225	19.4%	$ 6,166	5.7%	$ 347,250	40.6%	$ 39,271	6.9%
Medicaid	46,782	49.6%	53,979	49.7%	290,515	33.9%	254,719	44.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	10,314	11.0%	32,023	29.5%	91,530	10.7%	159,653	28.2%
Self Pay	18,270	19.4%	16,455	15.1%	124,403	14.5%	113,058	19.9%
Other	590	0.6%	-	0.0%	2,404	0.3%	305	0.1%
TOTAL	**$ 94,181**	**100.0%**	**$ 108,624**	**100.0%**	**$ 856,103**	**100.0%**	**$ 567,006**	**100.0%**
TOTAL NET REVENUE	45,855		193,856		861,588		1,438,754	
% OF GROSS REVENUE	17.1%		47.0%		41.8%		53.8%	
VARIANCE	48,325		(85,233)		(5,485)		(871,748)	
% VARIANCE TO CASH COLLECTIONS	105.4%		-44.0%		-0.6%		-60.6%	

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
MARCH 2020

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	$ 34,660	20.3%	$ 23,431	22.5%	$ 266,906	22.8%	$ 224,602	16.6%
Medicaid	60,967	35.7%	$ 23,494	22.6%	335,269	28.5%	534,760	39.6%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	28,679	16.8%	$ 16,254	15.6%	237,001	20.2%	263,919	19.5%
Self Pay	46,173	27.0%	$ 40,788	39.2%	330,034	28.2%	326,521	24.2%
Other	285	0.2%	$ -	0.0%	3,086	0.3%	294	0.0%
TOTAL	**$ 170,764**	**100.0%**	**$ 103,968**	**100.0%**	**$ 1,172,296**	**100.0%**	**$ 1,350,097**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 10,819	19.4%	$ 8,501	24.8%	$ 76,159	24.6%	$ 55,404	17.4%
Medicaid	27,772	49.6%	9,016	26.3%	107,209	34.5%	127,909	40.1%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	6,123	11.0%	12,090	35.2%	60,395	19.5%	92,905	29.1%
Self Pay	10,846	19.4%	4,695	13.7%	64,703	20.9%	42,528	13.3%
Other	351	0.6%	16	0.0%	1,587	0.5%	16	0.0%
TOTAL	**$ 55,910**	**100.0%**	**$ 34,317**	**100.0%**	**$ 310,054**	**100.0%**	**$ 318,763**	**100.0%**
TOTAL NET REVENUE	35,373		37,428		328,449		535,623	
% OF GROSS REVENUE	20.7%		36.0%		28.0%		39.7%	
VARIANCE	20,537		(3,111)		(18,395)		(216,860)	
% VARIANCE TO CASH COLLECTIONS	58.1%		-8.3%		-5.6%		-40.5%	

ECTOR COUNTY HOSPITAL DISTRICT
SCHEDULE OF CASH AND INVESTMENTS - HOSPITAL ONLY
MARCH 2020

Cash and Cash Equivalents	Frost	Hilltop	Total
Operating	$ 8,427,197	$ -	$ 8,427,197
Mission Fitness	460,116	-	460,116
Petty Cash	9,150	-	9,150
Dispro	-	2,986,272	2,986,272
General Liability	-	690,449	690,449
Professional Liability	-	95,608	95,608
Funded Worker's Compensation	-	573,685	573,685
Funded Depreciation	-	14,644,620	14,644,620
Designated Funds	-	1,232,111	1,232,111
Total Cash and Cash Equivalents	$ 8,896,463	**$ 20,222,744**	**$ 29,119,207**

Investments	Other	Hilltop	Total
Dispro	$ -	$ 2,400,000	$ 2,400,000
Funded Depreciation	-	20,000,000	20,000,000
Funded Worker's Compensation	-	1,700,000	1,700,000
General Liability	-	2,300,000	2,300,000
Professional Liability	-	3,000,000	3,000,000
Designated Funds	30,802	2,000,000	2,030,802
Allowance for Change in Market Values		57,984	57,984
Total Investments	$ 30,802	$ 31,457,984	**$ 31,488,786**
Total Unrestricted Cash and Investments			**$ 60,607,993**

Restricted Assets	Reserves	Prosperity	Total
Assets Held By Trustee - Bond Reserves	$ 3,841,524	$ -	$ 3,841,524
Assets Held By Trustee - Debt Payment Reserves	946,331	-	946,331
Assets Held In Endowment-Board Designated	-	6,375,547	6,375,547
Restricted TPC, LLC-Equity Stake	522,753	-	522,753
Restricted MCH West Texas Services-Equity Stake	2,289,090	-	2,289,090
Total Restricted Assets	$ 7,599,698	$ 6,375,547	**$ 13,975,245**
Total Cash & Investments			**$ 74,583,238**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
MARCH 2020

	Hospital	Procare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:			
Excess of Revenue over Expenses	$ (12,846,556)	$ -	$ (12,846,556)
Noncash Expenses:			
Depreciation and Amortization	8,879,497	76,461	8,955,958
Unrealized Gain/Loss on Investments	186,025	-	186,025
Accretion (Bonds)	-	-	-
Changes in Assets and Liabilities			
Patient Receivables, Net	199,264	(1,134,580)	(935,316)
Taxes Receivable/Deferred	8,624,594	(84,733)	8,539,861
Inventories, Prepaids and Other	(9,488,811)	(15,713)	(9,504,524)
Accounts Payable	3,104,193	1,244,735	4,348,928
Accrued Expenses	137,244	(86,120)	51,124
Due to Third Party Payors	(256,277)	-	(256,277)
Accrued Post Retirement Benefit Costs	3,930,924	-	3,930,924
Net Cash Provided by Operating Activities	$ 2,470,096	$ 50	$ 2,470,146
Cash Flows from Investing Activities:			
Investments	$ 12,604,905	$ -	$ 12,604,905
Acquisition of Property and Equipment	(4,718,786)	-	(4,718,786)
Net Cash used by Investing Activities	$ 7,886,119	$ -	$ 7,886,119
Cash Flows from Financing Activities:			
Current Portion Debt	$ (1,538,483)	$ -	$ (1,538,483)
Net Repayment of Long-term Debt/Bond Issuance	(344,407)	-	(344,407)
Net Cash used by Financing Activities	(1,882,890)	0	(1,882,890)
Net Increase (Decrease) in Cash	8,473,325	50	8,473,375
Beginning Cash & Cash Equivalents @ 9/30/2019	34,621,128	4,700	34,625,828
Ending Cash & Cash Equivalents @ 3/31/2020	$ 43,094,452	$ 4,750	$ 43,099,202
Balance Sheet			
Cash and Cash Equivalents	$ 29,119,207	$ 4,750	$ 29,123,957
Restricted Assets	13,975,245	-	13,975,245
Ending Cash & Cash Equivalents @ 3/31/2020	$ 43,094,452	$ 4,750	$ 43,099,202

ECTOR COUNTY HOSPITAL DISTRICT
TAX COLLECTIONS
FISCAL 2020

	ACTUAL COLLECTIONS	BUDGETED COLLECTIONS	VARIANCE	PRIOR YEAR COLLECTIONS	VARIANCE
AD VALOREM					
OCTOBER	$ 357,473	$ 1,510,369	$ (1,152,896)	$ 347,199	$ 10,274
NOVEMBER	1,151,010	1,510,369	(359,359)	863,534	287,476
DECEMBER	3,300,400	1,510,369	1,790,031	3,052,335	248,065
JANUARY	4,845,249	1,510,369	3,334,880	4,374,472	470,777
FEBRUARY	6,455,075	1,510,369	4,944,706	5,039,715	1,415,360
MARCH	1,361,450	1,510,369	(148,919)	1,683,658	(322,208)
SUB TOTAL	17,470,655	9,062,214	8,408,441	15,360,911	2,109,744
TOTAL	$ 17,470,655	$ 9,062,214	$ 8,408,441	$ 15,360,911	$ 2,109,744
SALES					
OCTOBER	$ 4,204,814	$ 4,083,969	$ 120,845	$ 4,584,041	$ (379,228)
NOVEMBER	4,143,047	4,109,569	33,478	4,601,483	(458,436)
DECEMBER	4,251,049	4,166,072	84,977	4,814,865	(563,815)
JANUARY	3,763,912	4,205,740	(441,828)	4,940,411	(1,176,499)
FEBRUARY	3,771,703	4,566,473	(794,770)	4,702,958	(931,255)
MARCH	3,855,612	4,638,267	(782,655)	4,472,410	(616,798)
SUB TOTAL	23,990,137	25,770,090	(1,779,953)	28,116,168	(4,126,032)
ACCRUAL	(502,279)	-	(502,279)	-	(502,279)
TOTAL	$ 23,487,858	$ 25,770,090	$ (2,282,232)	$ 28,116,168	$ (4,628,311)
TAX REVENUE	**$ 40,958,513**	**$ 34,832,304**	**$ 6,126,209**	**$ 43,477,079**	**$ (2,518,566)**

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAID SUPPLEMENTAL PAYMENTS
FISCAL YEAR 2020

CASH ACTIVITY	TAX (IGT) ASSESSED	GOVERNMENT PAYOUT	NET INFLOW
DSH			
1st Qtr	$ (1,200,156)	$ 3,056,849	$ 1,856,693
2nd Qtr	(668,408)	1,709,047	1,040,639
3rd Qtr	-	-	-
4th Qtr	-	-	-
DSH TOTAL	$ (1,868,564)	$ 4,765,896	$ 2,897,332
UC			
1st Qtr	$ -	$ -	-
2nd Qtr	(503,626)	1,287,716	784,090
3rd Qtr	-	-	-
4th Qtr	-	-	-
UC TOTAL	$ (503,626)	$ 1,287,716	$ 784,090
DSRIP			
1st Qtr	$ -	$ -	$ -
2nd Qtr	(1,803,212)	4,600,459	2,797,247
3rd Qtr	-	-	-
4th Qtr	-	-	-
DSRIP UPL TOTAL	$ (1,803,212)	$ 4,600,459	$ 2,797,247
UHRIP			
1st Qtr	$ (1,880,035)	$ 1,978,942	$ 98,907
2nd Qtr	-	6,806	6,806
3rd Qtr	-	-	-
4th Qtr	-	-	-
UHRIP TOTAL	$ (1,880,035)	$ 1,985,748	$ 105,713
GME			
1st Qtr	$ -	$ -	$ -
2nd Qtr	(220,796)	564,552	343,756
3rd .	-	-	-
4th Qtr	-	-	-
GME TOTAL	$ (220,796)	$ 564,552	$ 343,756
Blended Cash Activity	**$ (6,276,233)**	**$ 13,204,371**	**$ 6,928,138**

INCOME STATEMENT ACTIVITY:	MCH	BLENDED
FY 2020 Accrued / (Deferred) Adjustments:		
DSH Accrual	$ 6,996,230	$ 6,996,230
Uncompensated Care Accrual	7,339,980	7,339,980
Regional UPL Accrual	-	-
URIP	(2,213,798)	(2,213,798)
GME	564,552	564,552
Regional UPL Benefit	-	-
Medicaid Supplemental Payments	12,686,963	12,686,963
DSRIP Accrual	2,876,754	2,876,754
Total Adjustments	**$ 15,563,717**	**$ 15,563,717**

ECTOR COUNTY HOSPITAL DISTRICT
CONSTRUCTION IN PROGRESS - HOSPITAL ONLY
AS OF MARCH 31, 2020

ITEM	CIP BALANCE AS OF 2/29/2020	MARCH "+" ADDITIONS	MARCH "-" ADDITIONS	MARCH TRANSFERS	CIP BALANCE AS OF 3/31/2020	ADD: AMOUNTS CAPITALIZED	PROJECT TOTAL	BUDGETED AMOUNT	UNDER/(OVER) APRVD/BUDGET
RENOVATIONS									
ICU/CCU UPGRADES	402,156	-	(19,704)	-	382,452	-	382,452	500,000	117,548
DIABETES CENTER	124,781	57,870	-	-	182,651	-	182,651	150,000	(32,651)
ODP MOB UPGRADES	29,775	75,051	-	-	104,826	-	104,826	150,000	45,174
REGIONAL LAB	5,603	-	-	-	5,603	-	5,603	150,000	144,398
SUITE 250 CHW	32,599	814	-	-	33,413	-	33,413	45,000	11,587
BUSINESS OFFICE RENOVATION	-	-	-	-	-	-	-	75,000	75,000
SUB-TOTAL	$ 594,913	$ 133,734	$ (19,704)	$ -	$ 708,944	$ -	$ 708,944	$ 1,070,000	$ 361,056
MINOR BUILDING IMPROVEMENT									
SECURITY FENCING	23,224	-	-	(23,224)	-	-	-	45,000	45,000
L&D SLEEP ROOM	10,802	-	-	-	10,802	-	10,802	45,000	34,198
REFRACTORY BOILER UPGRADE	-	-	-	-	-	-	-	30,000	30,000
REHAB EXPANSION	27,261	-	-	-	27,261	-	27,261	25,000	(2,261)
CATH LAB #2 REPLACEMENT	-	2,178	-	-	2,178	-	2,178	20,000	17,822
LOADING DOCK IMPROVEMENTS	-	4,355	-	-	4,355	-	4,355	40,000	35,645
SUB-TOTAL	$ 61,287	$ 6,533	$ -	$ (23,224)	$ 44,596	$ -	$ 44,596	$ 205,000	$ 160,404
EQUIPMENT & SOFTWARE PROJECTS - CIP INCOMPLETE									
VARIOUS CAPITAL EXPENDITURE PROJECTS	$ 964,423	$ 573,999	$ (631,683)	$ -	$ 906,738	$ -	$ 906,738	$ 2,000,000	$ 1,093,262
SUB-TOTAL	$ 964,423	$ 573,999	$ (631,683)	$ -	$ 906,738	$ -	$ 906,738	$ 2,000,000	$ 1,093,262
TOTAL CONSTRUCTION IN PROGRESS	**$ 1,620,624**	**$ 714,266**	**$ (651,387)**	**$ (23,224)**	**$ 1,660,278**	**$ -**	**$ 1,660,278**	**$ 3,275,000**	**$ 1,614,722**

ECTOR COUNTY HOSPITAL DISTRICT
CAPITAL PROJECT & EQUIPMENT EXPENDITURES
MARCH 2020

ITEM	CLASS	BOOKED AMOUNT
TRANSFERRED FROM CONSTRUCTION IN PROGRESS/RENOVATION PROJECTS		
Security Fencing - Family Health Clinic	BUILDING	$ 23,224
TOTAL PROJECT TRANSFERS		**$ 23,224**
EQUIPMENT PURCHASES		
None		$ -
TOTAL EQUIPMENT PURCHASES		**$ -**
TOTAL TRANSFERS FROM CIP/EQUIPMENT PURCHASES		**$ 23,224**

ECTOR COUNTY HOSPITAL DISTRICT
FISCAL 2020 CAPITAL EQUIPMENT
CONTINGENCY FUND
MARCH 2020

MONTH/ YEAR	DESCRIPTION	DEPT NUMBER	BUDGETED AMOUNT	P.O AMOUNT	ACTUAL AMOUNT	TO/(FROM) CONTINGENCY
	Available funds from budget		**$ 600,000**	**$ -**	**$ -**	**$ 600,000**
Oct-19	ER RENOVATION	6850	125,000	-	100,988	24,012
Oct-19	9C TELEMETRY UPGRADE	6190	45,000	-	33,964	11,036
Oct-19	Imaging (X-Ray)	7260	-	-	186,900	(186,900)
Oct-19	Anesthesia CareAware	7370	-	-	57,166	(57,166)
Oct-19	Cart	6620	-	-	4,876	(4,876)
Oct-19	Savi Scout Surgical Guidance System	7240	-	-	65,000	(65,000)
Oct-19	Walter Lorenz Surgical Assist Arm	6620	-	-	45,320	(45,320)
Oct-19	Portable Monitors	6850	-	-	20,744	(20,744)
Oct-19	Bio-Console 560 Speed Controller System	6620	-	-	15,000	(15,000)
Nov-19	Isolation Room Renovations	8200	151,650	-	179,298	(27,648)
Nov-19	Procare Administration Renovation	9300	298,800	-	300,245	(1,445)
Nov-19	Windows 2012 Server	9100	-	-	14,476	(14,476)
Nov-19	Ice Maker	8020	-	-	3,500	(3,500)
Nov-19	Monitor (Cardiac)	6090	-	-	176,453	(176,453)
Nov-19	Air Curtain Refrigerator	8020	-	-	10,075	(10,075)
Nov-19	Vital Signs Monitor	6630	-	-	7,399	(7,399)
Dec-19	Drainage Repairs	8200	45,000	-	15,315	29,685
Dec-19	ER Restrooms Renovation	8200	45,000	-	29,137	15,863
Dec-19	PeriFlux 6000 Stand Alone TCPO2 System	7460	-	-	10,174	(10,174)
Dec-19	Honda Odyssey	9300	-	-	29,500	(29,500)
Jan-20	3M 360 Encompass System	9180	-	-	237,638	(237,638)
Jan-20	Steamer	8020	-	-	6,937	(6,937)
Jan-20	RF Controller	6620	-	-	27,500	(27,500)
Jan-20	Hot Food Serving Table	8020	-	-	3,000	(3,000)
Jan-20	9 Central 4 Central Restrooms	8200	30,000	-	26,458	3,542
Feb-20	Pathology Renovation	7040	20,000	-	16,033	3,967
Feb-20	SQL Server	9100	-	-	44,941	(44,941)
Feb-20	Prime TC Swing - Away Model	7230	-	-	2,836	(2,836)
Feb-20	Fluent System	6620	-	-	27,000	(27,000)
Feb-20	AED Wall Mount Bracket for Lifepak	6850	-	-	2,791	(2,791)
Mar-20	Security Fencing - Family Health Clinic	8200	45,000	-	23,224	21,776
			$ 1,405,450	**$ -**	**$ 1,723,888**	**$ (318,438)**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF ACCOUNTS RECEIVABLE - OTHER
MARCH 2020

	CURRENT YEAR	PRIOR YEAR HOSPITAL AUDITED	PRIOR YEAR PRO CARE AUDITED	CURRENT YEAR CHANGE
AR DISPRO/UPL	$ 4,193,375	$ 94,477	$ -	$ 4,098,898
AR UNCOMPENSATED CARE	6,555,890	-	-	6,555,890
AR DSRIP	3,250,835	3,171,328	-	79,507
AR NURSING HOME UPL	-	-	-	-
AR UHRIP	1,366,714	4,192,740	-	(2,826,026)
AR GME	220,796	-	-	220,796
AR BAB REVENUE	79,530	82,117	-	(2,587)
AR PHYSICIAN GUARANTEES	167,974	210,927	-	(42,953)
AR ACCRUED INTEREST	100,460	220,763	-	(120,304)
AR OTHER:	2,358,787	1,966,337	45,727	346,723
Procare On-Call Fees	-	-	-	-
Procare A/R - FHC	-	-	-	-
Other Misc A/R	2,358,787	1,966,337	45,727	346,723
AR DUE FROM THIRD PARTY PAYOR	3,816,987	4,281,519	-	(464,532)
TOTAL ACCOUNTS RECEIVABLE - OTHER	$ 21,696,064	$ 12,414,472	$ 45,727	$ 9,235,865

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF HOSPITAL TEMPORARY LABOR FTE'S
MARCH 2020

	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**
9 CENTRAL	4.1	2.2	91.4%	2.0	104.5%	4.2	2.3	84.3%	1.7	146.0%
5 CENTRAL	3.6	0.2	1394.6%	-	0.0%	2.9	0.3	1012.1%	-	0.0%
OPERATING ROOM	3.7	-	0.0%	-	0.0%	2.8	-	0.0%	-	0.0%
PM&R - PHYSICAL	2.9	1.9	50.6%	-	0.0%	2.8	2.0	35.3%	-	0.0%
CARDIOPULMONARY	3.2	-	0.0%	-	0.0%	2.5	-	0.0%	0.4	569.0%
6 Central	1.8	0.1	1589.8%	-	0.0%	2.4	0.4	588.2%	0.0	19813.2%
IMAGING - DIAGNOSTICS	2.0	-	0.0%	-	0.0%	2.0	-	0.0%	-	0.0%
STERILE PROCESSING	1.1	-	0.0%	3.7	-71.6%	1.9	-	0.0%	4.5	-57.7%
LABOR AND DELIVERY	2.1	0.0	4528.1%	0.1	2012.1%	1.8	0.0	3756.9%	0.0	10840.7%
INTENSIVE CARE UNIT 4 (CCU)	3.9	0.3	1127.5%	-	0.0%	1.8	0.3	427.6%	0.4	355.7%
7 CENTRAL	2.0	0.0	17833.0%	-	0.0%	1.8	0.0	15461.8%	-	0.0%
8 CENTRAL	0.6	0.1	430.6%	-	0.0%	1.4	0.1	1009.1%	-	0.0%
4 CENTRAL	3.3	0.1	6330.7%	-	0.0%	1.4	0.1	2427.4%	0.0	11362.1%
4 EAST	1.9	0.3	466.2%	0.5	249.2%	1.1	0.3	232.7%	0.1	1124.4%
LABORATORY - CHEMISTRY	3.2	-	0.0%	-	0.0%	0.6	-	0.0%	-	0.0%
MEDICAL STAFF	-	0.5	-100.0%	-	0.0%	0.5	0.5	2.5%	-	0.0%
IMAGING - ULTRASOUND	-	0.2	-100.0%	1.1	-100.0%	0.5	0.3	86.4%	0.9	-49.3%
6 West	0.1	0.2	-29.2%	-	0.0%	0.3	0.2	61.1%	-	0.0%
RAD MCH CVI	0.7	-	0.0%	-	0.0%	0.3	-	0.0%	-	0.0%
NURSING ORIENTATION	0.3	-	0.0%	-	0.0%	0.3	-	0.0%	-	0.0%
EMERGENCY DEPARTMENT	-	-	0.0%	-	0.0%	0.1	-	0.0%	-	0.0%
IMAGING - NUCLEAR MEDICINE	0.6	-	0.0%	1.1	-46.9%	0.1	-	0.0%	0.5	-81.0%
PM&R - SPEECH	-	0.2	-100.0%	-	0.0%	0.0	0.2	-80.4%	-	0.0%
IMAGING - CT SCAN	0.2	-	0.0%	-	0.0%	0.0	-	0.0%	-	0.0%
INTENSIVE CARE UNIT 2	-	0.2	-100.0%	-	0.0%	0.0	0.3	-90.4%	0.3	-92.6%
INPATIENT REHAB	-	-	0.0%	-	0.0%	0.0	-	0.0%	0.7	-96.4%
5 WEST	-	-	0.0%	-	0.0%	0.0	-	0.0%	-	0.0%
INPATIENT REHAB - THERAPY	-	-	0.0%	0.3	-100.0%	-	-	0.0%	0.7	-100.0%
NEO-NATAL INTENSIVE CARE	-	0.2	-100.0%	-	0.0%	-	0.1	-100.0%	0.0	-100.0%
RECOVERY ROOM	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
OP SURGERY	-	-	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%
PHARMACY DRUGS/I.V. SOLUTIONS	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
PM&R - OCCUPATIONAL	-	1.0	-100.0%	-	0.0%	-	1.0	-100.0%	0.5	-100.0%
CARDIOPULMONARY - NICU	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
CHW - SPORTS MEDICINE	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
PERFORMANCE IMPROVEMENT (QA)	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TRAUMA SERVICE	-	-	0.0%	1.1	-100.0%	-	-	0.0%	0.5	-100.0%
FOOD SERVICE	-	-	0.0%	-	0.0%	-	-	0.0%	0.5	-100.0%
ENGINEERING	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
FINANCIAL ACCOUNTING	-	-	0.0%	1.8	-100.0%	-	-	0.0%	1.1	-100.0%
PATIENT ACCOUNTING	-	-	0.0%	-	0.0%	-	-	0.0%	0.3	-100.0%
CERNER	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
IT OPERATIONS	-	-	0.0%	1.1	-100.0%	-	-	0.0%	1.1	-100.0%
ADMINISTRATION	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
HUMAN RESOURCES	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
SUBTOTAL	**41.3**	**7.9**	**425.7%**	**12.9**	**221.7%**	**33.6**	**8.5**	**296.4%**	**14.3**	**135.2%**
TRANSITION LABOR										
LABORATORY - CHEMISTRY	2.0	2.9	-31.0%	5.4	-62.4%	3.1	3.1	-0.7%	4.3	-28.7%
INTENSIVE CARE UNIT 4 (CCU)	-	-	0.0%	3.0	-100.0%	1.1	-	0.0%	3.7	-70.2%
INPATIENT REHAB - THERAPY	0.8	1.0	-20.5%	1.0	-20.0%	0.9	1.1	-12.1%	0.9	2.1%
7 CENTRAL	-	0.1	-100.0%	3.1	-100.0%	0.9	0.1	876.5%	3.6	-75.8%
NEO-NATAL INTENSIVE CARE	-	0.1	-100.0%	5.2	-100.0%	0.6	0.1	792.6%	5.8	-89.5%
PM&R - OCCUPATIONAL	-	1.0	-100.0%	0.9	-100.0%	0.5	1.0	-55.8%	1.0	-55.0%
INTENSIVE CARE UNIT 2	-	0.1	-100.0%	2.2	-100.0%	0.4	0.1	550.9%	1.9	-77.9%
4 EAST	-	-	0.0%	2.4	-100.0%	0.1	-	0.0%	2.0	-95.9%
9 CENTRAL	-	-	0.0%	0.1	-100.0%	0.0	-	0.0%	0.1	-90.4%
8 CENTRAL	-	-	0.0%	1.5	-100.0%	-	-	0.0%	2.7	-100.0%
INPATIENT REHAB	-	1.0	-100.0%	1.3	-100.0%	-	1.0	-100.0%	1.5	-100.0%
OPERATING ROOM	-	2.0	-100.0%	1.8	-100.0%	-	2.0	-100.0%	1.9	-100.0%
6 Central	-	-	0.0%	1.3	-100.0%	-	-	0.0%	0.9	-100.0%
LABORATORY - HEMATOLOGY	-	-	0.0%	1.0	-100.0%	-	-	0.0%	1.1	-100.0%
EMERGENCY DEPARTMENT	-	-	0.0%	-	0.0%	-	-	0.0%	0.5	-100.0%
5 CENTRAL	-	-	0.0%	-	0.0%	-	-	0.0%	0.5	-100.0%
4 CENTRAL	-	-	0.0%	0.1	-100.0%	-	-	0.0%	0.0	-100.0%
LABOR AND DELIVERY	-	-	0.0%	0.2	-100.0%	-	-	0.0%	0.0	-100.0%
6 West	-	-	0.0%	0.1	-100.0%	-	-	0.0%	0.0	-100.0%
5 WEST	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
OP SURGERY	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
CHW - SPORTS MEDICINE	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
PM&R - PHYSICAL	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
CERNER	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TRAUMA SERVICE	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
SUBTOTAL	**2.8**	**8.1**	**-65.1%**	**30.5**	**-90.7%**	**7.5**	**8.4**	**-10.2%**	**32.5**	**-76.8%**
GRAND TOTAL	**44.2**	**16.0**	**176.8%**	**43.4**	**1.8%**	**41.2**	**16.9**	**143.8%**	**46.8**	**-12.1%**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF TEMPORARY LABOR, TRANSITION LABOR & PURCHASED SERVICES - HOSPITAL ONLY
MARCH 2020

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR
RT TEMPORARY LABOR	$ 35,669	$ -	$ 35,669	100.0%	$ -	100.0%	$ 252,005	$ -	$ 252,005	100.0%	$ 21,594	1067.0%
OR TEMPORARY LABOR	95,011	-	95,011	100.0%	-	100.0%	301,387	-	301,387	100.0%	-	100.0%
IMCU9 TEMPORARY LABOR	60,796	26,911	33,885	125.9%	22,864	165.9%	366,750	169,347	197,403	116.6%	115,096	218.6%
5C TEMPORARY LABOR	45,926	2,928	42,998	1468.5%	-	100.0%	222,205	18,417	203,788	1106.5%	-	100.0%
6C TEMPORARY LABOR	24,718	1,433	23,285	1624.9%	-	100.0%	197,132	27,066	170,066	628.3%	616	31880.1%
DIAG TEMPORARY LABOR	20,520	-	20,520	100.0%	-	100.0%	157,234	-	157,234	100.0%	-	100.0%
L & D TEMPORARY LABOR	32,934	610	32,324	5299.0%	1,192	2662.8%	172,083	3,643	168,440	4623.7%	1,192	14336.0%
SP Temporary Labor	12,567	-	12,567	100.0%	37,220	-66.2%	131,348	-	131,348	100.0%	304,935	-56.9%
7C TEMPORARY LABOR	26,244	122	26,122	21411.2%	-	100.0%	144,449	764	143,685	18806.9%	-	100.0%
8C TEMPORARY LABOR	11,014	1,320	9,694	734.4%	-	100.0%	112,443	8,539	103,904	1216.8%	-	100.0%
PT TEMPORARY LABOR	50,757	28,926	21,831	75.5%	-	100.0%	279,275	178,705	100,570	56.3%	-	100.0%
ICU4 TEMPORARY LABOR	55,984	5,165	50,819	983.9%	-	100.0%	146,753	32,219	114,534	355.5%	38,818	278.0%
IMCU4 TEMPORARY LABOR	45,578	1,210	44,368	3666.8%	-	100.0%	109,894	7,369	102,525	1391.3%	1,640	6601.3%
4E TEMPORARY LABOR	28,391	4,356	24,035	551.8%	6,512	335.9%	100,705	26,265	74,440	283.4%	6,512	1446.3%
ALL OTHER	57,619	44,938	12,681	28.2%	86,775	-33.6%	308,066	273,447	34,619	12.7%	501,975	-38.6%
TOTAL TEMPORARY LABOR	$ 603,727	$ 117,919	$ 485,808	412.0%	$ 154,563	290.6%	$ 3,001,729	$ 745,781	$ 2,255,948	302.5%	$ 992,379	202.5%
ICU4 TRANSITION LABOR	$ 4,561	$ -	$ 4,561	100.0%	$ 29,005	-84.3%	$ 72,021	$ -	$ 72,021	100.0%	$ 220,491	-67.3%
7C TRANSITION LABOR	-	984	(984)	-100.0%	32,187	-100.0%	57,798	6,151	51,647	839.6%	225,436	-74.4%
NICU TRANSITION LABOR	4,381	824	3,557	431.6%	58,262	-92.5%	50,368	4,782	45,586	953.3%	394,311	-87.2%
CHEM TRANSITION LABOR	26,426	19,117	7,309	38.2%	43,576	-39.4%	156,517	118,194	38,323	32.4%	195,177	-19.8%
REHAB TRANSITION LABOR	8,480	11,718	(3,238)	-27.6%	10,495	-19.2%	59,655	73,795	(14,140)	-19.2%	41,909	42.3%
ALL OTHER	3,801	36,810	(33,009)	-89.7%	147,196	-97.4%	72,516	222,570	(150,054)	-67.4%	1,017,535	-92.9%
TOTAL TRANSITION LABOR	$ 47,649	$ 69,453	$ (21,804)	-31.4%	$ 320,721	-85.1%	$ 468,876	$ 425,492	$ 43,384	10.2%	$ 2,094,858	-77.6%
GRAND TOTAL TEMPORARY LABOR	$ 651,376	$ 187,372	$ 464,004	247.6%	$ 475,284	37.0%	$ 3,470,605	$ 1,171,273	$ 2,299,332	196.3%	$ 3,087,238	12.4%
HIM CODING SERVICES	$ 90,296	$ 23,250	$ 67,046	288.4%	$ 342,383	-73.6%	$ 2,493,368	$ 430,854	$ 2,062,514	478.7%	$ 3,027,956	-17.7%
PA OTHER PURCH SVCS	786,820	151,904	634,916	418.0%	156,306	403.4%	3,432,279	896,724	2,535,555	282.8%	550,301	523.7%
ECHDA OTHER PURCH SVCS	315,235	191,395	123,840	64.7%	21,816	1345.0%	1,413,427	1,148,370	265,057	23.1%	607,053	132.8%
PA ELIGIBILITY FEES	145,486	34,846	110,640	317.5%	116,515	24.9%	444,134	205,704	238,430	115.9%	279,103	59.1%
ADMIN LEGAL FEES	36,600	39,583	(2,983)	-7.5%	(210,912)	-117.4%	459,206	237,498	221,708	93.4%	203,533	125.6%
ADM PHYS RECRUITMENT	67,944	4,293	63,651	1482.7%	14,159	379.9%	211,210	25,758	185,452	720.0%	36,925	472.0%
SP OTHER PURCH SVCS	50,382	35,000	15,382	43.9%	-	100.0%	343,515	210,000	133,515	63.6%	61,858	455.3%
COMPLIANCE CONSULTING FEES	17,777	10,112	7,665	75.8%	3,076	478.0%	193,950	60,672	133,278	219.7%	74,923	158.9%
AMBULANCE FEES	32,289	11,173	21,116	189.0%	15,390	109.8%	165,764	65,957	99,807	151.3%	56,319	194.3%
MED ASSETS CONTRACT	66,146	25,148	40,998	163.0%	23,517	181.3%	239,609	150,888	88,721	58.8%	82,961	188.8%
NSG OTHER PURCH SVCS	13,212	5,736	7,476	130.3%	704	1776.9%	118,917	34,416	84,501	245.5%	21,314	457.9%
DIET OTHER PURCH SVCS	35,189	9,746	25,443	261.1%	12,070	191.5%	140,363	58,476	81,887	140.0%	62,845	123.3%
FA EXTERNAL AUDIT FEES	111,621	18,000	93,621	520.1%	154,604	-27.8%	188,211	108,000	80,211	74.3%	179,288	5.0%
ADMIN OTHER FEES	22,863	19,120	3,743	19.6%	107,930	-78.8%	173,276	114,720	58,556	51.0%	160,524	7.9%
HR RECRUITING FEES	56,993	33,788	23,205	68.7%	9,502	499.8%	256,568	202,728	53,840	26.6%	158,157	62.2%
PI FEES (TRANSITION NURSE PROGRAM)	25,075	40,667	(15,592)	-38.3%	76,165	-67.1%	288,962	244,002	44,960	18.4%	290,999	-0.7%
HISTOLOGY SERVICES	35,767	35,737	30	0.1%	27,858	28.4%	257,688	214,422	43,266	20.2%	189,490	36.0%
OR FEES (PERFUSION SERVICES)	28,860	28,135	725	2.6%	23,523	22.7%	206,339	168,810	37,529	22.2%	154,765	33.3%
UOM (EHR FEES)	21,154	16,905	4,249	25.1%	18,180	16.4%	137,135	101,430	35,705	35.2%	104,666	31.0%
LAB ADMIN OTHER PURCH SVCS	3,652	4,303	(651)	-15.1%	2,484	47.0%	57,958	25,818	32,140	124.5%	27,134	113.6%
NSG ED OTHER PURCH SVCS	6,493	7,865	(1,372)	-17.4%	6,140	5.8%	75,759	47,190	28,569	60.5%	59,663	27.0%
CREDIT CARD FEES	21,281	19,354	1,927	10.0%	21,086	0.9%	141,364	114,252	27,112	23.7%	115,602	22.3%
MM OTHER PURCH SVCS	5,772	5,667	105	1.9%	5,420	6.5%	54,608	34,002	20,606	60.6%	32,521	67.9%
ENGINEERING OTHER PURCH SVCS	9,888	7,347	2,541	34.6%	14,310	-30.9%	61,804	44,082	17,722	40.2%	44,866	37.8%
PH CONTRACT PURCH SVC	18,849	7,278	11,571	159.0%	9,424	100.0%	56,654	43,668	12,986	29.7%	41,123	37.8%
FIN ACCT COST REPORT/CONSULTANT FEES	713	14,643	(13,930)	-95.1%	82,256	-99.1%	73,126	87,858	(14,732)	-16.8%	144,523	-49.4%
REHAB OTHER PURCH SVCS	4,977	11,552	(6,575)	-56.9%	10,052	-50.5%	52,195	69,312	(17,117)	-24.7%	75,401	-30.8%
MISSION FITNESS OTHER PURCH SVCS	7,251	14,455	(7,204)	-49.8%	11,628	-37.6%	60,861	92,196	(31,335)	-34.0%	62,500	-2.6%
UC-WEST CLINIC - PURCH SVCS-OTHER	26,234	30,901	(4,667)	-15.1%	27,797	-5.6%	176,906	185,406	(8,500)	-4.6%	186,789	-5.3%
UC-CPC 42ND STREET PURCH SVCS-OTHER	52,539	43,398	9,141	21.1%	34,327	53.1%	265,949	260,388	5,561	2.1%	223,636	18.9%
PHARMACY SERVICES	19,961	23,545	(3,584)	-15.2%	24,639	-19.0%	69,963	141,270	(71,307)	-50.5%	166,713	-58.0%
PRIMARY CARE WEST OTHER PURCH SVCS	46,846	61,156	(14,310)	-23.4%	27,539	70.1%	312,437	368,147	(55,710)	-15.1%	275,577	13.4%
COMM REL MEDIA PLACEMENT	100,659	50,000	50,659	101.3%	7,272	1284.3%	192,919	300,000	(107,081)	-35.7%	149,772	28.8%
ADM CONSULTANT FEES	37,276	85,417	(48,141)	-56.4%	101,233	-63.2%	228,820	512,502	(283,682)	-55.4%	823,490	-72.2%
FHC OTHER PURCH SVCS	69,083	112,881	(43,798)	-38.8%	111,559	-38.1%	450,898	679,273	(228,376)	-33.6%	593,542	-24.0%
PT ACCTS COLLECTION FEES	183,790	1,014,884	(831,094)	-81.9%	462,073	-60.2%	1,977,777	5,991,090	(4,013,313)	-67.0%	2,546,652	-22.3%
ALL OTHERS	2,583,314	2,644,467	(61,153)	-2.3%	2,519,632	2.5%	14,672,737	15,886,602	(1,213,865)	-7.6%	14,362,307	2.2%
TOTAL PURCHASED SERVICES	$ 5,079,513	$ 4,819,352	$ 260,161	5.4%	$ 4,329,534	17.3%	$ 29,703,798	$ 29,116,691	$ 587,107	2.0%	$ 25,824,363	15.0%

Ector County Hospital District
Debt Service Coverage Calculation
MARCH 2020

Average Annual Debt Service Requirements of 110%:

	FYTD			Annualized
	ProCare	ECHD	Consolidated	Consolidated
Change in net position	-	(12,846,556)	(12,846,556)	(25,693,112)
Depreciation/amortization	108,988	9,125,166	9,234,153	18,468,307
GASB 68 Expense	-	3,744,548	3,744,548	7,489,096
GASB 75 Expense	-	7,935	7,935	15,869
Interest expense	-	1,489,754	1,489,754	2,979,509
(Gain) or loss on fixed assets	6,132	877	7,009	14,018
Unusual / infrequent / extraordinary items	-	-	-	-
Unrealized (gains) / losses on investments	-	(186,025)	(186,025)	(372,049)
Consolidated net revenues	115,120	1,335,698	1,450,818	2,901,637
GASB 68/Pension Expense, per TB		7,884,548		
District Required Contributions		(4,140,000)		
GASB 68/Pension Expense to remove		3,744,548		
GASB 75/OPEB Expense, per TB		667,935		
District Required Contributions		(660,000)		
GASB 75/OPEB Expense to remove		7,935		

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%
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
	3,702,628.95	606,814.63	4,309,443.57	

OR

2.)

Next Year Debt Service - sum of principal and interest due in the next fiscal year:

	Bonds	
Debt Service	4,679,639	*higher of the two*

Covenant Computation	**Current FYTD**		
	31.0%	(needs to be 110% or higher)	**62.0%**

Liquidity Requirement

Cash on Hand Requirement

2020	80
2021+	100

	MARCH 2020
Consolidated operating costs	203,870,369
Less depreciation and amortization	(9,234,153)
Add: Interest Expense	1,489,754
Less: BABs	(474,594)
Less other non cash expenses:	
GASB 68 - from above	(3,744,548)
GASB 75 - from above	(7,934.51)
Adjusted expenses	191,898,894
Expenses per day	**1,048,628**
Unrestricted cash and cash equivalents	29,123,957
Internally designated noncurrent cash and investments	31,488,786
Assets held in endowment, board designated	6,375,547
Total cash for calculation	**66,988,290**
Days cash on hand	**63.88**

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED RATIO ANALYSIS
MARCH 31, 2020

		YTD MARCH 2020	2018 S&P Comparison**	YTD September 2019	YTD September 2018	YTD September 2017
Statement of Operations:						
Salaries & Benefits/Net Pt Rev (%)	↓	65.6	57.5	67.4	69.1	68.6
Bad Debt Exp/Total Operating Revenue (%)	↑	42.4	N/A	41.1	34.6	19.2
Maximum Debt Service Coverage (x)	↓	-1.1	2.6	5.3	7.1	7.9
Maximum Debt Service/Total Operating Rev	↓	1.2	N/A	1.3	1.7	1.8
Interest Coverage (x) [1]						
EBITDA Margin (%) [1]	↓	-1.1	8.7	5.6	74.3	51.7
Operating Margin (%)	↓	-4.1	0.7	-2.0	-0.7	0.7
Profit Margin (%)	↓	-6.7	2.3	-1.1	-8.4	47.4
Balance Sheet:						
Average Age Net Fixed Assets (years)	↑	16.3	12.4	13.2	13.8	12.7
Cushion Ratio (x)	↑	16.0	13.3	15.5	15.0	11.3
Days' Cash on Hand	↓	63.9	159.1	65.5	71.4	58.9
Days in Accounts Receivable	↑	53.4	46.8	44.5	53.6	54.6
Cash Flow/Total Liabilities (%)	↓	-3.7	9.9	9.9	-0.3	190.2
Unrestricted Cash/Long-Term Debt (%)	↑	152.5	131.3	130.6	177.7	193.1
Long-Term Debt/Capitilization (%)	↑	20.4	34.3	19.7	18.0	18.6
Payment Period (days)	↓	62.1	N/A	63.1	57.9	51.0
Other Ratios:						
Inventory Turnover [2]	↓	8.7	17.0	9.4	12.0	5.5

****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

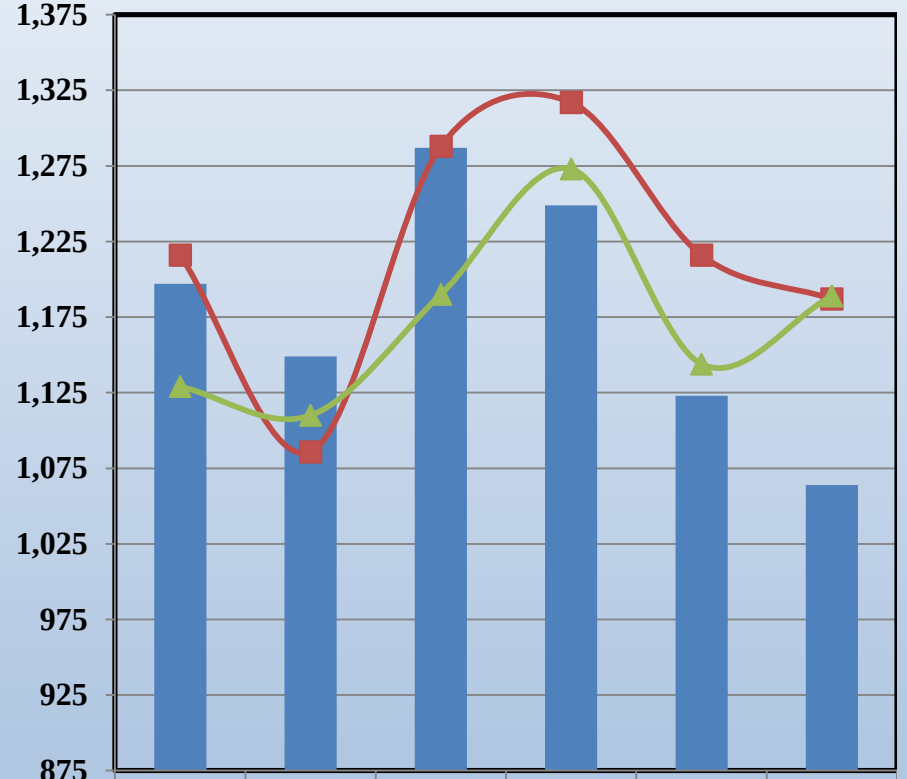
For the Month Ended

March 31, 2020


Volume

Admissions

Total – Adults and NICU

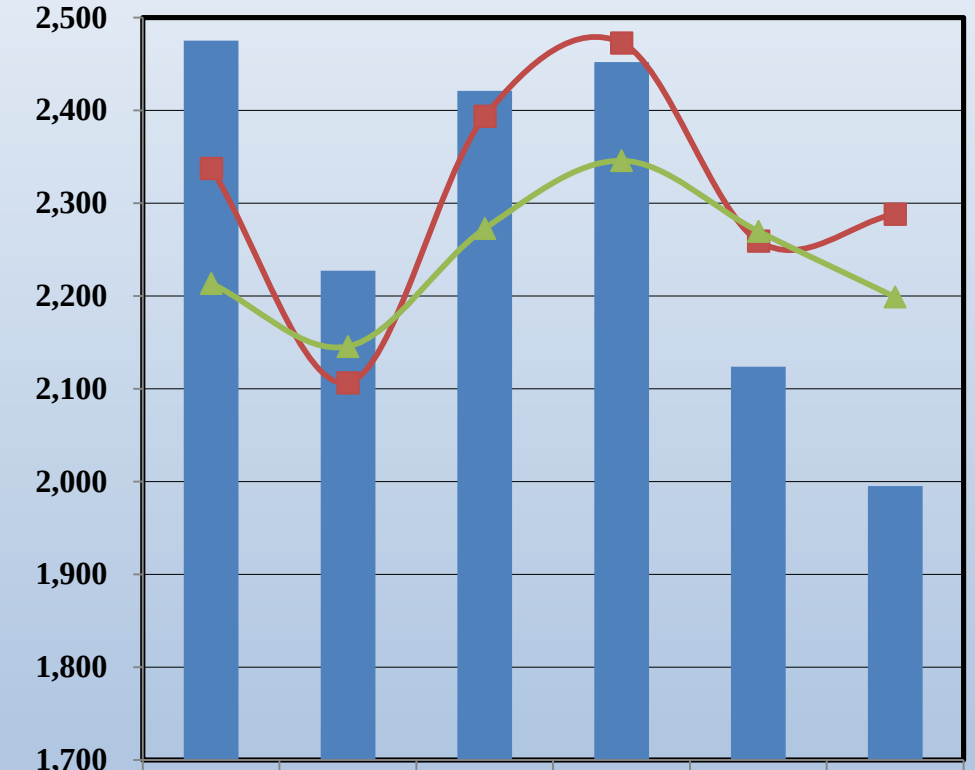


	Oct	Nov	Dec	Jan	Feb	Mar
Act	1,197	1,149	1,287	1,249	1,123	1,064
Bud	1,216	1,086	1,288	1,317	1,216	1,187
Prior	1,129	1,110	1,190	1,273	1,144	1,189

	Actual	Budget	Prior Year
Month	1,064	1,187	1,189
Var %		-10.4%	-10.5%
Year-To-Date	7,069	7,310	7,035
Var %		-3.3%	0.5%
Annualized	14,136	14,022	13,809
Var %		0.8%	2.4%

Adjusted Admissions

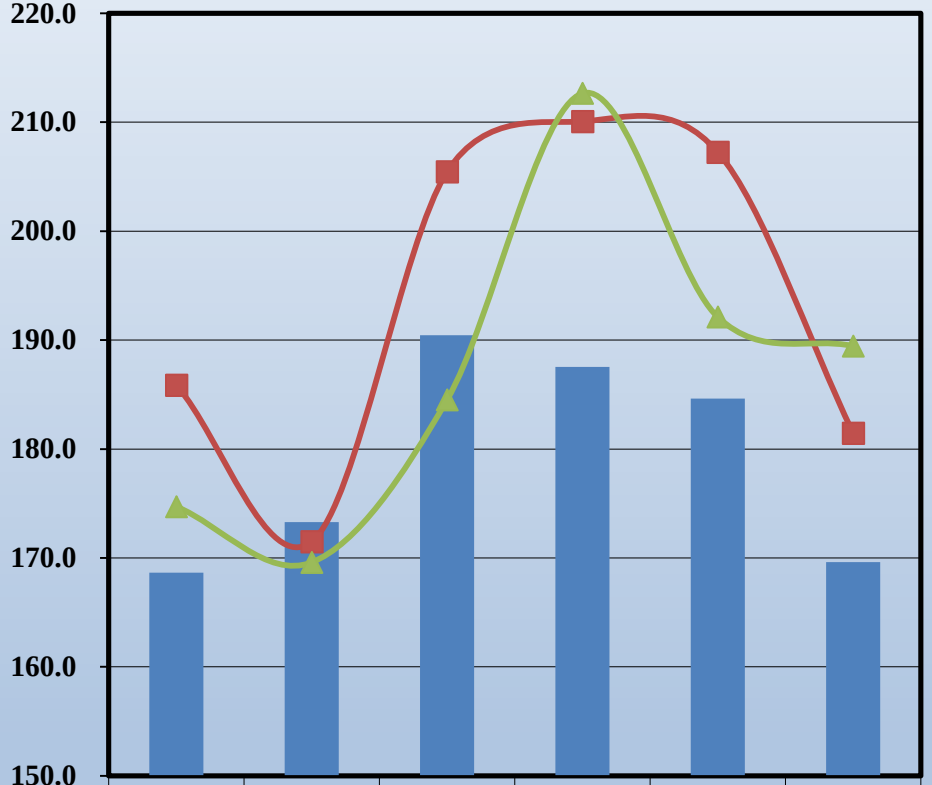
Including Acute & Rehab Unit



	Oct	Nov	Dec	Jan	Feb	Mar
Act	2,475	2,227	2,421	2,452	2,124	1,995
Bud	2,338	2,106	2,394	2,473	2,259	2,288
Prior	2,214	2,146	2,273	2,346	2,270	2,199

	Actual	Budget	Prior Year
Month	1,995	2,288	2,199
Var %		-12.8%	-9.3%
Year-To-Date	13,695	13,859	13,435
Var %		-1.2%	1.9%
Annualized	27,502	26,694	26,543
Var %		3.0%	3.6%

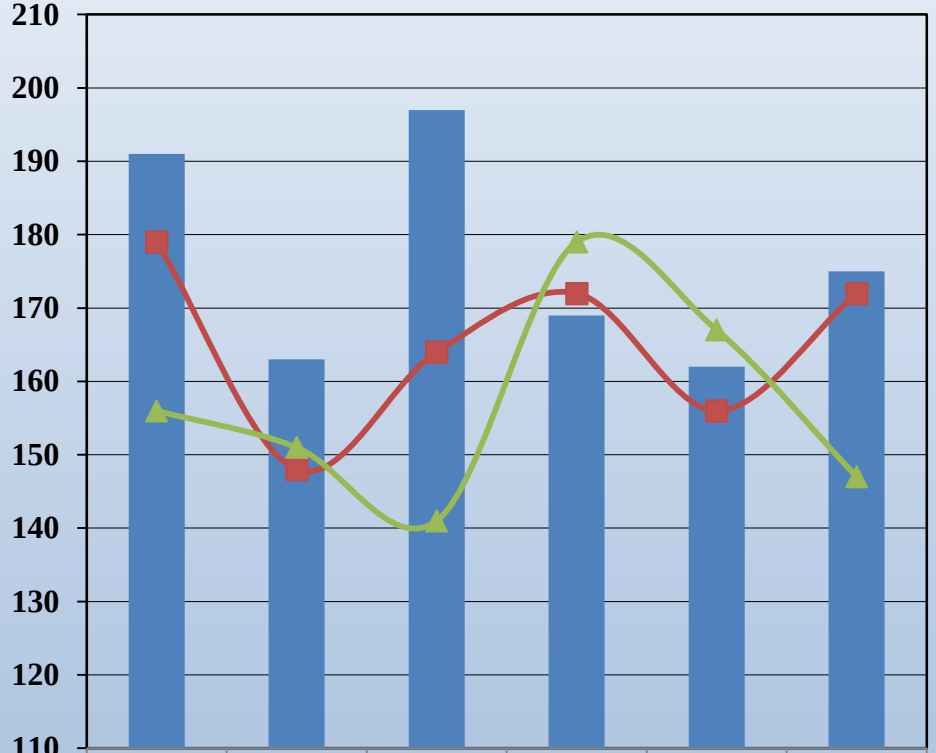
Average Daily Census



	Oct	Nov	Dec	Jan	Feb	Mar
Act	168.6	173.3	190.5	187.5	184.6	169.6
Bud	185.9	171.5	205.5	210.1	207.2	181.5
Prior	174.7	169.6	184.5	212.6	192.1	189.5

	Actual	Budget	Prior Year
Month	169.6	181.5	189.5
Var %		-6.5%	-10.5%
Year-To-Date	179.0	193.6	187.2
Var %		-7.5%	-4.4%
Annualized	177.5	186.7	180.8
Var %		-4.9%	-1.8%

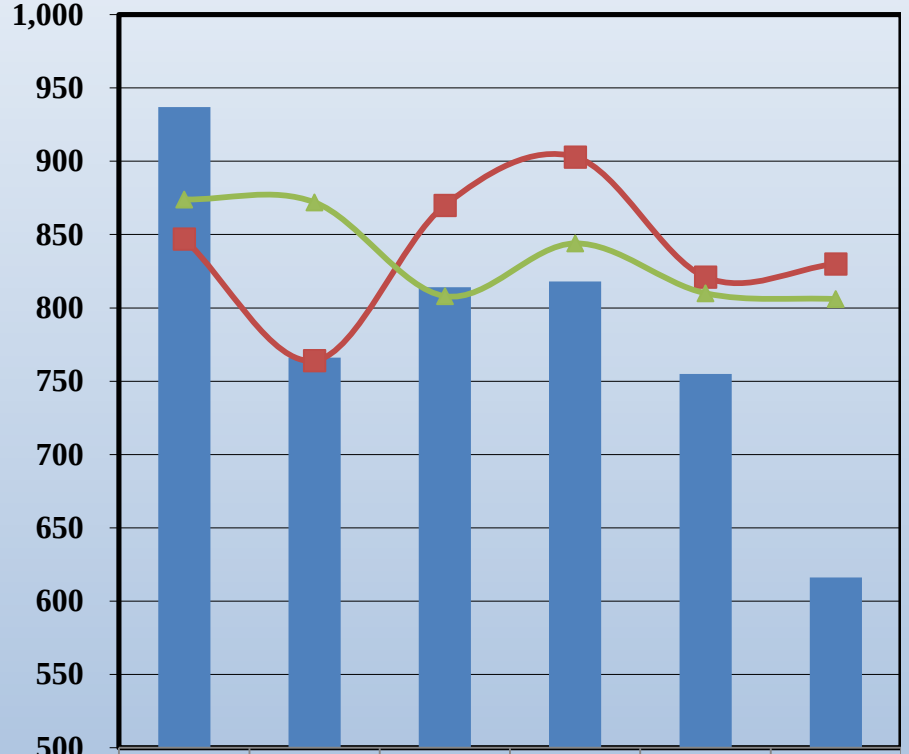
Deliveries



	Oct	Nov	Dec	Jan	Feb	Mar
Act	191	163	197	169	162	175
Bud	179	148	164	172	156	172
Prior	156	151	141	179	167	147

	Actual	Budget	Prior Year
Month	175	172	147
Var %		1.7%	19.0%
Year-To-Date	1,057	991	941
Var %		6.7%	12.3%
Annualized	2,163	1,962	1,863
Var %		10.2%	16.1%

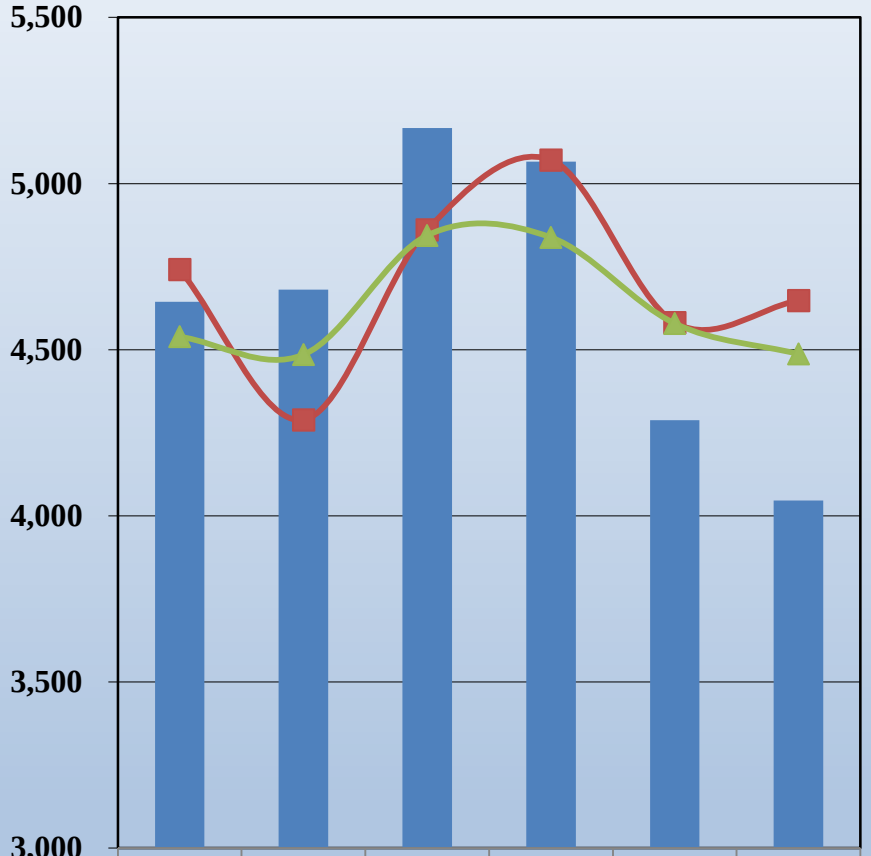
Total Surgical Cases



	Oct	Nov	Dec	Jan	Feb	Mar
Act	937	766	814	818	755	616
Bud	847	764	870	903	821	830
Prior	874	872	808	844	810	806

	Actual	Budget	Prior Year
Month	616	830	806
Var %		-25.8%	-23.6%
Year-To-Date	4,706	5,035	5,014
Var %		-6.5%	-6.1%
Annualized	9,821	10,656	10,257
Var %		-7.8%	-4.3%

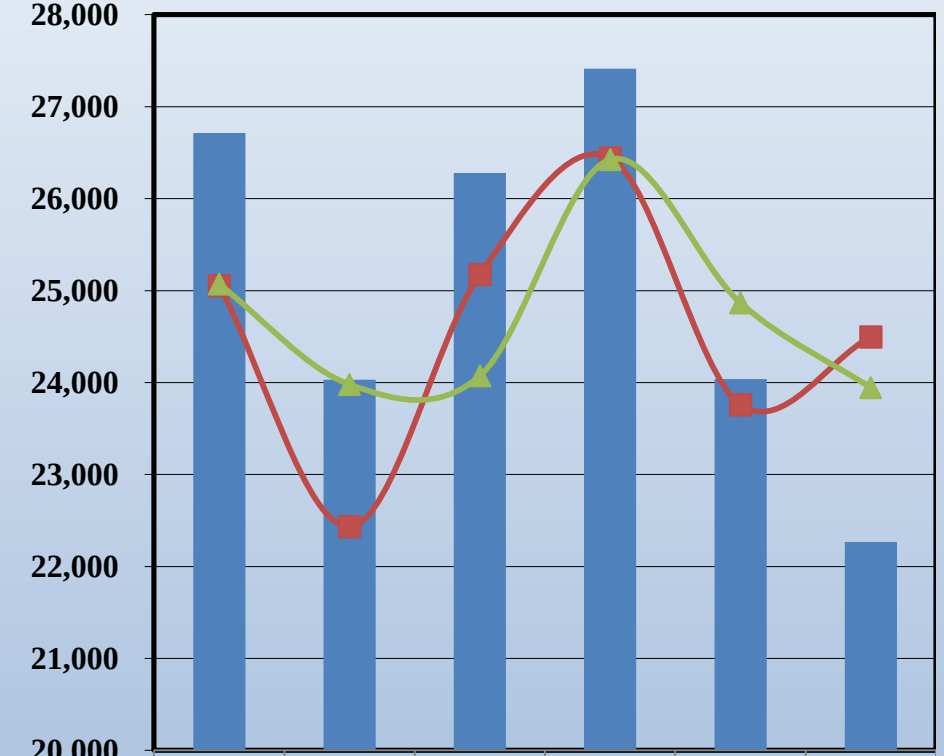
Emergency Room Visits



	Oct	Nov	Dec	Jan	Feb	Mar
Act	4,644	4,681	5,167	5,066	4,288	4,046
Bud	4,741	4,289	4,861	5,071	4,582	4,648
Prior	4,539	4,485	4,844	4,838	4,579	4,487

	Actual	Budget	Prior Year
Month	4,046	4,648	4,487
Var %		-13.0%	-9.8%
Year-To-Date	27,892	28,192	27,772
Var %		-1.1%	0.4%
Annualized	54,622	54,808	53,999
Var %		-0.3%	1.2%

Total Outpatient Occasions of Service

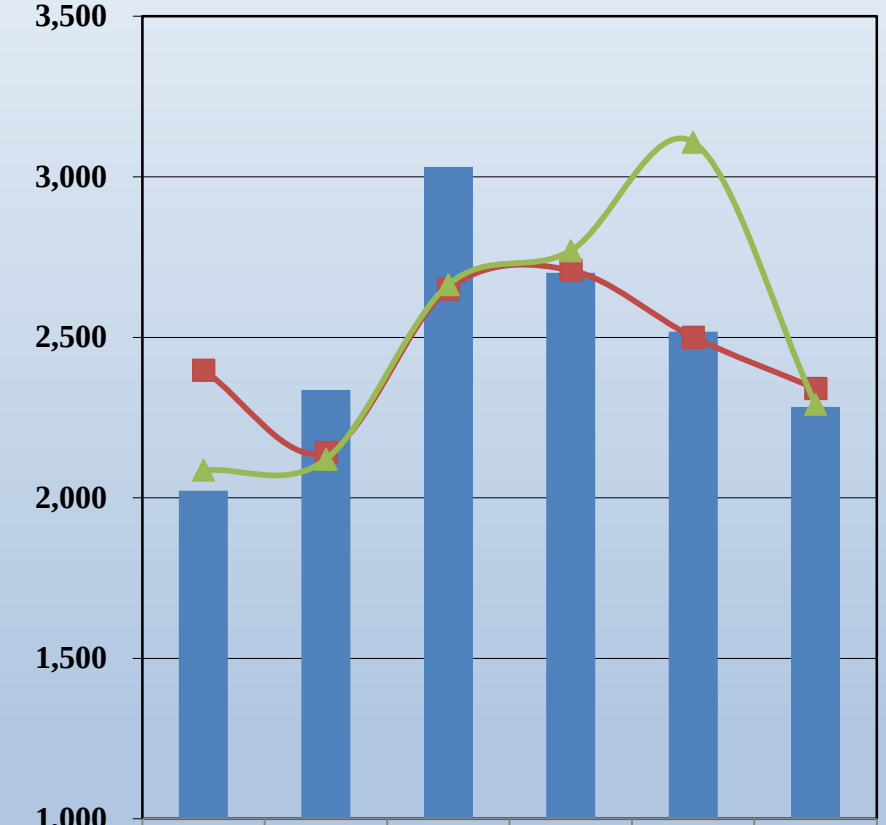


	Oct	Nov	Dec	Jan	Feb	Mar
Act	26,714	24,032	26,279	27,413	24,037	22,266
Bud	25,055	22,432	25,175	26,444	23,758	24,497
Prior	25,070	23,979	24,072	26,425	24,865	23,943

	Actual	Budget	Prior Year
Month	22,266	24,497	23,943
Var %		-9.1%	-7.0%
Year-To-Date	150,739	147,361	148,354
Var %		2.3%	1.6%
Annualized	297,367	286,148	290,310
Var %		3.9%	2.4%

Urgent Care Visits

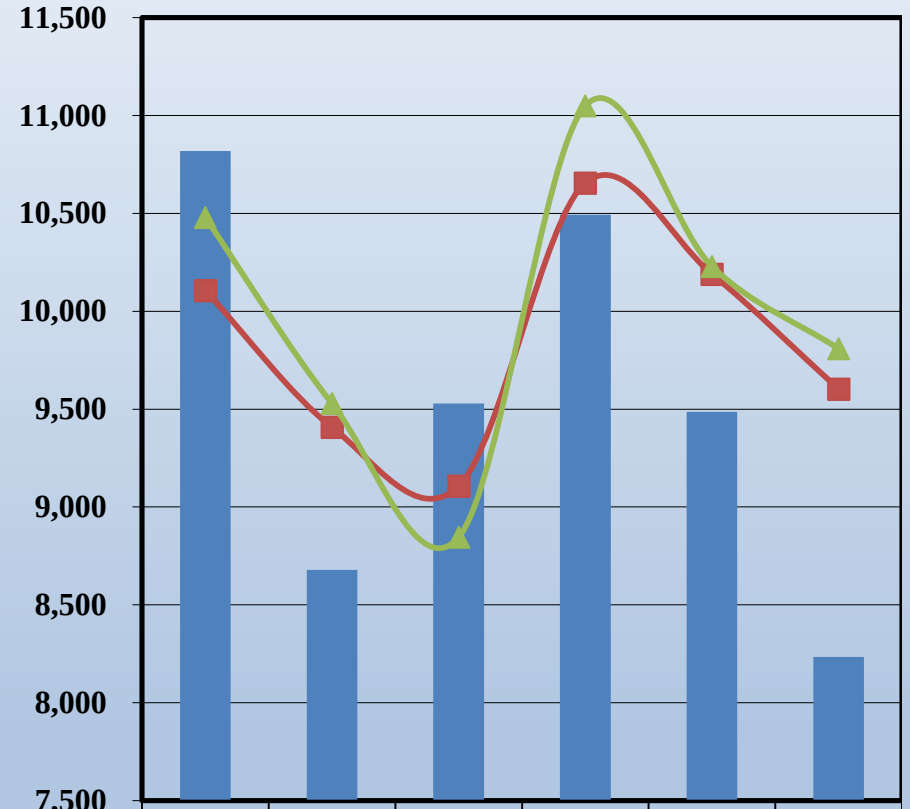
(JBS Clinic, West University & 42nd Street)



	Oct	Nov	Dec	Jan	Feb	Mar
Act	2,022	2,336	3,031	2,701	2,518	2,283
Bud	2,398	2,142	2,651	2,709	2,501	2,341
Prior	2,086	2,120	2,664	2,770	3,108	2,291

	Actual	Budget	Prior Year
Month	2,283	2,341	2,291
Var %		-2.5%	-0.3%
Year-To-Date	14,891	14,742	15,039
Var %		1.0%	-1.0%
Annualized	25,373	30,644	26,188
Var %		-17.2%	-3.1%

Total ProCare Office Visits



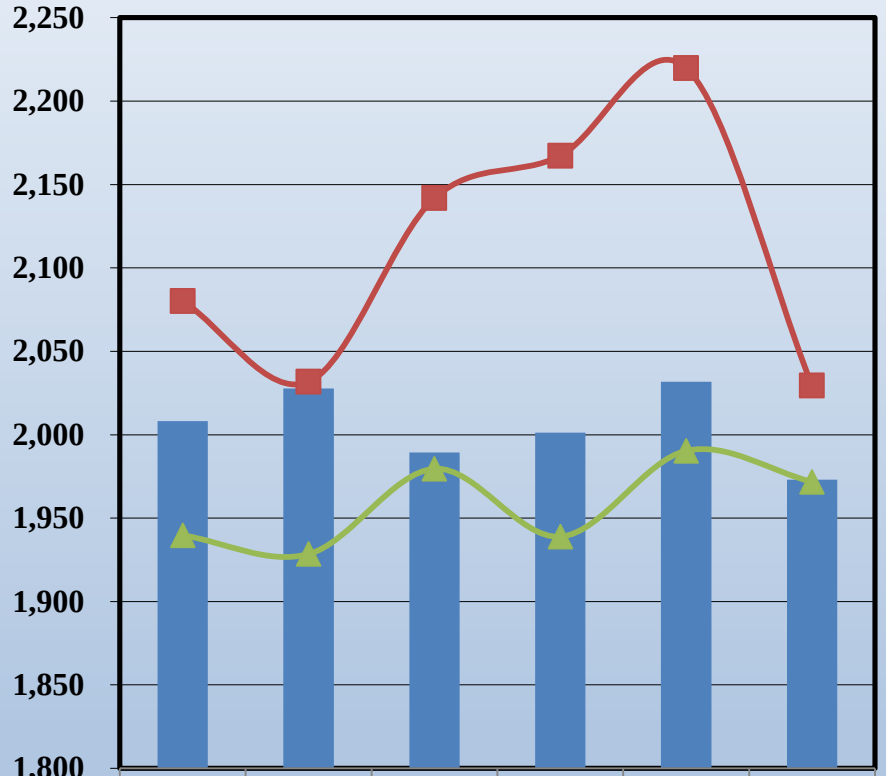
	Oct	Nov	Dec	Jan	Feb	Mar
Act	10,819	8,679	9,529	10,493	9,486	8,234
Bud	10,106	9,408	9,107	10,656	10,190	9,602
Prior	10,479	9,529	8,846	11,050	10,229	9,809

	Actual	Budget	Prior Year
Month	8,234	9,602	9,809
Var %		-14.3%	-16.1%
Year-To-Date	57,240	59,069	59,942
Var %		-3.1%	-4.5%
Annualized	116,528	119,432	118,764
Var %		-2.4%	-1.9%

Staffing

Blended FTE's

Including Contract Labor and Management Services

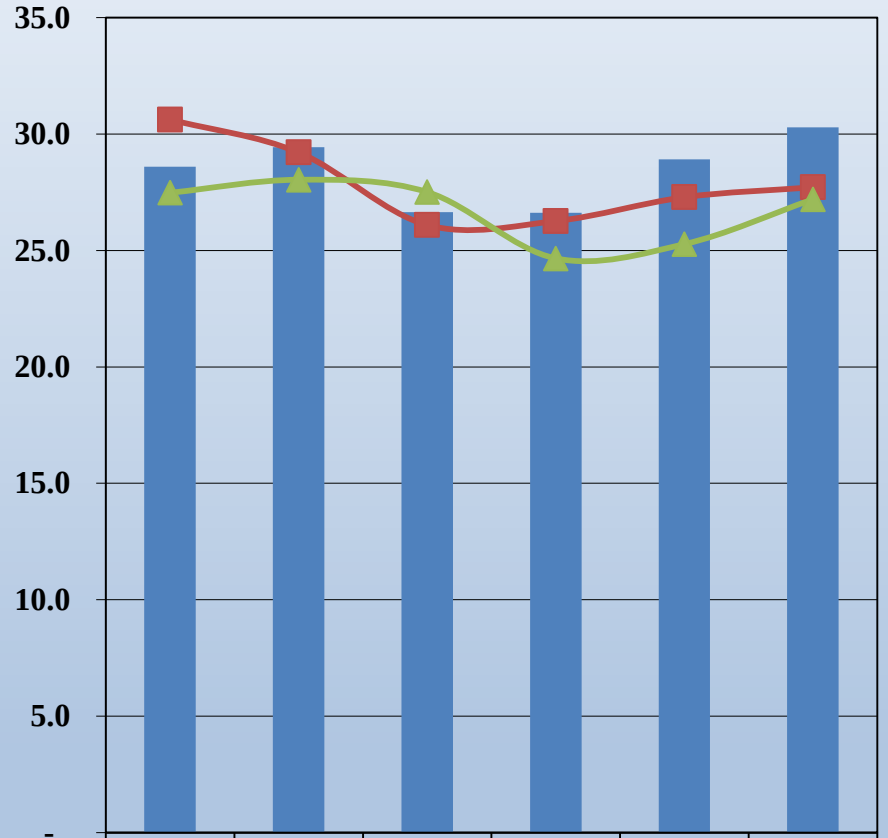


	Oct	Nov	Dec	Jan	Feb	Mar
Act	2,008	2,028	1,989	2,001	2,032	1,973
Bud	2,080	2,032	2,142	2,167	2,220	2,029
Prior	1,940	1,928	1,980	1,939	1,990	1,972

	Actual	Budget	Prior Year
Month	1,973	2,029	1,972
Var %		-2.8%	0.1%
Year-To-Date	2,004	2,111	1,958
Var %		-5.1%	2.3%
Annualized	1,986	2,071	1,933
Var %		-4.1%	2.7%

Paid Hours per Adjusted Patient Day

(Ector County Hospital District)



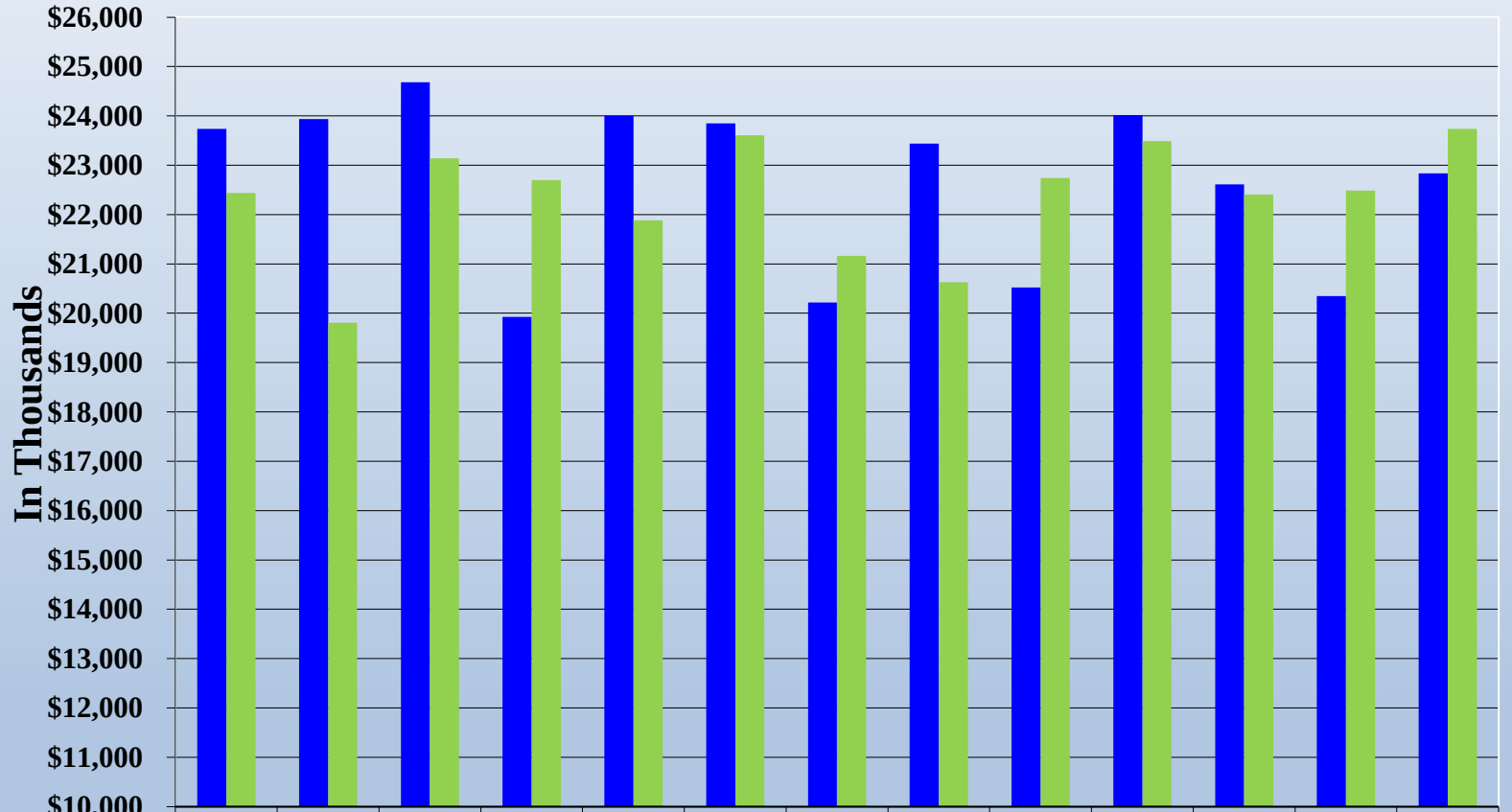
	Oct	Nov	Dec	Jan	Feb	Mar
Act	28.6	29.4	26.7	26.6	28.9	30.3
Bud	30.6	29.2	26.1	26.3	27.3	27.7
Prior	27.5	28.0	27.5	24.7	25.3	27.2

	Actual	Budget	Prior Year
Month	30.3	27.7	27.2
Var %		9.3%	11.3%
Year-To-Date	28.4	27.9	26.7
Var %		1.8%	6.4%
Annualized	28.2	28.0	26.9
Var %		0.7%	4.8%


Accounts Receivable

Total AR Cash Receipts

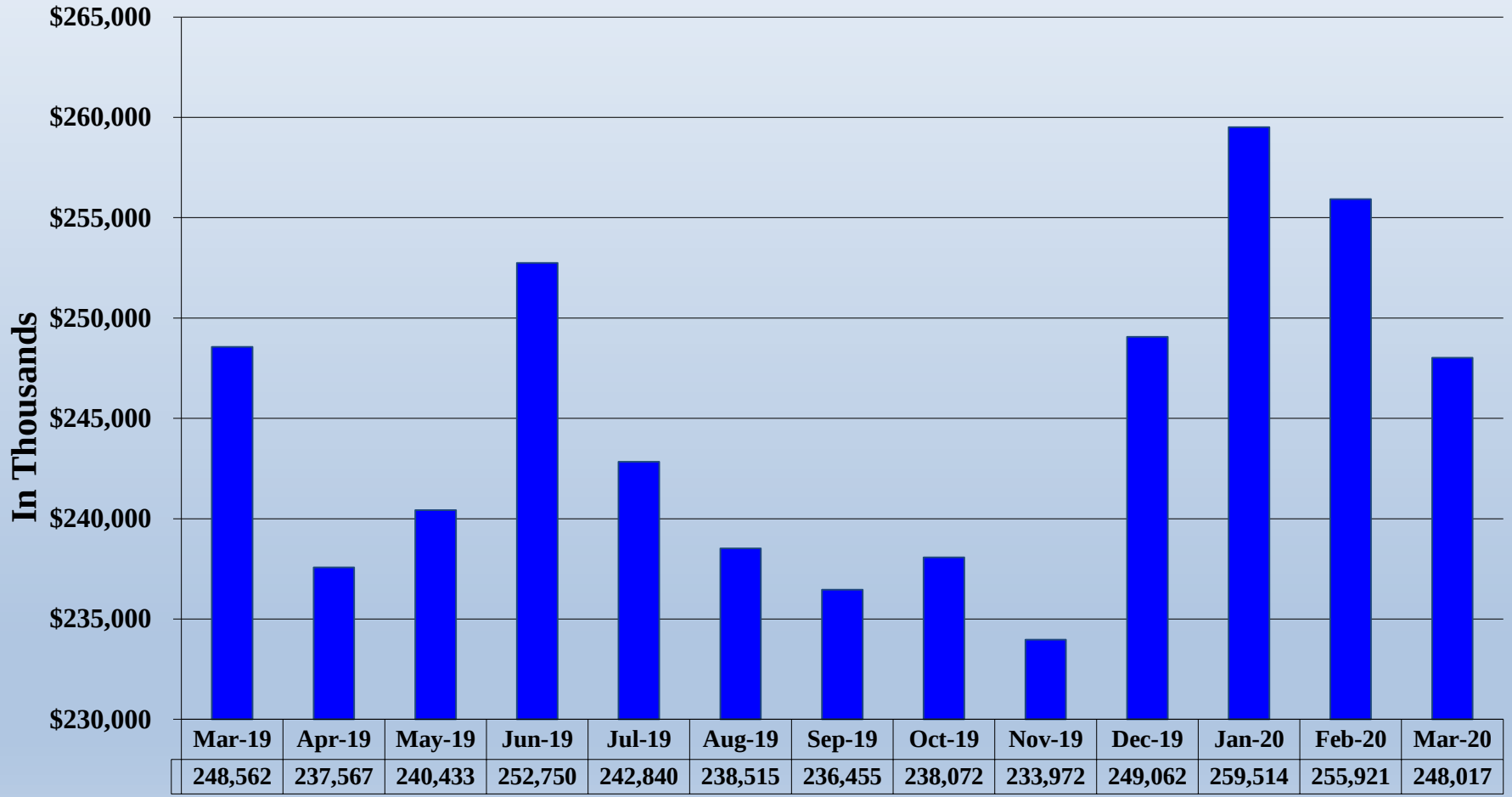
13 Month Trending



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CY	23,739	23,935	24,683	19,923	24,007	23,850	20,215	23,438	20,519	24,018	22,609	20,345	22,838
PY	22,436	19,808	23,138	22,700	21,887	23,609	21,160	20,631	22,739	23,486	22,410	22,485	23,739

Total Accounts Receivable – Gross

Thirteen Month Trending

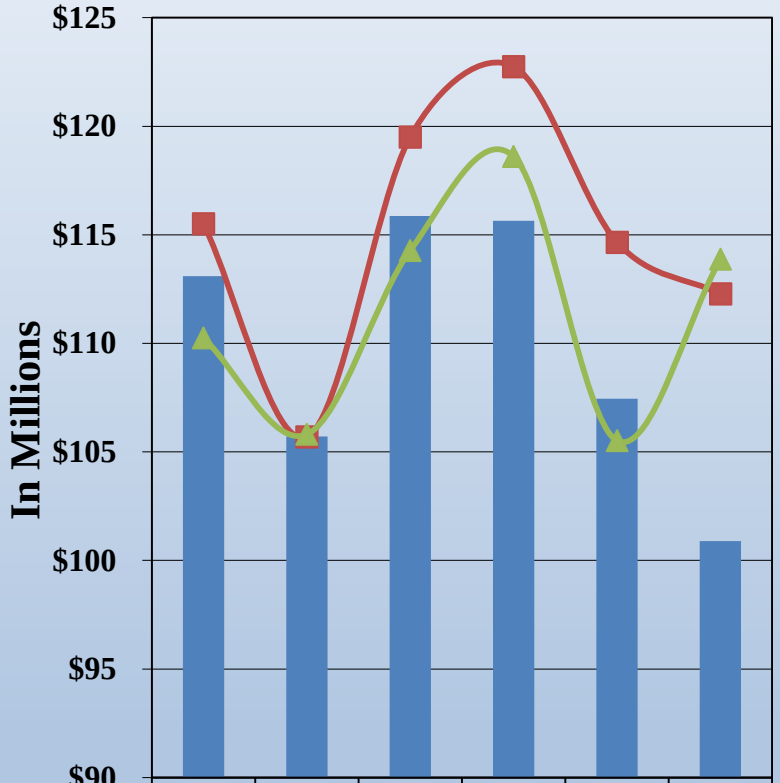


	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	248,562	237,567	240,433	252,750	242,840	238,515	236,455	238,072	233,972	249,062	259,514	255,921	248,017

Revenues & Revenue Deductions

Total Patient Revenues

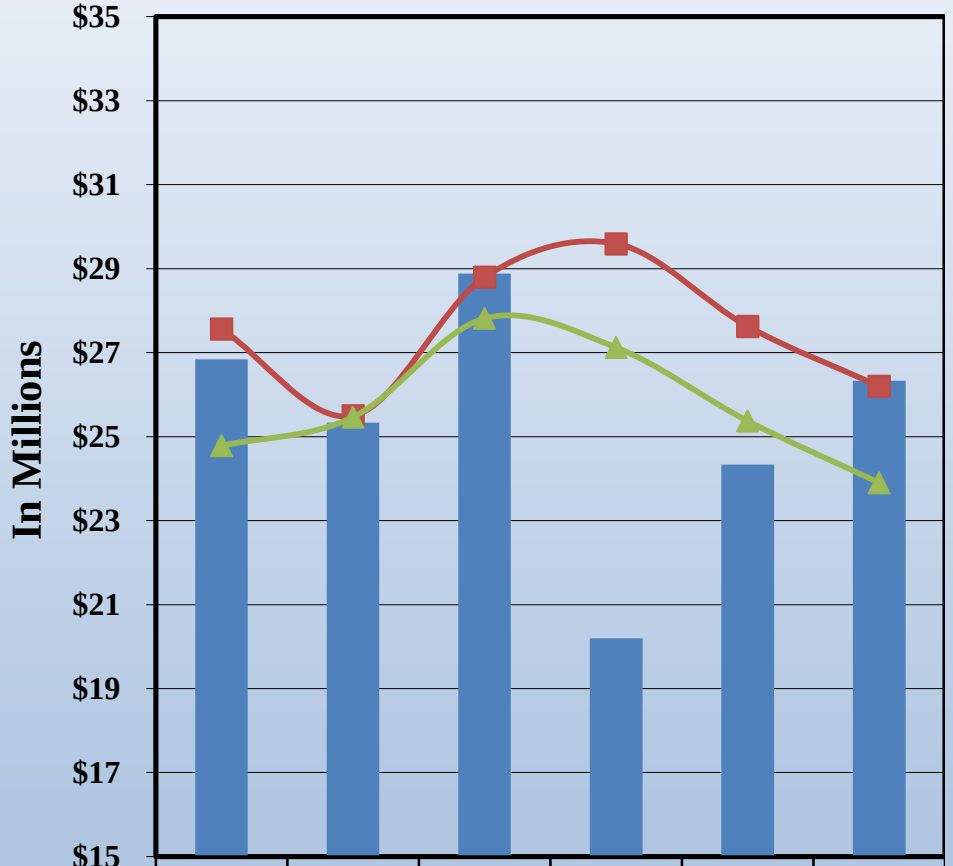
(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar
Act	$113.1	$105.7	$115.9	$115.7	$107.4	$100.9
Bud	$115.5	$105.7	$119.5	$122.8	$114.7	$112.3
Prior	$110.2	$105.8	$114.3	$118.6	$105.5	$113.9

	Actual	Budget	Prior Year
Month	$ 100.9	$ 112.3	$ 113.9
Var %		-10.1%	-11.4%
Year-To-Date	$ 658.7	$ 690.4	$ 668.3
Var %		-4.6%	-1.4%
Annualized	$ 1,326.4	$ 1,336.9	$ 1,296.8
Var %		-0.8%	2.3%

Total Net Patient Revenues



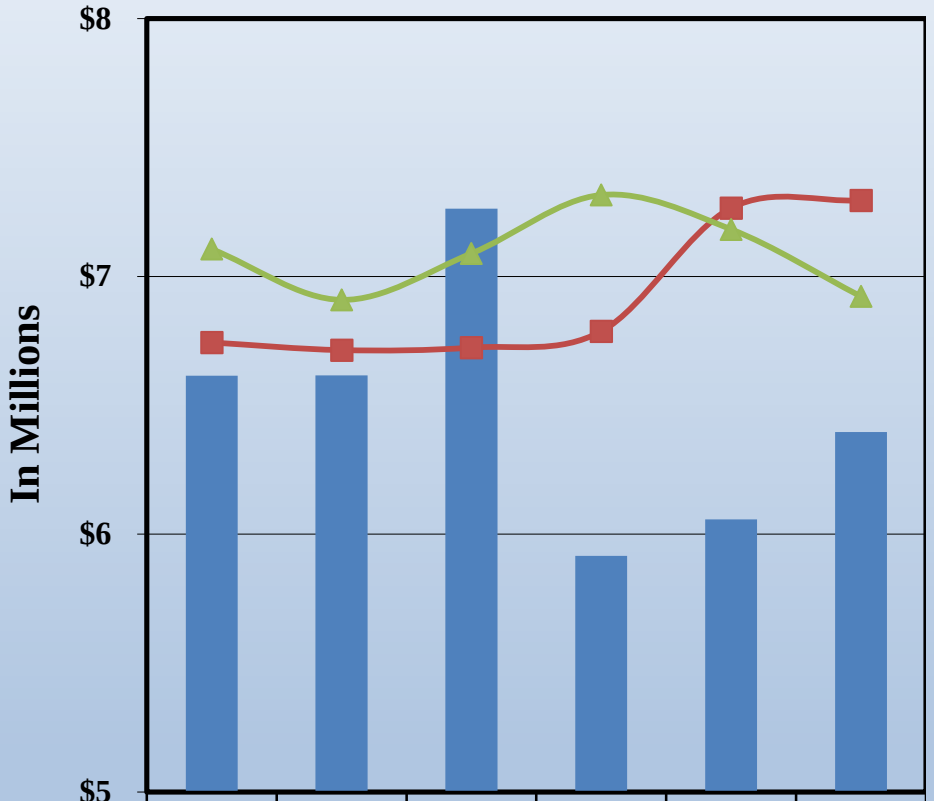
	Oct	Nov	Dec	Jan	Feb	Mar
Act	$26.8	$25.3	$28.9	$20.2	$24.3	$26.3
Bud	$27.6	$25.5	$28.8	$29.6	$27.6	$26.2
Prior	$24.8	$25.5	$27.8	$27.1	$25.4	$23.9

	Actual	Budget	Prior Year
Month	$ 26.3	$ 26.2	$ 23.9
Var %		0.5%	10.1%
Year-To-Date	$ 151.9	$ 165.3	$ 154.5
Var %		-8.1%	-1.6%
Annualized	$ 288.4	$ 308.5	$ 293.8
Var %		-6.5%	-1.8%

Other Revenue

(Ector County Hospital District)

Including Tax Receipts, Interest & Other Operating Income



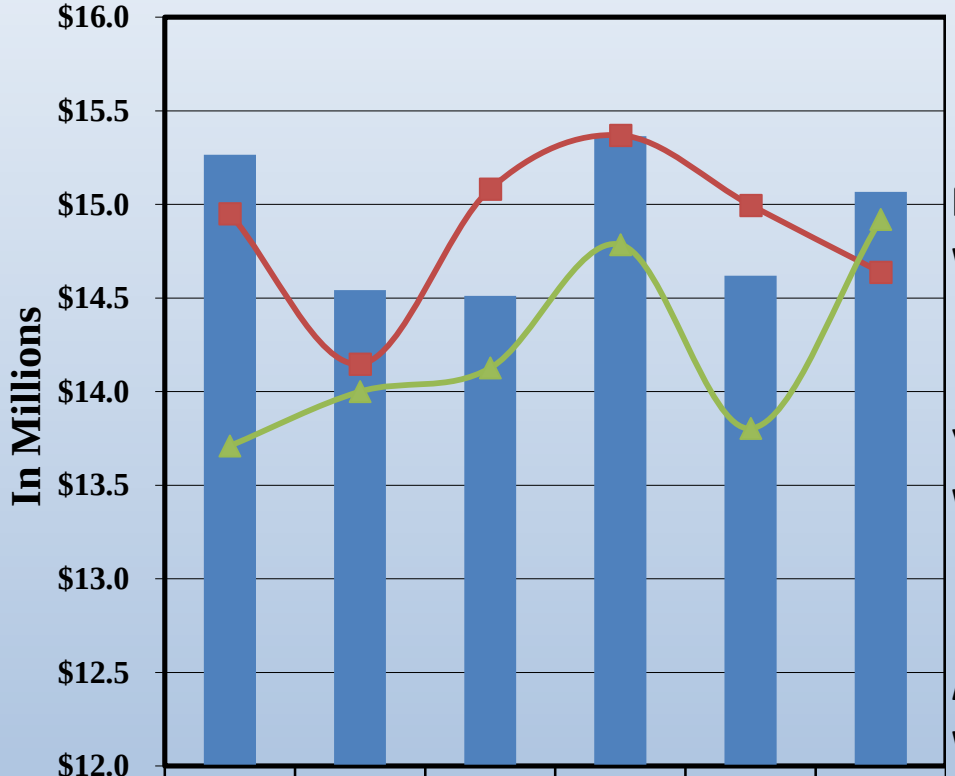
	Oct	Nov	Dec	Jan	Feb	Mar
Act	$6.6	$6.6	$7.3	$5.9	$6.1	$6.4
Bud	$6.7	$6.7	$6.7	$6.8	$7.3	$7.3
Prior	$7.1	$6.9	$7.1	$7.3	$7.2	$6.9

	Actual	Budget	Prior Year
Month	$ 6.4	$ 7.3	$ 6.9
Var %		-12.3%	-7.6%
Year-To-Date	$ 38.9	$ 41.5	$ 42.5
Var %		-6.4%	-8.6%
Annualized	$ 81.1	$ 84.1	$ 86.6
Var %		-3.5%	-6.3%

Operating Expenses

Salaries, Wages & Contract Labor

(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar
Act	$15.3	$14.5	$14.5	$15.4	$14.6	$15.1
Bud	$15.0	$14.1	$15.1	$15.4	$15.0	$14.6
Prior	$13.7	$14.0	$14.1	$14.8	$13.8	$14.9

	Actual	Budget	Prior Year
Month	$ 15.1	$ 14.6	$ 14.9
Var %		3.4%	1.3%
Year-To-Date	$ 89.4	$ 89.2	$ 85.3
Var %		0.2%	4.8%
Annualized	$ 176.6	$ 171.8	$ 167.5
Var %		2.8%	5.4%

Employee Benefit Expense

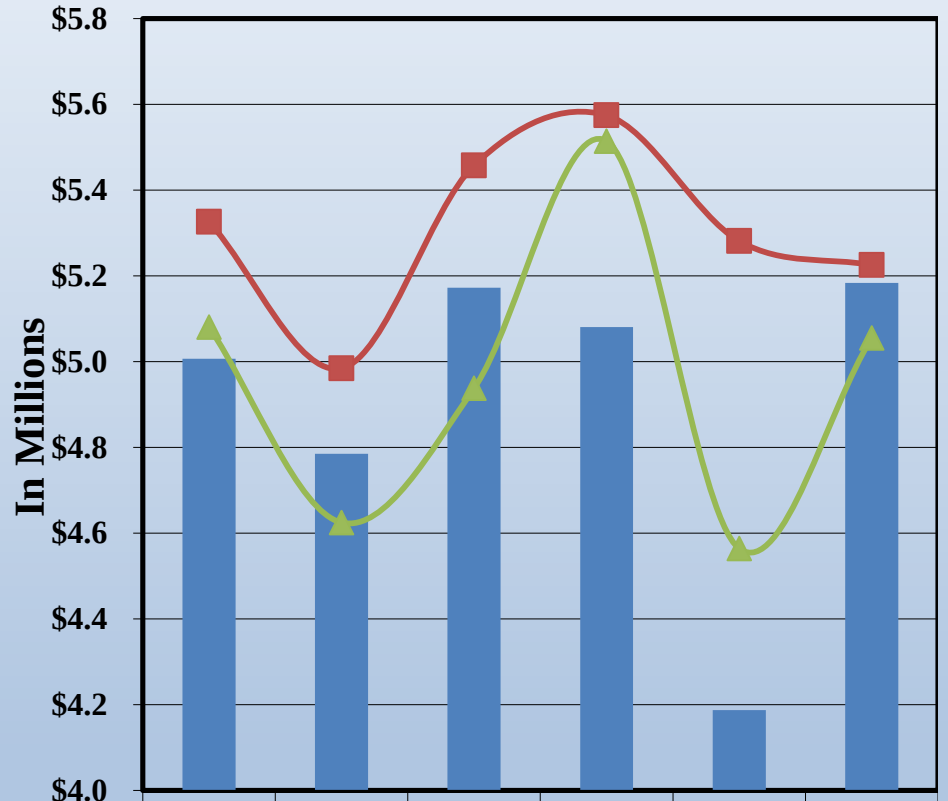
(Ector County Hospital District)

	Oct	Nov	Dec	Jan	Feb	Mar
Act	$2.9	$2.5	$3.7	$3.0	$3.3	$1.8
Bud	$3.0	$2.9	$3.1	$3.1	$3.0	$3.1
Prior	$3.2	$2.8	$4.1	$2.3	$2.5	$3.1

	Actual	Budget	Prior Year
Month	$ 1.8	$ 3.1	$ 3.1
Var %		-41.4%	-41.7%
Year-To-Date	$ 17.2	$ 18.2	$ 18.0
Var %		-5.5%	-4.5%
Annualized	$ 36.6	$ 37.4	$ 27.0
Var %		-2.1%	35.6%

Supply Expense

(Ector County Hospital District)

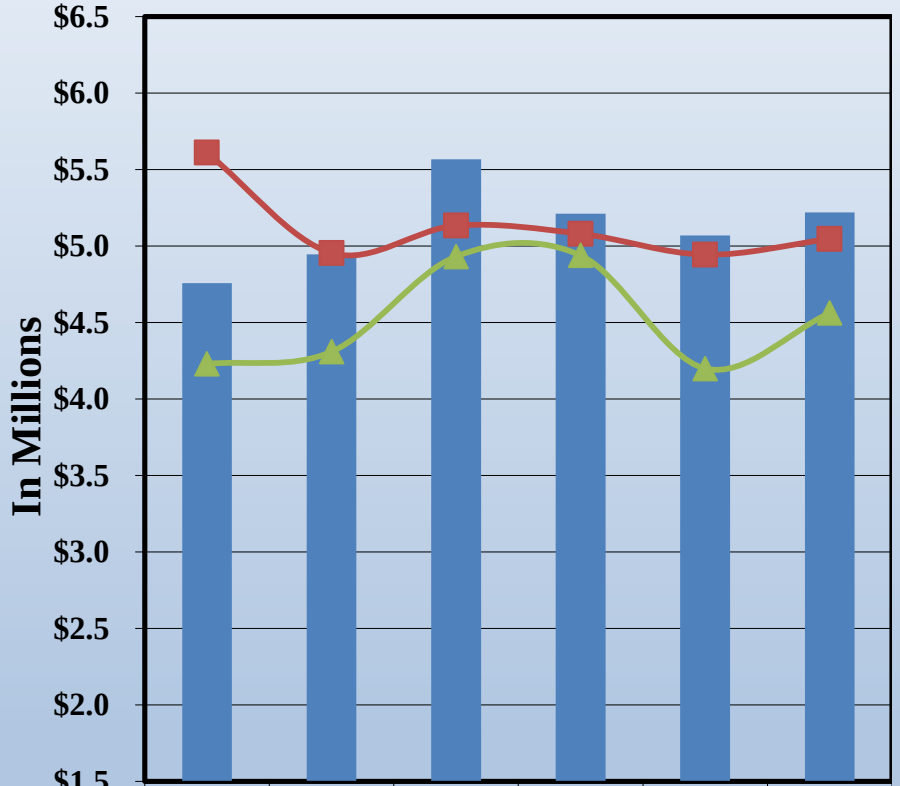


	Oct	Nov	Dec	Jan	Feb	Mar
Act	$5.0	$4.8	$5.2	$5.1	$4.2	$5.2
Bud	$5.3	$5.0	$5.5	$5.6	$5.3	$5.2
Prior	$5.1	$4.6	$4.9	$5.5	$4.6	$5.1

	Actual	Budget	Prior Year
Month	$ 5.2	$ 5.2	$ 5.1
Var %		-0.8%	2.5%
Year-To-Date	$ 29.4	$ 31.9	$ 29.8
Var %		-7.6%	-1.2%
Annualized	$ 58.0	$ 61.2	$ 57.7
Var %		-5.2%	0.5%

Purchased Services

(Ector County Hospital District)

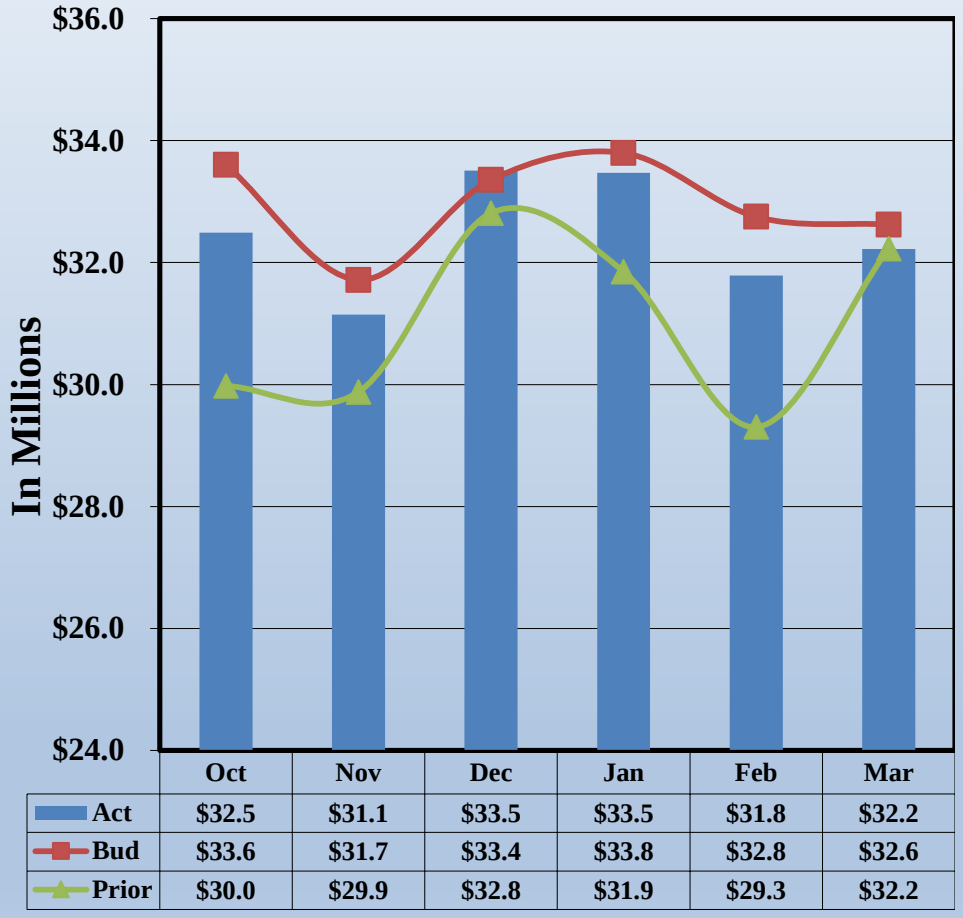


	Oct	Nov	Dec	Jan	Feb	Mar
Act	$4.8	$4.9	$5.6	$5.2	$5.1	$5.2
Bud	$5.6	$5.0	$5.1	$5.1	$4.9	$5.0
Prior	$4.2	$4.3	$4.9	$4.9	$4.2	$4.6

	Actual	Budget	Prior Year
Month	$ 5.2	$ 5.0	$ 4.6
Var %		3.4%	14.4%
Year-To-Date	$ 30.8	$ 30.8	$ 27.2
Var %		0.0%	13.2%
Annualized	$ 59.9	$ 53.1	$ 50.0
Var %		12.8%	19.8%

Total Operating Expense

(Ector County Hospital District)



	Oct	Nov	Dec	Jan	Feb	Mar
Act	$32.5	$31.1	$33.5	$33.5	$31.8	$32.2
Bud	$33.6	$31.7	$33.4	$33.8	$32.8	$32.6
Prior	$30.0	$29.9	$32.8	$31.9	$29.3	$32.2

	Actual	Budget	Prior Year
Month	$ 32.2	$ 32.6	$ 32.2
Var %		-1.2%	0.0%
Year-To-Date	$ 194.6	$ 197.8	$ 186.1
Var %		-1.6%	4.6%
Annualized	$ 387.5	$ 375.5	$ 354.9
Var %		3.2%	9.2%

Operating EBIDA

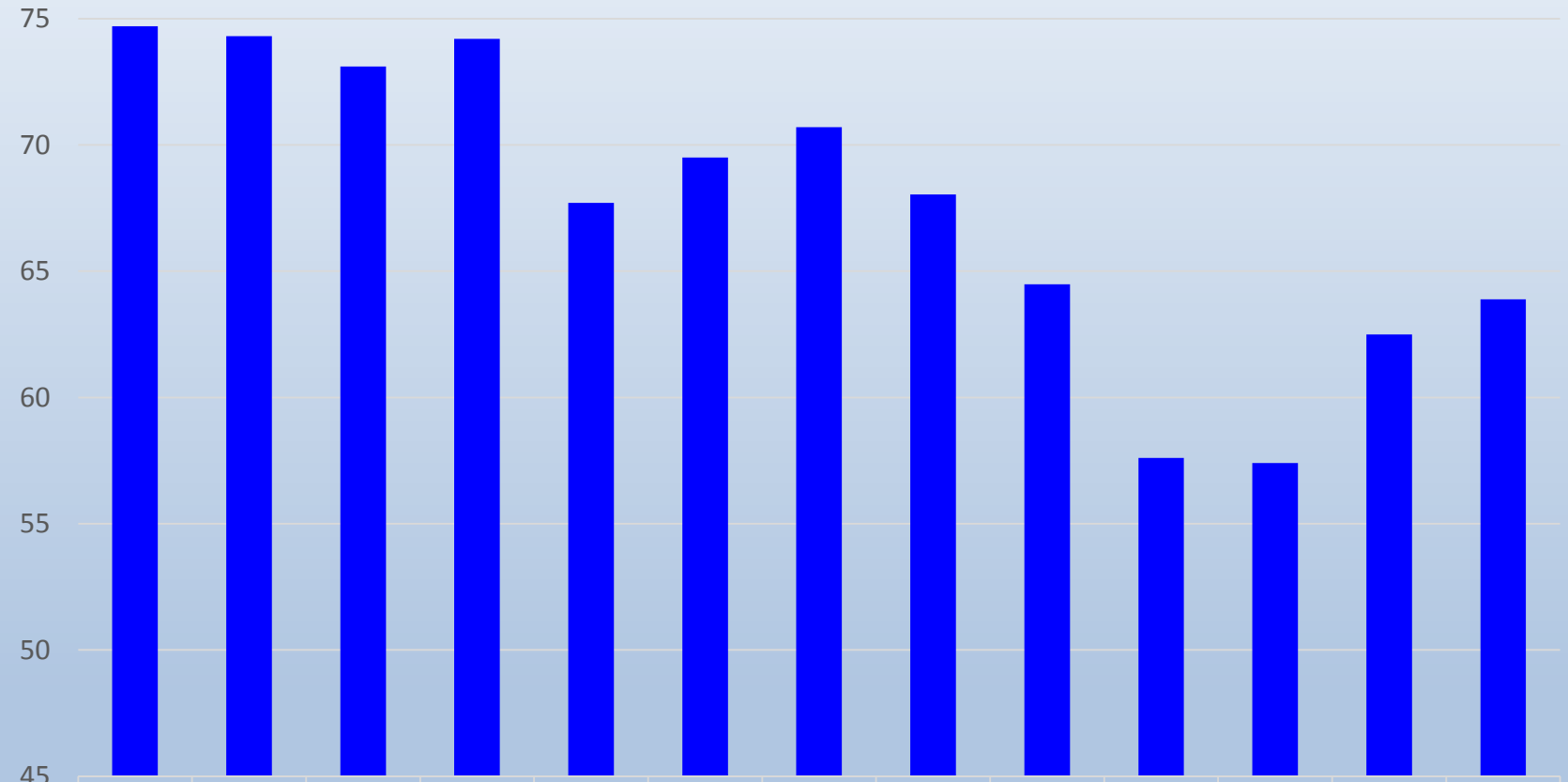
Ector County Hospital District Operations

	Oct	Nov	Dec	Jan	Feb	Mar
Act	$1.0	$1.0	$2.6	$(7.3)	$(1.2)	$0.4
Bud	$0.8	$0.6	$2.2	$2.6	$2.2	$0.9
Prior	$1.6	$2.6	$2.2	$2.7	$3.2	$(1.3)

	Actual	Budget	Prior Year
Month	$ 0.4	$ 0.9	$ (1.3)
Var %		-55.6%	-130.8%
Year-To-Date	$ (3.5)	$ 9.3	$ 11.0
Var %		-137.6%	-131.8%
Annualized	$ (19.1)	$ 17.5	$ 29.6
Var %		-209.1%	-164.5%

Days Cash on Hand

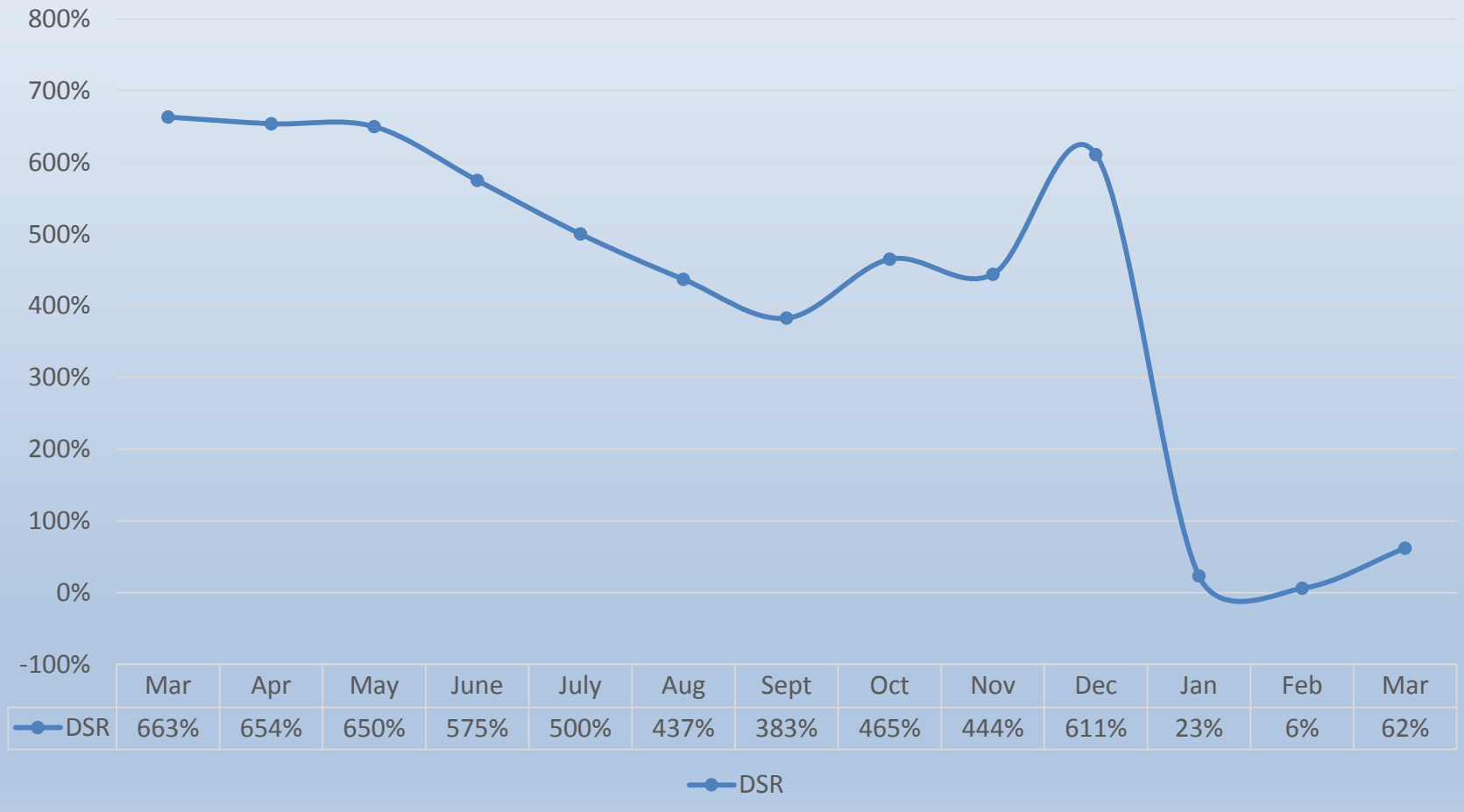
Thirteen Month Trending



	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Jan '20	Feb '20	Mar '20
Days	74.7	74.3	73.1	74.2	67.7	69.5	70.7	68.0	64.5	57.6	57.4	62.5	63.9

13 Month Debt Service Ratio

Must be Greater Than 110%



	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
DSR	663%	654%	650%	575%	500%	437%	383%	465%	444%	611%	23%	6%	62%


mch
mch


mch
TeleCare
A Member of Medical Center Health System

Medical Center Health System

Odessa, Texas

Increasing Access to Quality Care via Telehealth in the Permian Basin – MCH Telecare

PROGRAM OWNER

MASON RAVEN, MHA, CLSSBB

ADMINISTRATIVE FELLOW

EXECUTIVE OWNER

TONI LAND, MBA, BSN, RN, CPXP

CHIEF PATIENT EXPERIENCE & QUALITY OFFICER

Agenda

- Medical Center Health System
- Regional Population Health
- Scope of Telehealth
- MCH Telecare
- Business Development & Strategy
- Proforma
- Funding

Medical Center Health System (MCHS)

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 – Integrity

C – Customer Centered

A – Accountability

R – Respect

E – Excellence

Medical Center Health System Cont'd

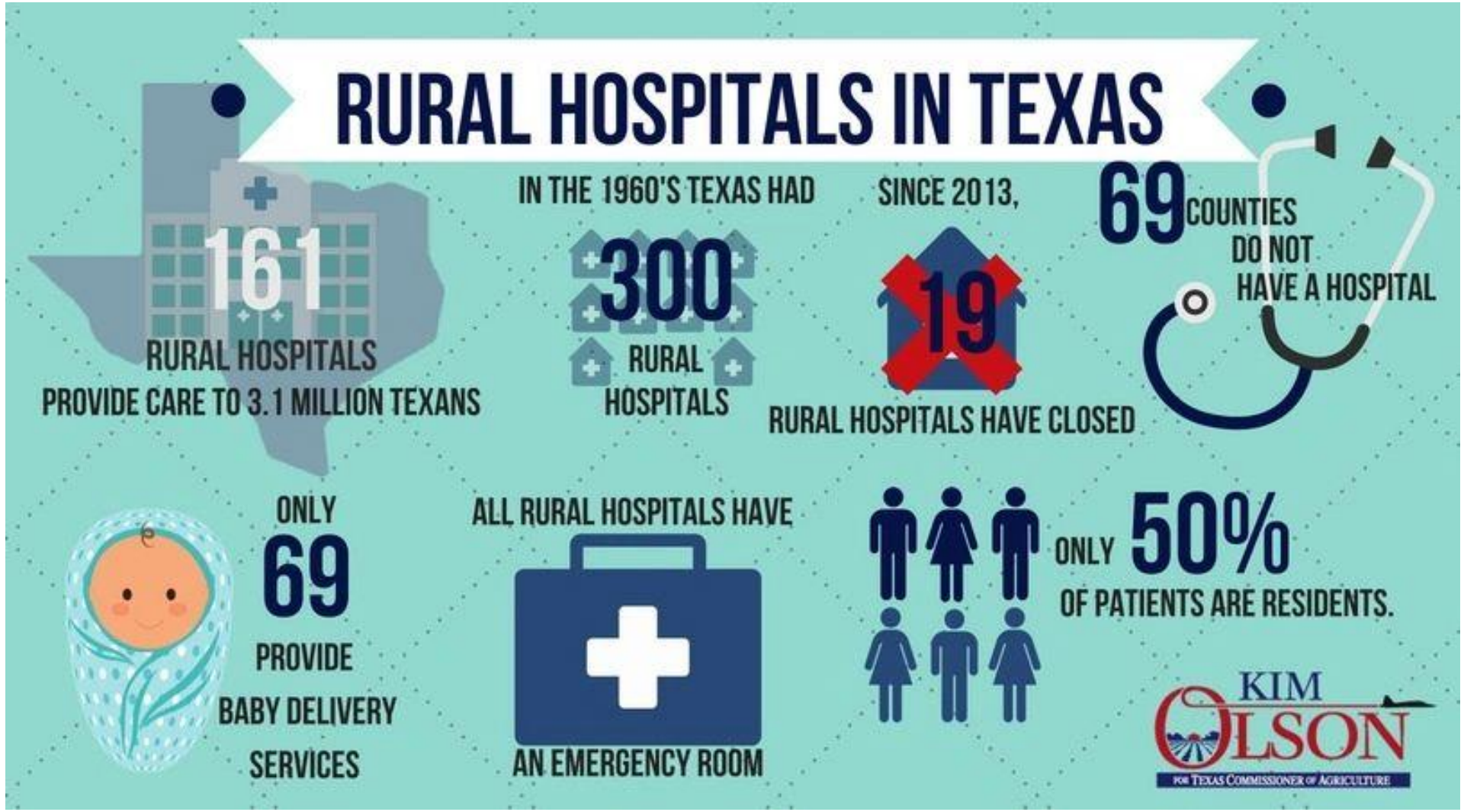
- 402-bed acute care hospital
- 3 Urgent Cares
- 2 Retail Clinics
- 15 Outpatient Clinics
- Hospital District serving 19 Counties across 36,000 square miles

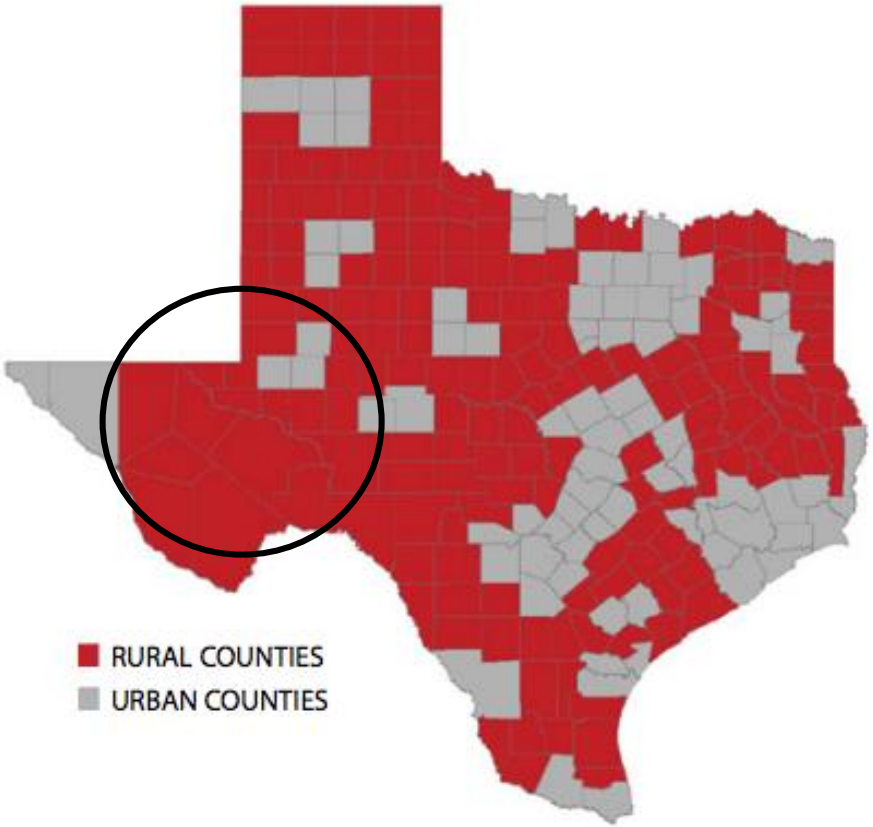
Capabilities

- Level II Trauma Center
- Level III NICU
- Chest Pain Center
- Stroke & STEMI Designations

By the Year Numbers

- 600,000+ People Served
- 100,000+ Lives Impacted
- 4,000+ Deliveries
- 60,000+ ED Visits
- 2400 FTEs


RURAL HOSPITALS IN TEXAS
161
RURAL HOSPITALS
PROVIDE CARE TO 3.1 MILLION TEXANS
IN THE 1960'S TEXAS HAD
300
RURAL
HOSPITALS
SINCE 2013,
19
RURAL HOSPITALS HAVE CLOSED
69
COUNTIES
DO NOT
HAVE A HOSPITAL
ONLY
69
PROVIDE
BABY DELIVERY
SERVICES
ALL RURAL HOSPITALS HAVE
AN EMERGENCY ROOM
ONLY 50%
OF PATIENTS ARE RESIDENTS.
KIM
OLSON
FOR TEXAS COMMISSIONER OF AGRICULTURE



TEXAS BY THE NUMBERS

Texas has an estimated population of 27,862,596 people, and 11 percent live in one of Texas's 172 rural counties.

The poverty rate in rural Texas is 18.1 percent, compared with 15.3 percent in urban areas of the state.

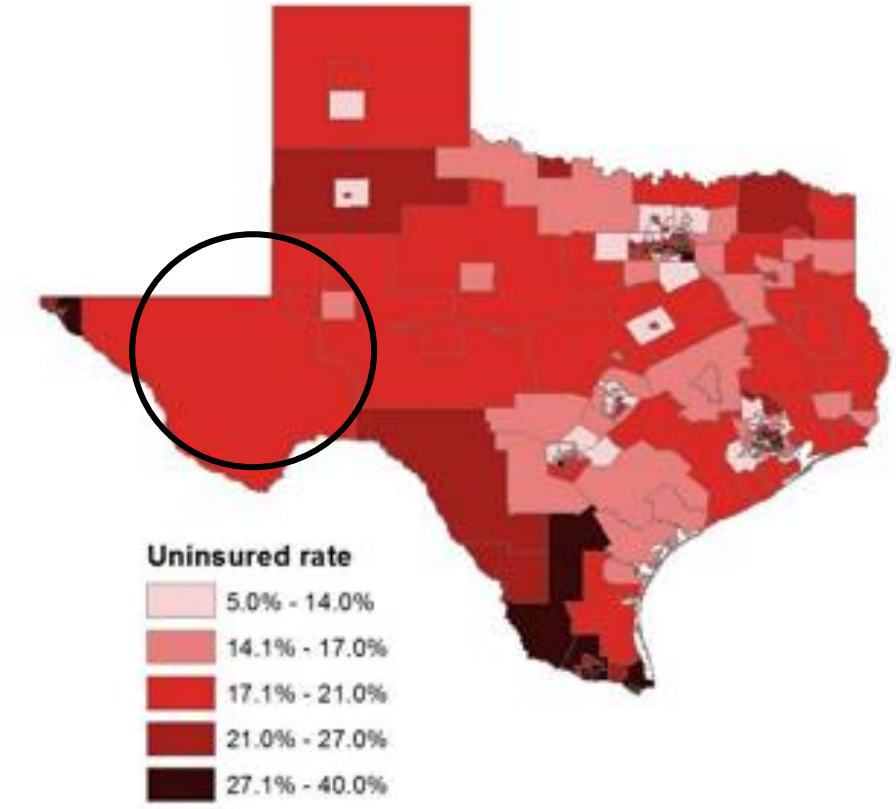
21.9 percent of the rural population has not completed high school, while 17.5 percent of the urban population lacks a high school diploma.

9.1 percent of rural Texas residents are U.S. military veterans, and 11.3 percent of the rural population under age 65 lives with a disability.

57 percent of the state's rural population is Non-Hispanic White, 7.9 percent is Black/African-American, 32.9 percent is Hispanic/Latino, 0.3 percent is American Indian/Alaska Native and 0.5 percent is Asian.

FIGURE 1

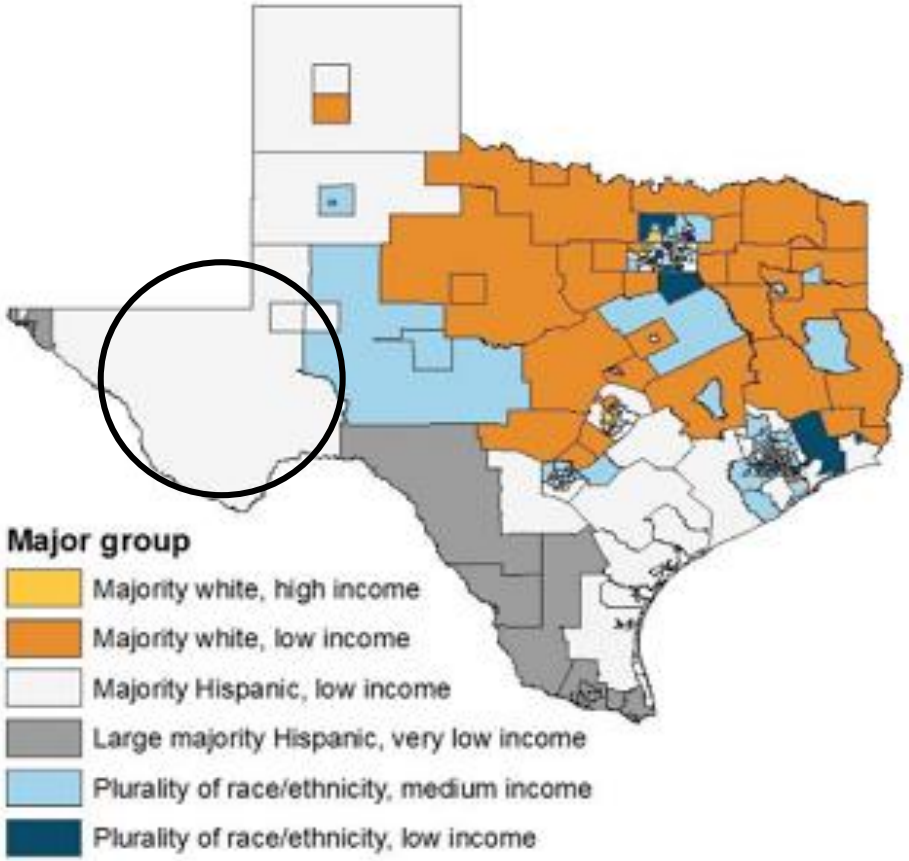
Local Area Uninsurance Rates of Nonelderly Texans, 2018



Source: Urban Institute, HIPSM 2018.

FIGURE 2

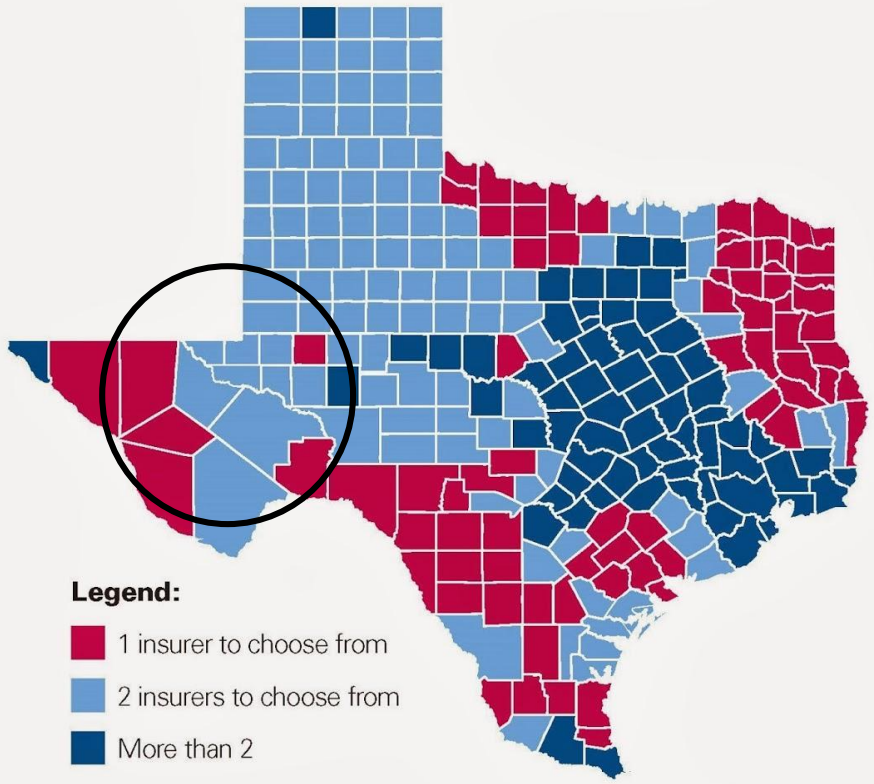
Local Area Variation in the Characteristics of Uninsured Texans, 2018



Source: Urban Institute, HIPSM 2018.

Texans' Choices of Marketplace Health Insurers

Of the 254 counties in Texas, 76 of them had only one health insurer providing benefits through the marketplace when it opened in October. 111 counties had just two insurers offering coverage.



Source: Healthcare.gov. Information current as of Oct. 1, 2013.

Health Status

Mortality – Leading Causes of Death Rates (2015-2017)

Mortality Category (2015-2017)	Ector County		Texas	
	Combined 3Yr. Rate	3Yr. Change	Combined 3Yr. Rate	3Yr. Change
Diseases of heart (I00-I09,I11,I13,I20-I51)	233.5	↓	169.5	↓
Malignant neoplasms (C00-C97)	175.0	↑	148.0	↓
Chronic lower respiratory diseases (J40-J47)	73.9	↑	40.4	↓
Accidents (unintentional injuries) (V01-X59,Y85-Y86)	59.4	↑	38.3	↑
Alzheimer's disease (G30)	52.8	↑	38.2	↑
Cerebrovascular diseases (I60-I69)	46.9	↑	42.0	↓
Diabetes mellitus (E10-E14)	30.9	↑	20.9	=
Chronic liver disease and cirrhosis (K70,K73-K74)	30.4	↑	13.8	↑
Septicemia (A40-A41)	28.2	↓	16.4	↓
Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)	15.9	↓	12.8	↑

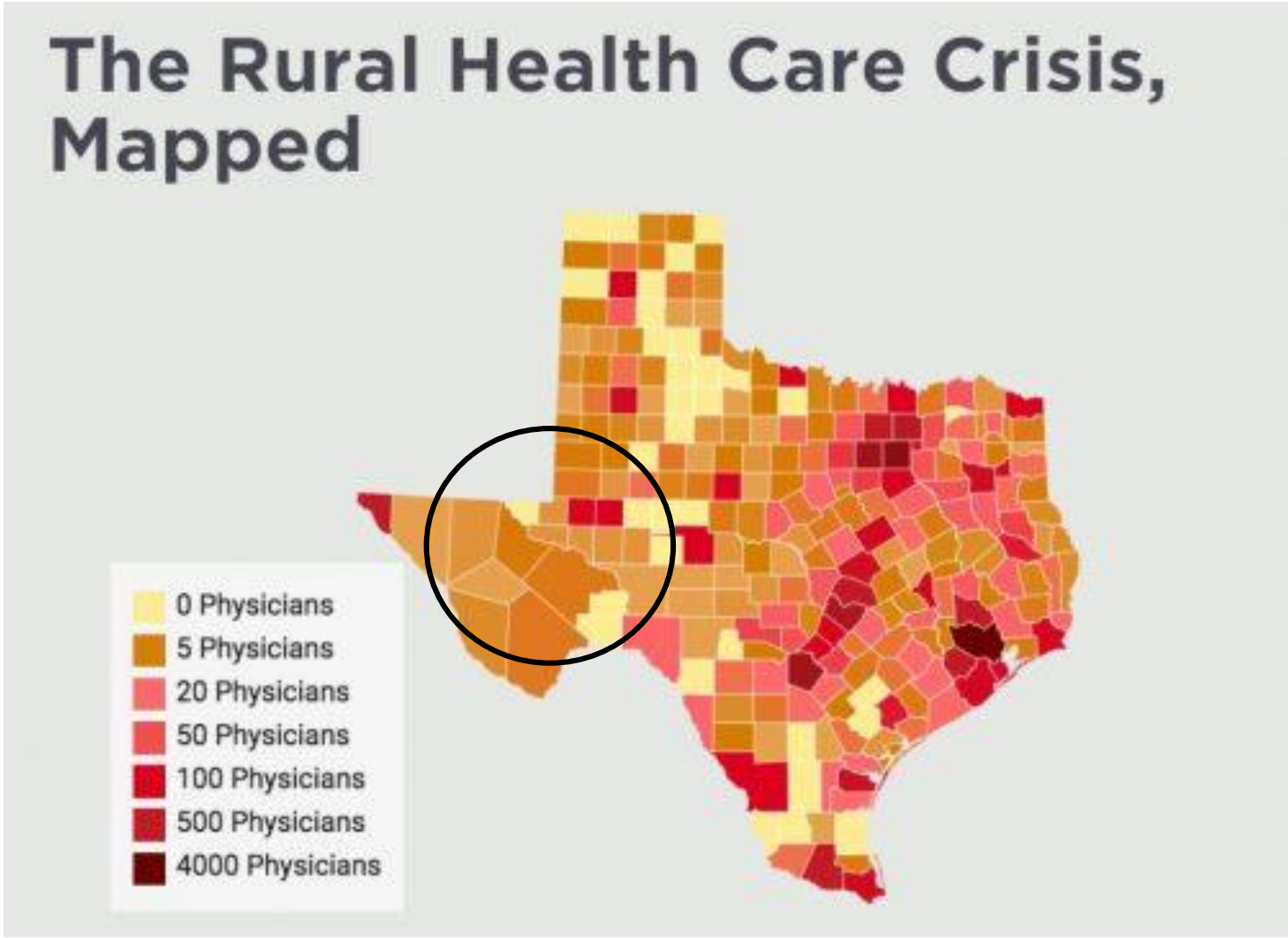
- indicates that the county's rate is lower than the state's rate for that disease category.
- indicates that the county's rate is higher than the state's rate for that disease category.
- ↓ indicates that the rate is trending downwards.
- ↑ indicates that the rate is trending upwards.
- = indicates that the rate has remained steady.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, http://wonder.cdc.gov/ucd-icd10.html; data accessed April 9, 2019.
Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.

CHC Community Hospital Consulting

Community Health Needs Assessment (CHNA)

The Rural Health Care Crisis, Mapped



Shortage of Providers

Primary Care

- **Issues**:
  - Increasing need for additional primary care providers, nurses due to difficulty with recruitment and retainment
  - Provider shortage leading to:
    - Increased use of advanced practitioners
    - Long wait times
    - Overuse of ER
  - Limited primary care options for un/underinsured, Medicaid, low income
  - Lack of emphasis on importance in establishing a medical home
  - Few providers accepting limited numbers of Medicaid, un/underinsured patients
  - Growing need for providers offering and encouraging immunizations
  - Frustration with hospitalist model and inability to see personal provider in the hospital
- **Needs**:
  - Continued efforts to recruit physicians, nurses
  - Education regarding importance in preventive care, establishing relationship with primary care providers
  - Emphasis on the primary care needs of un/underinsured, Medicaid, low income residents
  - Increased access to and promotion of physician office immunizations
  - Efforts to increase hospitalist coordination across the continuum of care and education on the benefits of hospitalist programs

"We need more doctors and nurses. There is a need for more access to medical care for people living out in the outer area."

"We have a high turnover rate. Providers are leaving the area simply because they can get paid more money in other areas."

"We have a nursing shortage at all of our hospitals. We've got shortages in all the major employment sectors like police, fire, nurses, teachers…but nurses are the primary concern. They can't afford to live here now."

"More than 50% of the time, you don't see a doctor. You see a physician's assistant or nurse practitioner."

"There are so few primary care providers. Practices are full. The ones taking patients have extremely long wait times. Access is even worse if you don't have insurance."

"The wait time is ridiculous. If someone is sick and calls to make an appointment, it may be a wait of 2 weeks. If they can't get in, they go to the Emergency Room."

"We do not have that medical home concept. People don't know how to help themselves or their children when it's 2am, so they go to the ER."

"A lot of practitioners accept Medicaid but only a limited number of those patients. It makes it harder to find a practitioner if they're low income or if they're Medicaid."

"…we have large percentages of children not getting immunizations. We still have to expel children because they don't have their shots."

"Most people do not feel comfortable with hospitalists because you get the hospitalist of the day, so you get a new doc every day. That makes it hard to maintain consistent health care, especially when somebody is in the hospital."

CHC Community Hospital Consulting

Source: Medical Center Hospital and Family Health Clinic Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; September 9, 2018 – December 12, 2018.

Shortage of Providers

Mental and Behavioral Health Care

- **Issues**:
  - Limited local resources leading to transferring of patients to San Angelo, Big Spring
  - Use of law enforcement to transfer patients outside of county
  - Concern surrounding unmet mental and behavioral health needs in youth, pediatric population
  - Shortage of providers leading to long wait times
  - Difficulty identifying providers accepting insurance types, limited promotion of providers accepting different coverage types
  - Lack of substance abuse treatment facilities
  - Increasing concerns among youth population (marijuana, anxiety, stress, depression)
  - Stigma associated with seeking care leading to lack of utilization of available resources
- **Needs**:
  - Continued efforts to improve access to local services for all payer types
  - Promotion of available services to community residents
  - Education on substance abuse, available options
  - Focus on pediatric and youth mental and behavioral health support programs
  - Efforts to reduce stigma associated with seeking care

"Mental health is an underserved area and definitely a need. Patients are sent out of the county for care because we are unable to care for them."

"Our law enforcement officers have to drive to San Angelo or Big Spring to transfer a patient who has mental health issues. That's taking an officer off the street for 5-6 hours."

"Lots of children are sent to San Angelo because we can't treat as many kids and adolescents here. We have a lot of children with unmet mental health needs."

"We lack behavioral health or psych in our area. It can be an 8 month to a year waiting list to see a psychiatrist."

"If they won't accept your insurance, you have to find other programs. There's nothing on mental health out there. You have to find something."

"If you have someone who comes in and they need substance abuse treatment or rehab, many leave the area for that. We are limited for substance abuse."

"Because of the attitude teenagers have about marijuana, they don't think its a risky thing to do. They don't understand marijuana affects the developing brain."

"…the stress, the anxiety, the pressure that so many teens and adolescents are under. There's quite a bit of influence from social media that keeps them wired in. Our counselors see more and more kids every year who are stressed out and bordering on depression."

"We have seen an increase in people that need mental health services and we're referring them, but those people aren't necessarily making it to those places. It's just a lot of shame and not feeling comfortable at those offices."

CHC Community Hospital Consulting

Source: Medical Center Hospital and Family Health Clinic Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; September 9, 2018 – December 12, 2018.

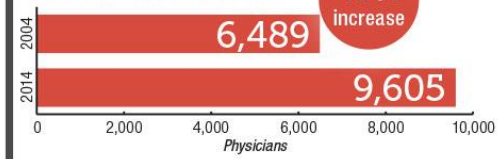
CHNA Cont'd

PHYSICIAN FACTS

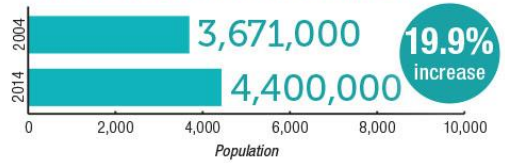
An April 2015 study by physician consulting firm Merritt Hawkins analyzed the physician shortage in Texas and several of its largest counties.

Texas ranks 41ST OF 50 states in physicians PER 100,000 PEOPLE

HARRIS COUNTY TOTAL PHYSICIANS



HARRIS COUNTY POPULATION



3 OUT OF 4
newly licensed physicians in Texas are graduates of schools from outside the state of Texas

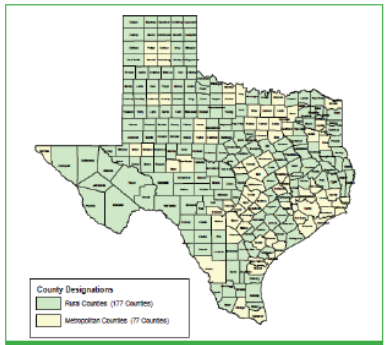
57%
of Texas physicians serve

44%
of the state's population, mainly in urban areas

STATE OF HEALTH CARE IN RURAL TEXAS

15-20%
of all jobs in rural communities are in a health care field.

TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER



HEALTH CARE PROVIDER SHORTAGES

50 % of future doctors who leave Texas to receive medical residency training never return to the Lone Star state

$150,000
annual training cost per physician

80%
of Texas is rural land.

Out of Texas' 254 counties, 177 are rural.

75% of Texas counties are federally designated Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA).

ACCESS TO CARE

64
Texas counties do not have a hospital

35
miles between critical access hospitals

25
counties do not have primary care physicians (PCP's)

FACT 1: Since 2010, **12 HOSPITALS** in rural Texas have closed.

FACT 2: Some Texans have to travel more than **100 MILES** to reach the nearest hospital.

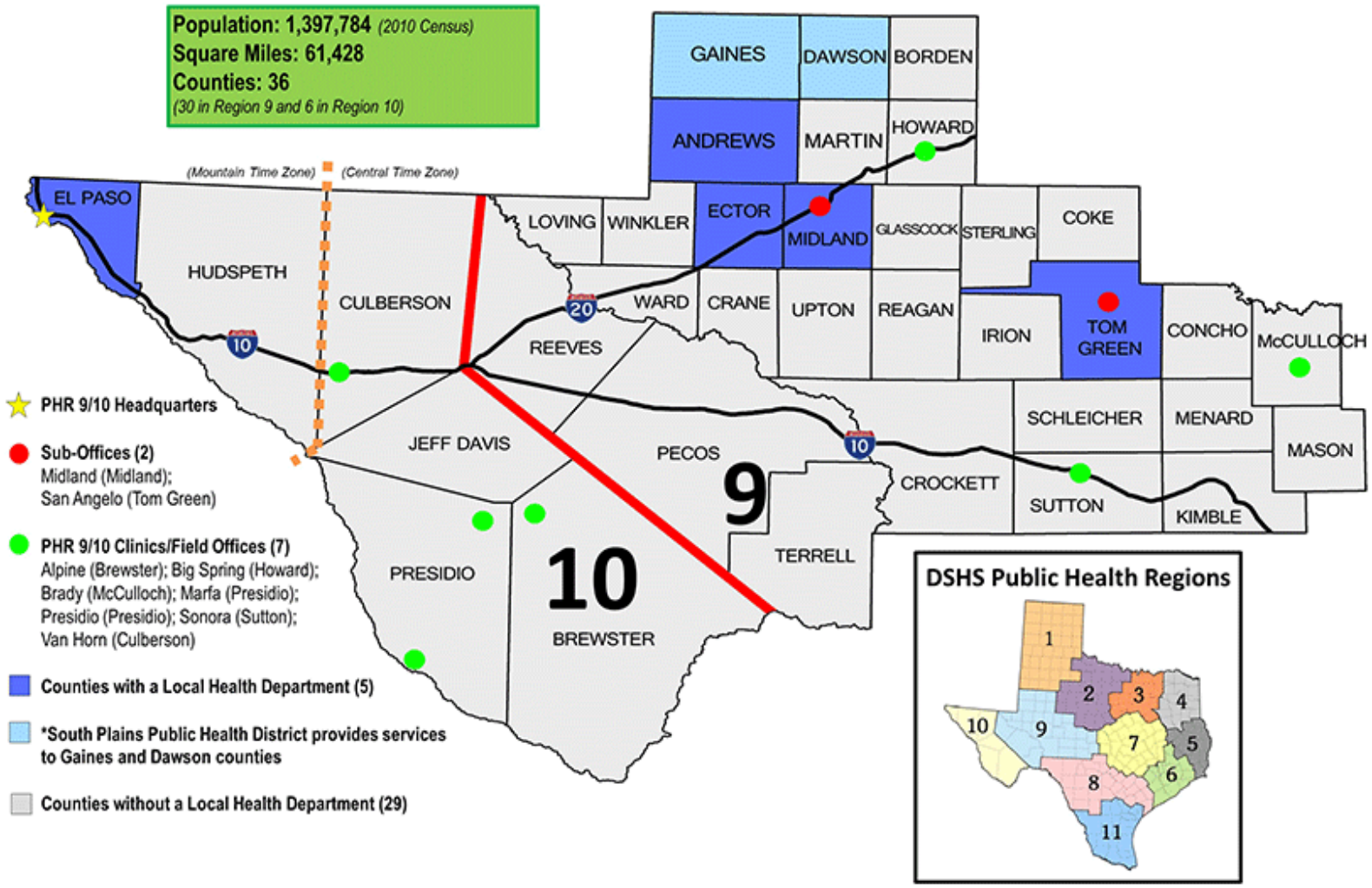
FACT 3: The first **60 MINUTES** after a trauma or cardiac event could mean the difference between life and death.

Health Resources and Services Administration (HRSA) – Health Professional Shortage Area (HPSA)

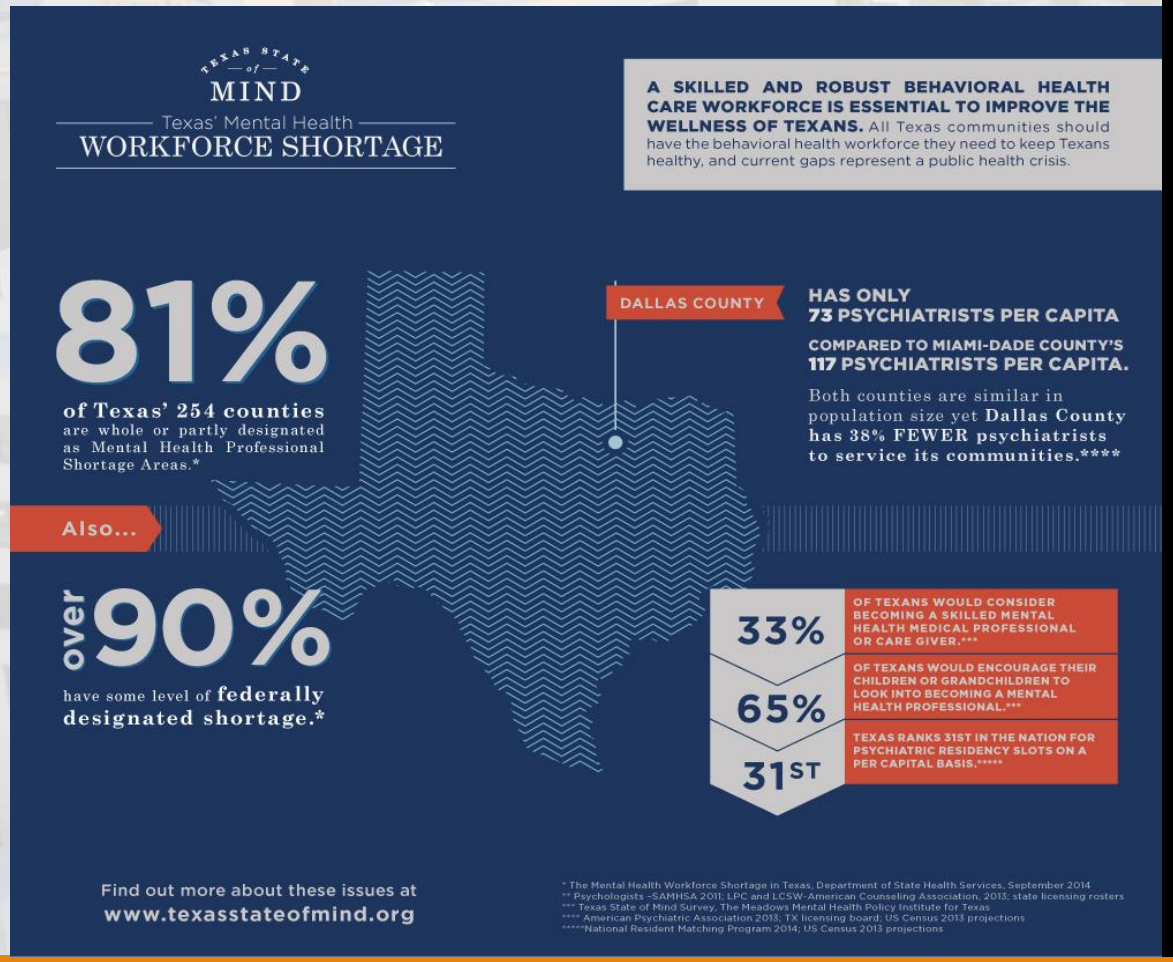
data.HRSA.gov – HPSA Find

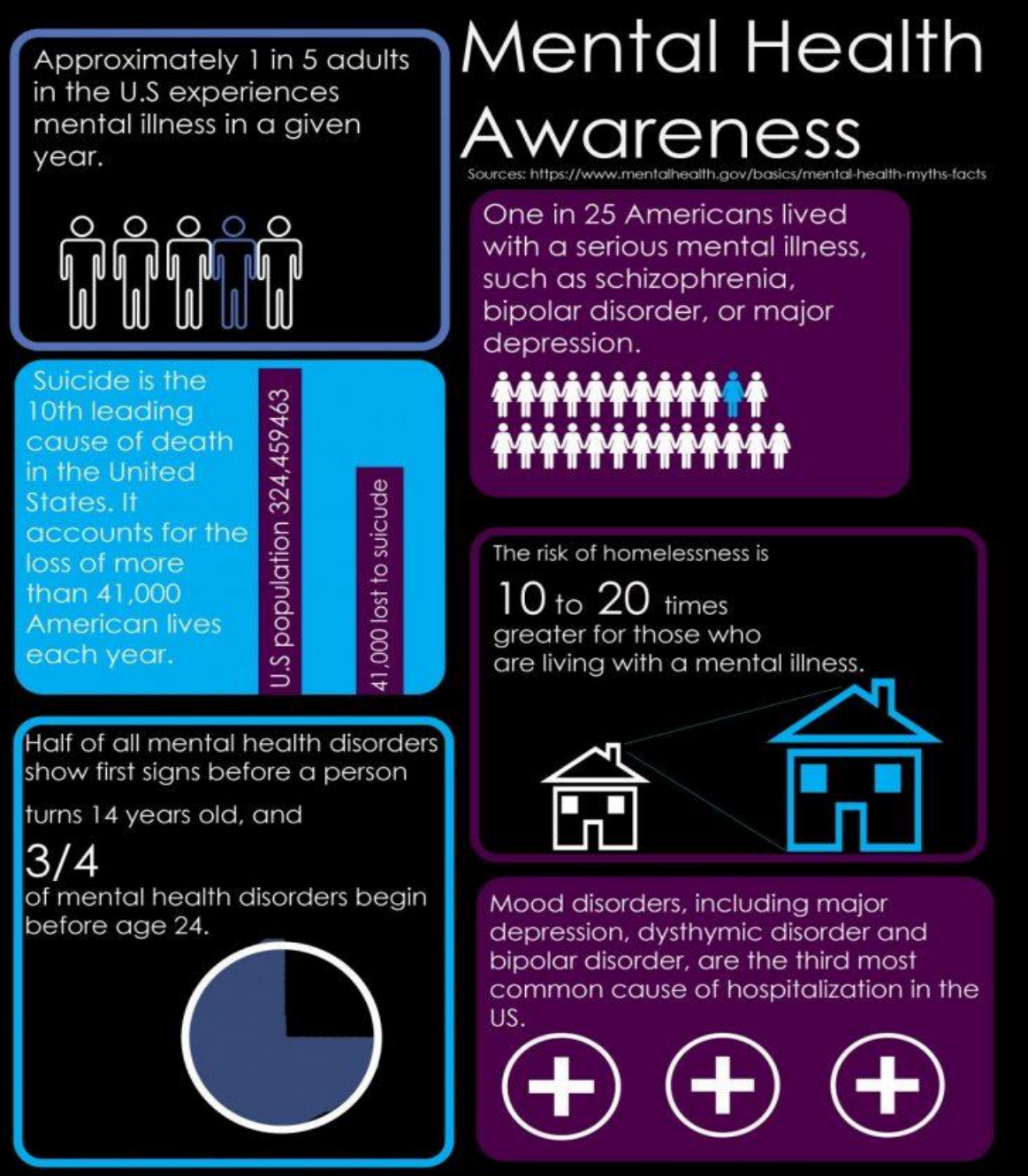
Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1482191523	Ector County	Geographic HPSA	Texas	Ector	12	Designated	Partially Rural	07/01/2019	07/01/2019
	Component State Name	**Component County Name**	**Component Name**	**Component Type**	**Component GEOID**	**Component Rural Status**				
	Texas	Ector County	Ector	Single County	48135	Partially Rural				
Primary Care	14899948Q5	Medical Center Hospital (Inc.)	Federally Qualified Health Center Look-alike	Texas	Ector	19	Designated	Non-Rural	09/28/2018	08/18/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**	**Rural Status**			
	Ector County Hospital District	840 W Clements St	Odessa	TX	79763-4601	Ector	Non-Rural			
	ECTOR COUNTY HOSPITAL DISTRICT	6030 W University Blvd	Odessa	TX	79764-8530	Ector	Non-Rural			
Mental Health	7489994807	Medical Center Hospital (Inc.)	Federally Qualified Health Center Look-alike	Texas	Ector	21	Designated	Non-Rural	09/28/2018	08/18/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**	**Rural Status**			
	Ector County Hospital District	840 W Clements St	Odessa	TX	79763-4601	Ector	Non-Rural			
	ECTOR COUNTY HOSPITAL DISTRICT	6030 W University Blvd	Odessa	TX	79764-8530	Ector	Non-Rural			
Dental Health	6489994803	Medical Center Hospital (Inc.)	Federally Qualified Health Center Look-alike	Texas	Ector	25	Designated	Non-Rural	09/28/2018	08/18/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**	**Rural Status**			
	Ector County Hospital District	840 W Clements St	Odessa	TX	79763-4601	Ector	Non-Rural			
	ECTOR COUNTY HOSPITAL DISTRICT	6030 W University Blvd	Odessa	TX	79764-8530	Ector	Non-Rural			
Mental Health	7488989333	Ector County	Geographic HPSA	Texas	Ector	17	Designated	Partially Rural	04/23/2019	04/23/2019
	Component State Name	**Component County Name**	**Component Name**	**Component Type**	**Component GEOID**	**Component Rural Status**				
	Texas	Ector County	Ector	Single County	48135	Partially Rural				

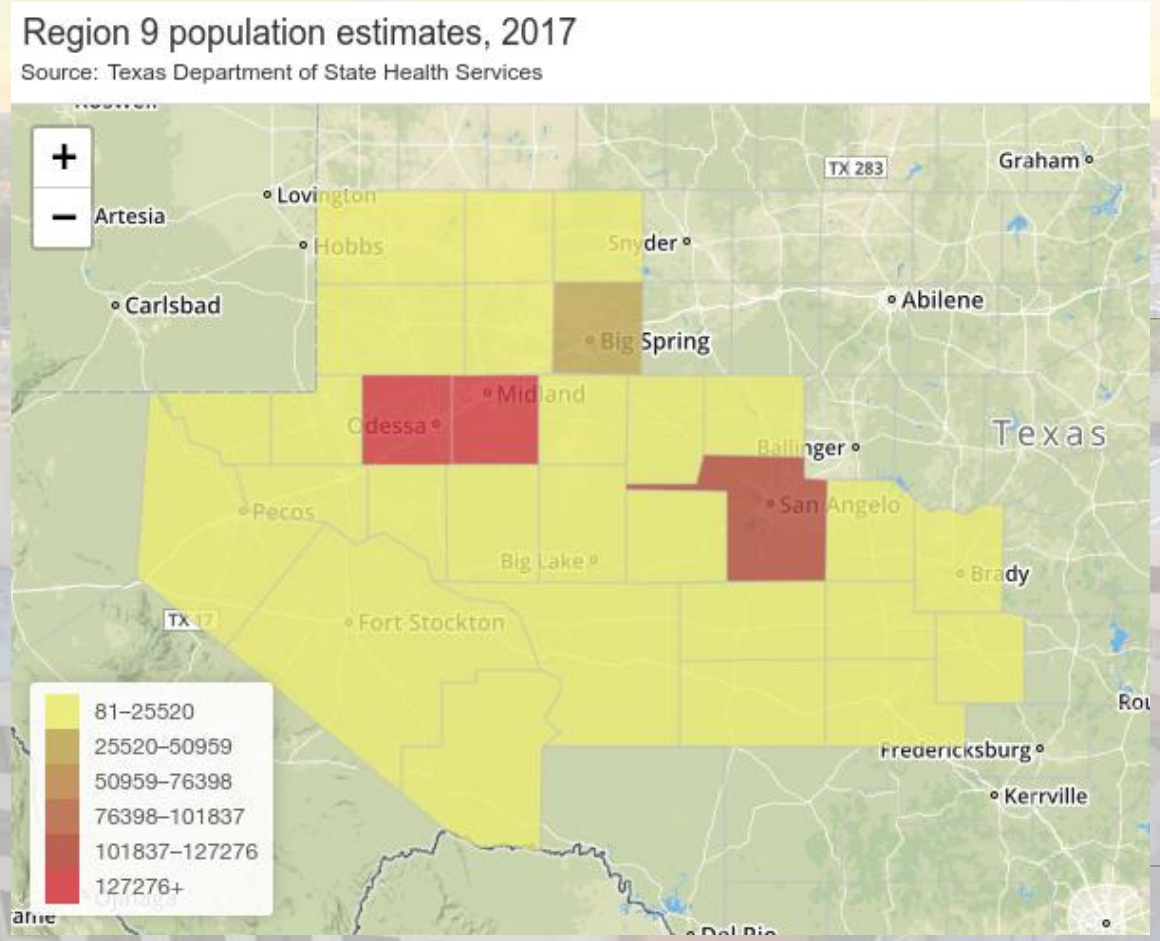
Public Health Region 9/10

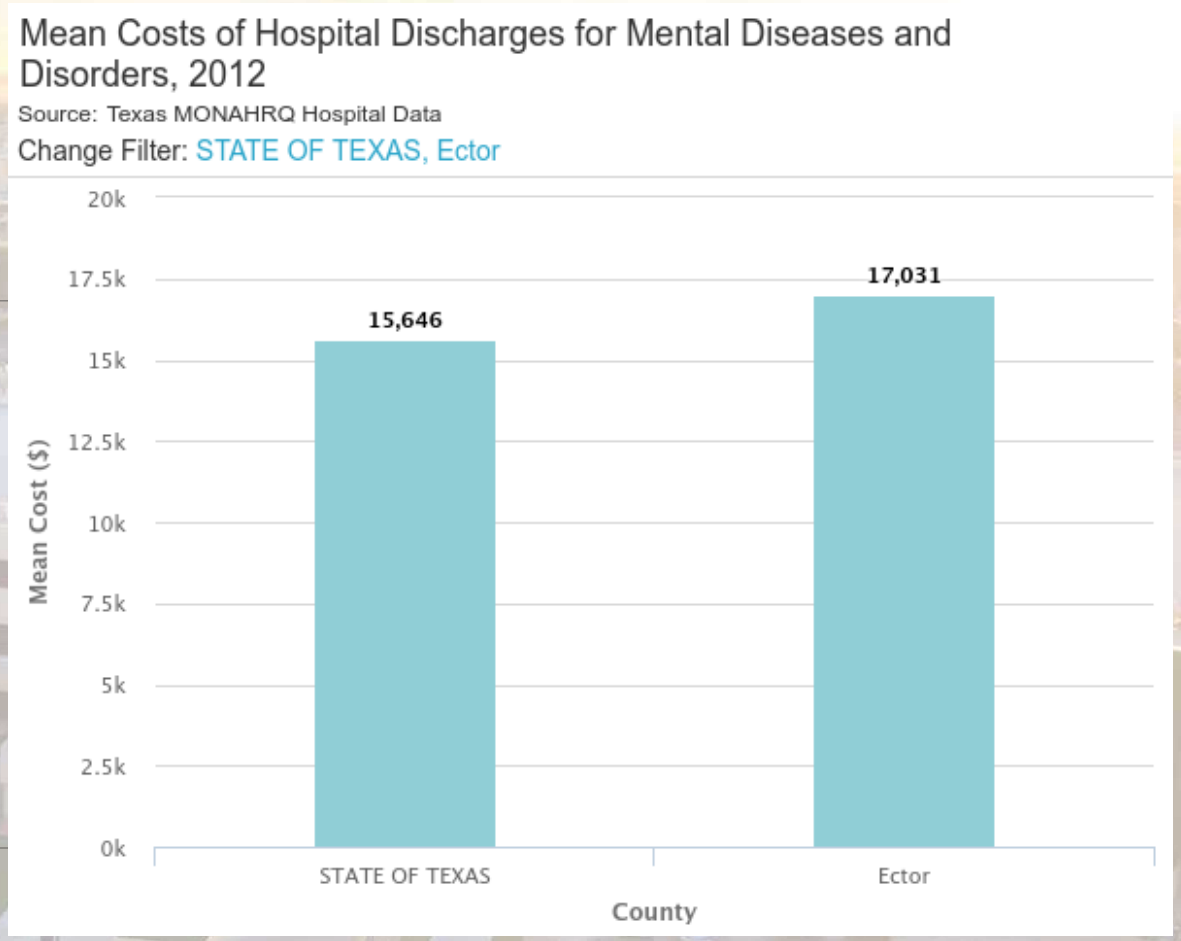


Mental & Behavioral Health









Mental Health in Region 9

What's the solution that will work in the Permian Basin?

Telehealth 101

- Drivers
  - Aging population
  - Consumer demand
  - Enhanced reimbursement
  - Eroding hospital margins
  - Provider shortages
  - Outcome based reimbursement
  - Readmission penalties
  - Specialty access
- Barriers
  - Access to broadband
  - Cost
  - Licensure
  - Limited reimbursement
  - Network speed
  - Privacy and security
  - Resistance to change

TELEHEALTH RESOURCE CENTERS

Telehealth 101 the basics

TELEHEALTH BRINGS THE RIGHT HEALTHCARE TO PATIENTS WHERE AND WHEN THEY NEED IT

Updated Sept 2017

Today's Technology is Being Leveraged to:

- Monitor patients' health status and behaviors remotely
- Meet face to face with patients using video conferencing to have discussions and provide treatment
- Obtain images for diagnostic purposes using specialized scopes and cameras
- Capture, store and then forward images to remote providers who can make a diagnosis and provide treatment recommendations
- Educate patients and providers through apps and video conferencing
- Monitor the impact of patients' daily activities on their health status
- Provide patients with tools to assist them in adopting behaviors to promote their health

What are your telehealth Goals?

Do You Hope To...

- Increase **Access** for Patients?
- Increase **Market** for Providers?
- **Reduce Costs?**
- Improve Health **Outcomes?**
- Improve **Patient Satisfaction?**
- Improve **Provider Satisfaction?**

Factors to Consider Regarding Licensure

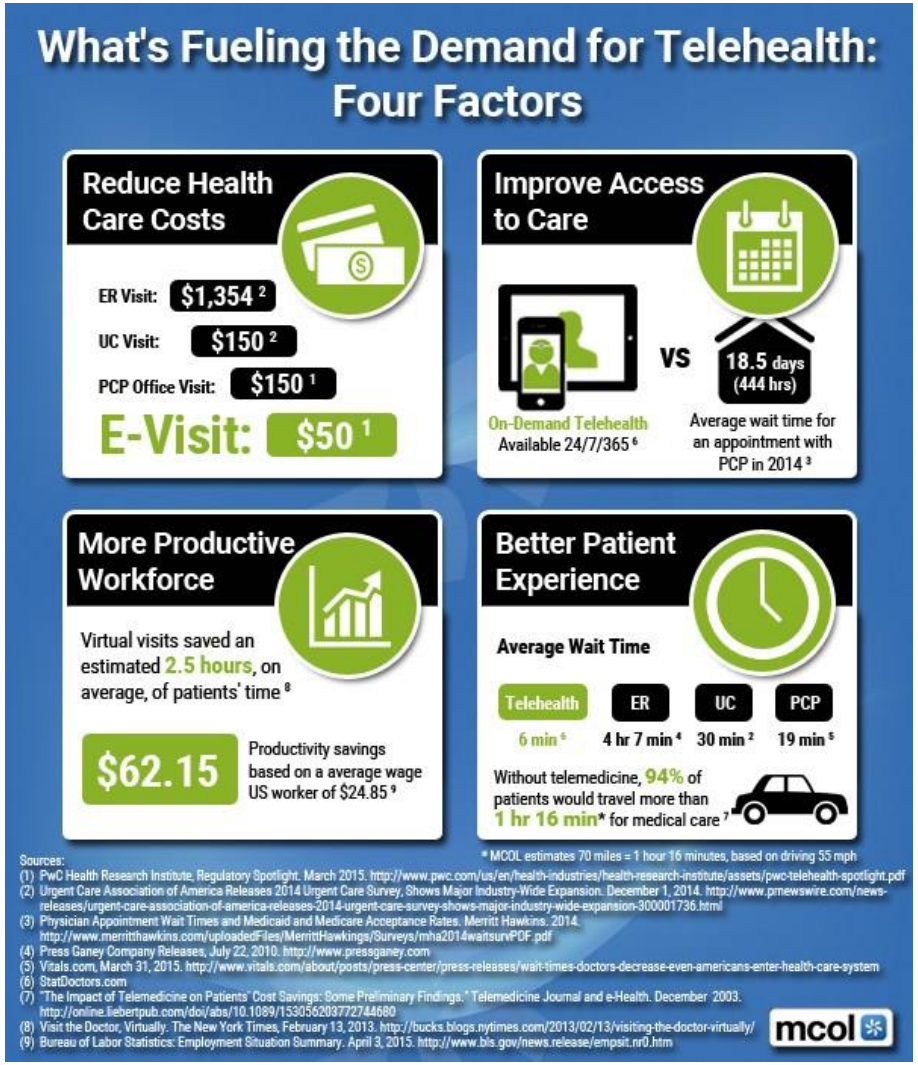
Providers should refer to the guidelines of their licensure boards. However, these general rules apply:

- Providers must be licensed in the state where the patient is located.
- Telehealth can be a valuable tool that allows all types of healthcare providers to work to the top of their license but not beyond it.
- Multi-state licensure compacts have been looked to as a solution for licensing barriers, though the methods vary. The Nurses Licensing Compact offers one license that is valid in multiple states. The Interstate Medical Licensure Compact for physicians offers an expedited process to obtain a license in a compact state.

Factors to Consider Regarding Credentialing

In July of 2001, the Centers for Medicare and Medicaid Services' final rule on credentialing and privileging established a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

Hospitals should also check their state Medicaid policies to ensure that they do not have additional requirements.


What's Fueling the Demand for Telehealth: Four Factors
Reduce Health Care Costs
ER Visit: $1,354 [2]
UC Visit: $150 [2]
PCP Office Visit: $150 [1]
E-Visit: $50 [1]
Improve Access to Care
VS
On-Demand Telehealth Available 24/7/365 [6]
18.5 days (444 hrs)
Average wait time for an appointment with PCP in 2014 [3]
More Productive Workforce
Virtual visits saved an estimated 2.5 hours, on average, of patients' time [8]
$62.15
Productivity savings based on a average wage US worker of $24.85 [9]
Better Patient Experience
Average Wait Time
Telehealth 6 min [6]
ER 4 hr 7 min [4]
UC 30 min [2]
PCP 19 min [5]
Without telemedicine, 94% of patients would travel more than 1 hr 16 min* for medical care [7]
* MCOL estimates 70 miles = 1 hour 16 minutes, based on driving 55 mph
Sources:
(1) PwC Health Research Institute, Regulatory Spotlight. March 2015. http://www.pwc.com/us/en/health-industries/health-research-institute/assets/pwc-telehealth-spotlight.pdf
(2) Urgent Care Association of America Releases 2014 Urgent Care Survey, Shows Major Industry-Wide Expansion. December 1, 2014. http://www.prnewswire.com/news-releases/urgent-care-association-of-america-releases-2014-urgent-care-survey-shows-major-industry-wide-expansion-300001736.html
(3) Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates. Merritt Hawkins. 2014. http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf
(4) Press Ganey Company Releases, July 22, 2010. http://www.pressganey.com
(5) Vitals.com, March 31, 2015. http://www.vitals.com/about/posts/press-center/press-releases/wait-times-doctors-decrease-even-americans-enter-health-care-system
(6) StatDoctors.com
(7) "The Impact of Telemedicine on Patients' Cost Savings: Some Preliminary Findings." Telemedicine Journal and e-Health. December 2003. http://online.liebertpub.com/doi/abs/10.1089/153056203772744680
(8) Visit the Doctor, Virtually. The New York Times, February 13, 2013. http://bucks.blogs.nytimes.com/2013/02/13/visiting-the-doctor-virtually/
(9) Bureau of Labor Statistics: Employment Situation Summary. April 3, 2015. http://www.bls.gov/news.release/empsit.nr0.htm
mcol

Why Telehealth? What's the Value?

Satisfaction | Costs

- Patient satisfaction
- Physician satisfaction
- Patient costs
- Physician costs

Key Performance Indicators

- Reduction in missed appointments
- Patient accountability
- Access to specialists regardless of location
- Outcomes improved due to coordinated patient care

Quality Care

- Extended clinical reach
- Improved outcomes due to timely patient care
- Reduction in unnecessary admissions or readmissions
- Avoidance of unnecessary transfers

How Telehealth?

Financial

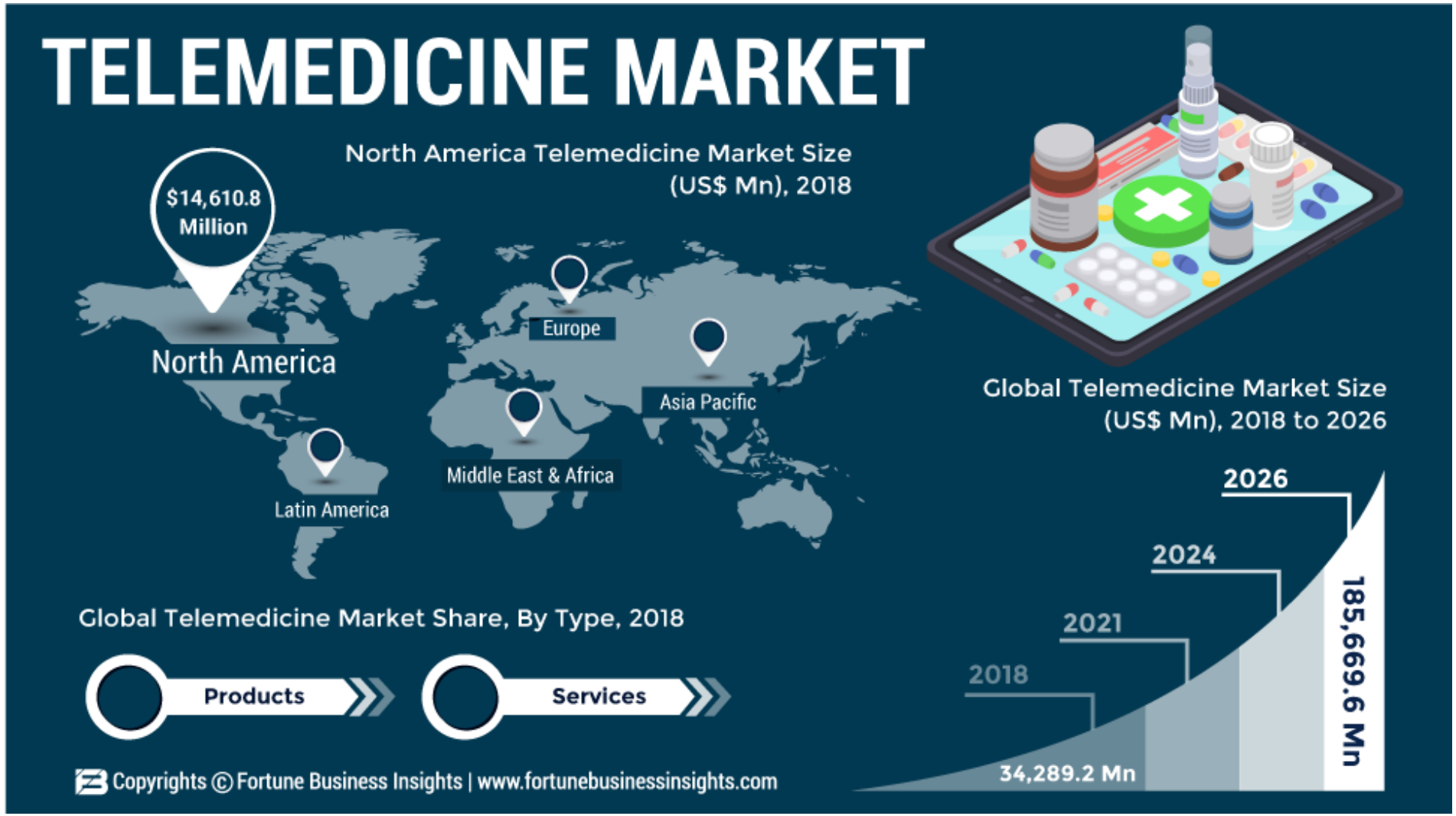
- Employee benefit program
- At-risk populations
- Population health

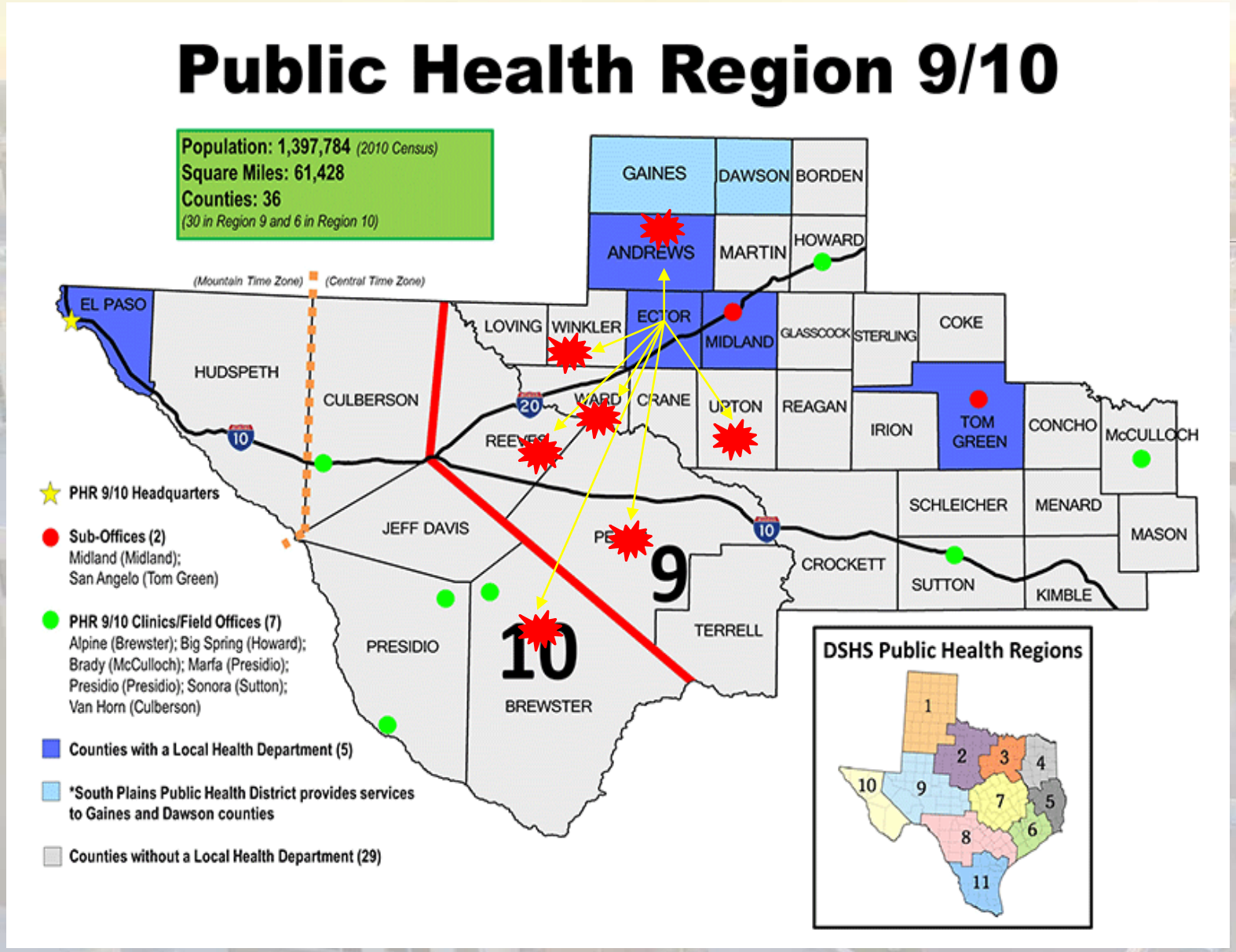
Access to Care

- Expand reach
- Primary and specialty care
- Balance loading
- Regional outreach and education

Growth

- Acquire & retain patients
- Strengthen brand
- Increase market share


TELEMEDICINE MARKET
North America Telemedicine Market Size
(US$ Mn), 2018
$14,610.8
Million
North America
Europe
Asia Pacific
Middle East & Africa
Latin America
Global Telemedicine Market Share, By Type, 2018
Products
Services
Copyrights © Fortune Business Insights | www.fortunebusinessinsights.com
Global Telemedicine Market Size
(US$ Mn), 2018 to 2026
2026
2024
2021
2018
185,669.6 Mn
34,289.2 Mn



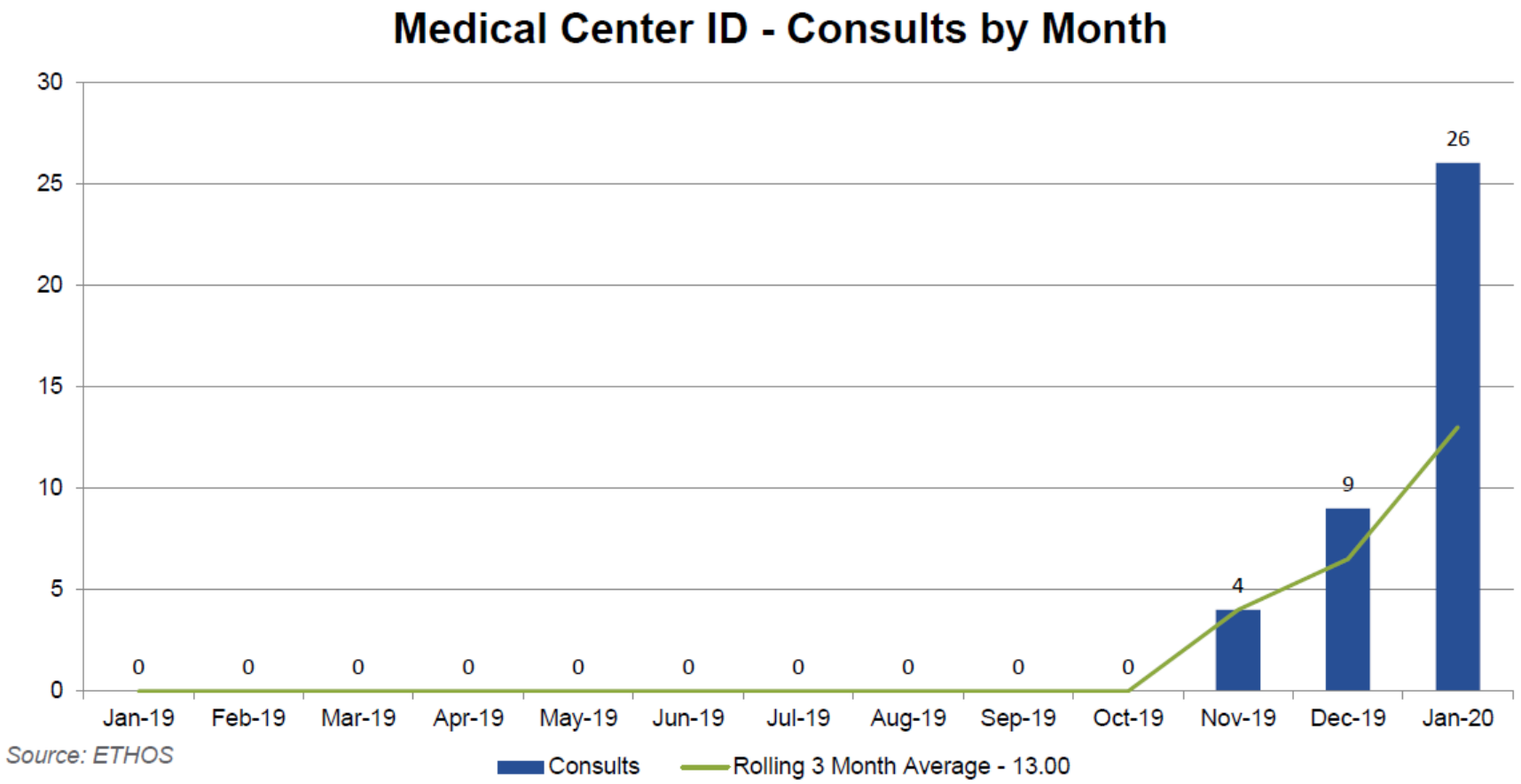
MCHS Regional Telehealth Footprint – Current Capabilities

Rolled out an ED & Stroke Telehealth platform to 7 outlying, rural and critical access hospitals (CAHs) approximately 2 years ago

- Have sat mostly vacant and unused
- equipment with Teladoc (same company now)

Currently utilize InTouch devices for Tele-ID (Telemedicine Infectious Disease)

Total Consults

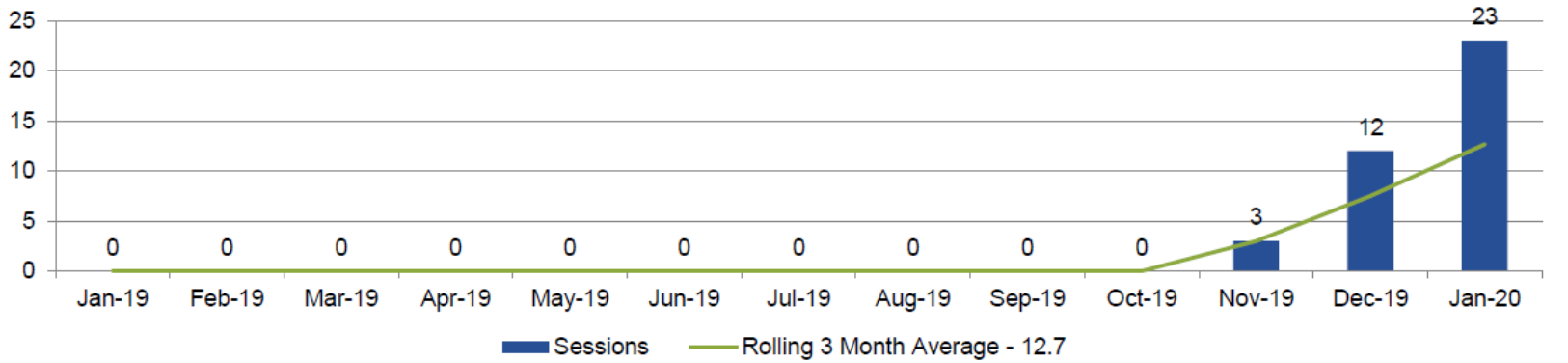


Source: ETHOS

InTouch Utilization

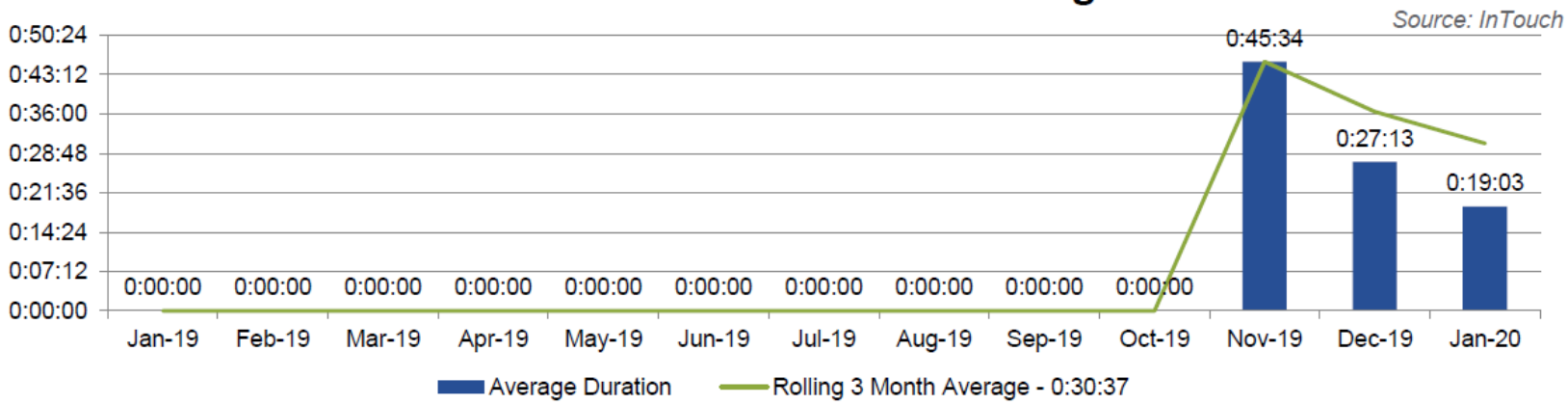
Medical Center ID InTouch Sessions

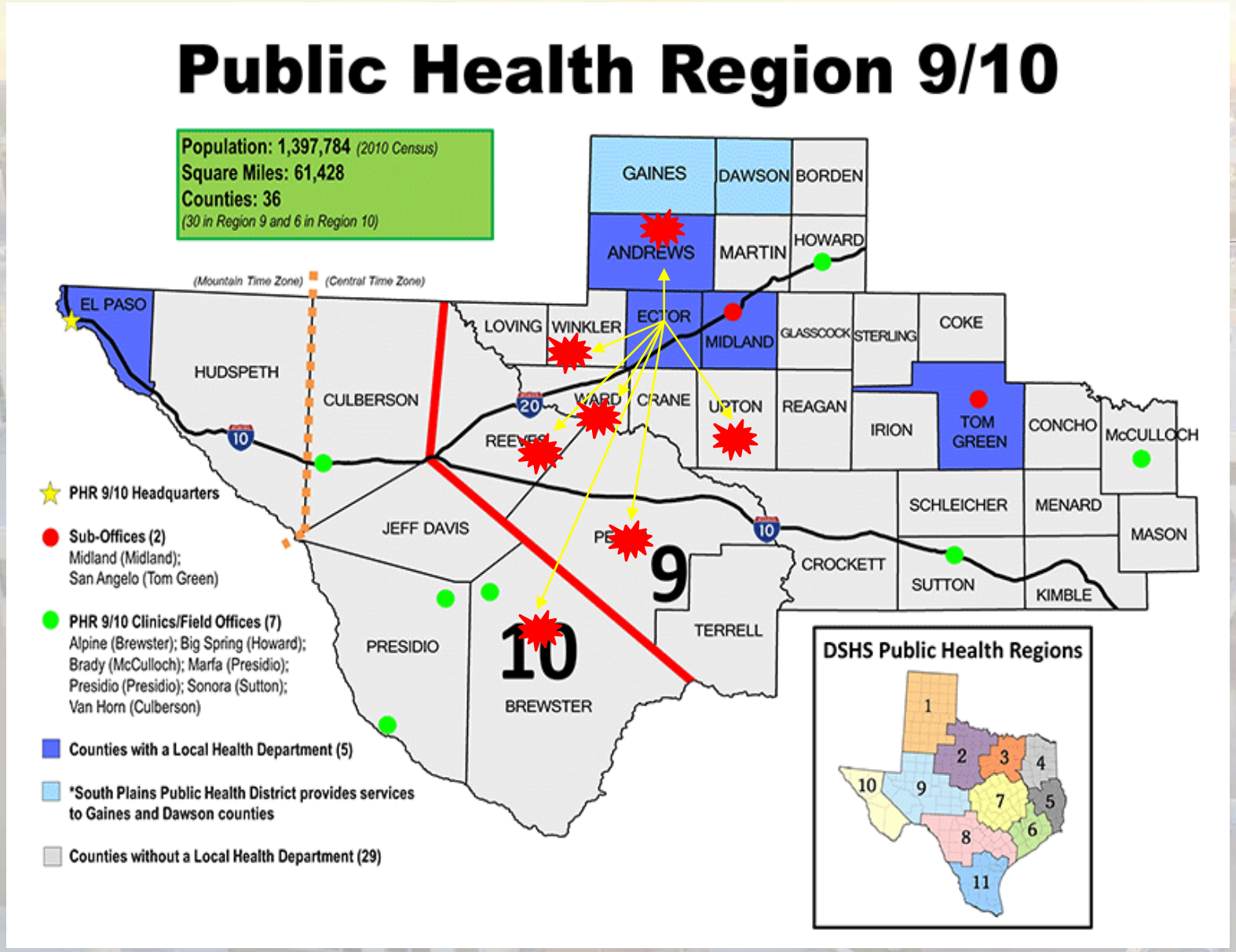
Source: InTouch



Medical Center ID InTouch Averages

Source: InTouch





MCHS Regional Telehealth Footprint – Potential Capabilities

Hope to integrate existing Telehealth equipment in outlying facilities with direct-to-consumer Telehealth vendor of choice

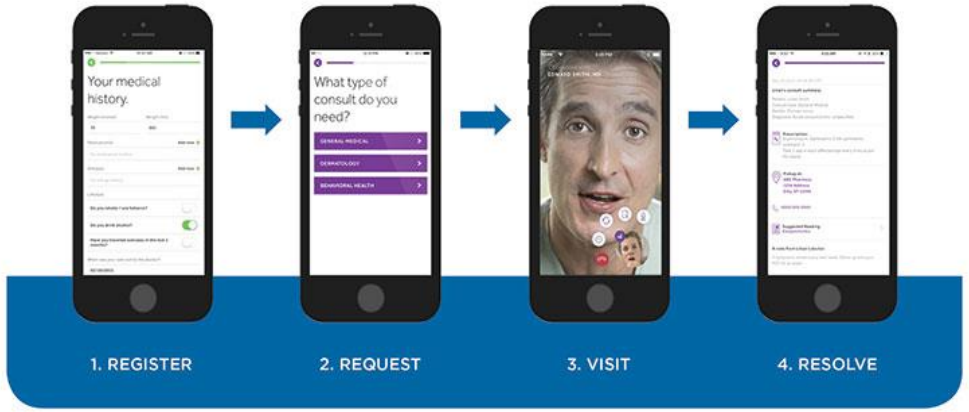
- Increase access to care
  - Specialties
    - Diabetes management, COPD, CHF, Hypertension, Mental & Behavioral Health
- Increase market for providers
- Reduce costs
- Improve health outcomes
- Improve patient satisfaction
- Improve provider satisfaction
- Optimize operational effectiveness and efficiency
- Improve regional access and throughput
- ED decompression to better serve region

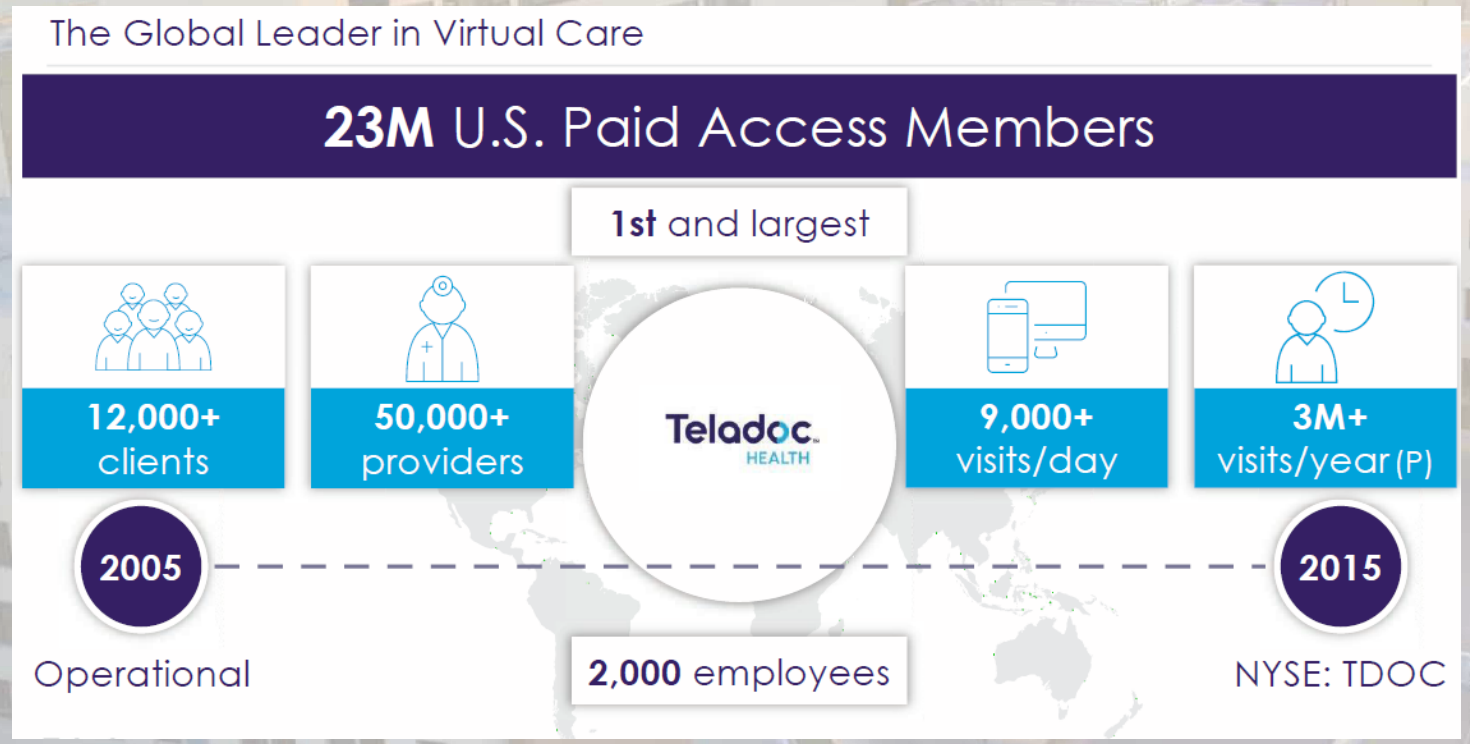
TELADOC™

Contact Teladoc

Talk with a Doctor

Resolve your Issue





- Reduce cost of healthcare and improve financial performance
- Increase access for low acuity primary care services
- Reduce readmission based on complex care management
- Focus on mental and behavioral health
- Reduce unnecessary ER visits
- Improve your brand and awareness throughout your community
- Leverage for future opportunities (e.g. chronic care management, pop. Health, etc.)
- Prepare for increased risk-based contracts with payors

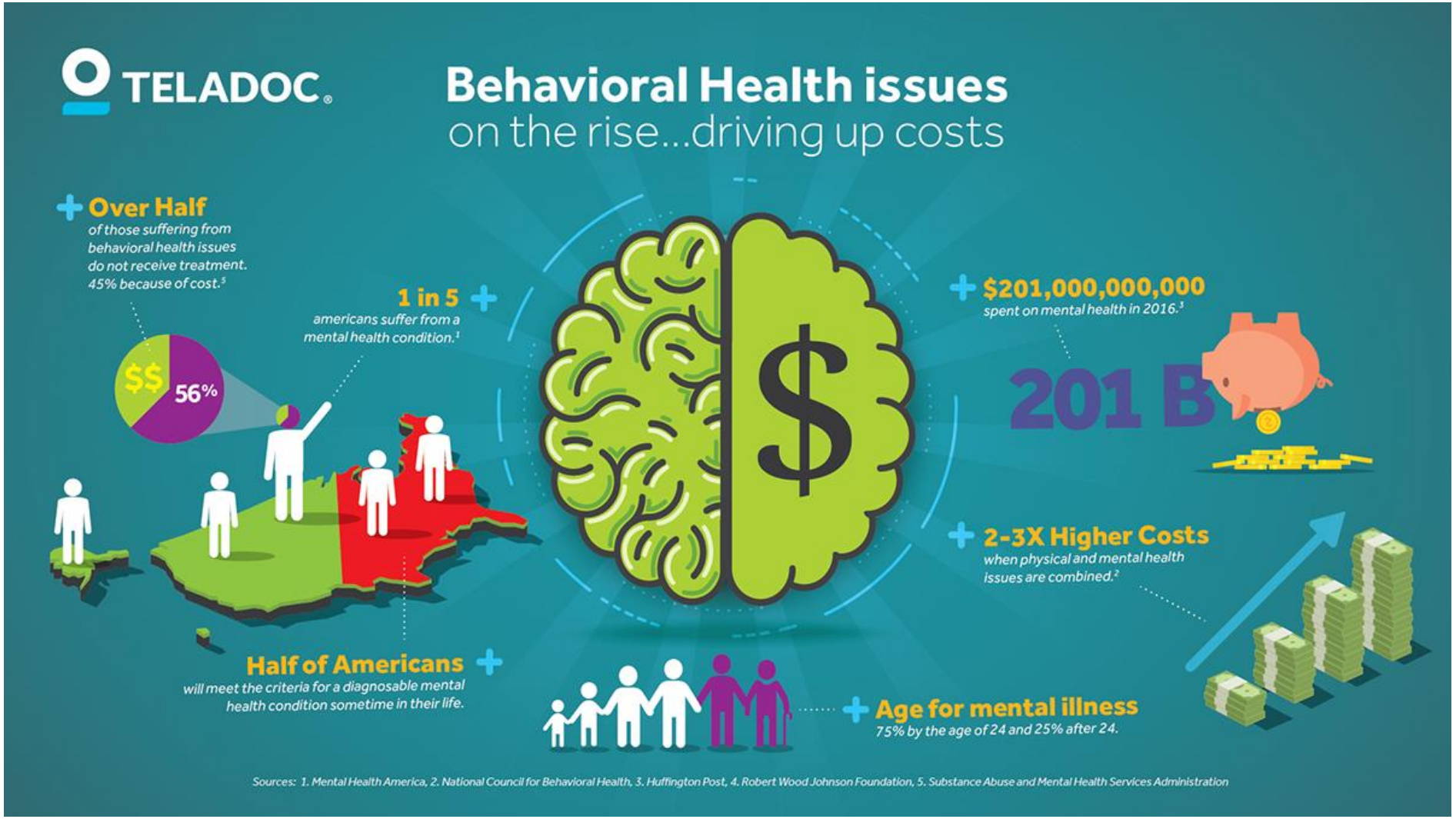
Teladoc Deep Dive

Beyond Acute Care

Financial Access Growth

Bariatric Services	Behavioral Specialist	Cardiovascular Surgery	Corporate Health	Endocrinology
ENT	GI	Home Health Services	Infectious Disease	Medicaid
Neurology	Nutrition Education	Occupational Health	Oncology	Orthopedic
Pathology	Pediatric Care	Post-Discharge	Post-Surgical F/U	Pre-Admission
Primary Care	Pulmonary Care	School Health	Second Opinion	Urology
Virtual Rounds	ACO Membership	Behavioral Health	Cardiology	CHF
Complex Case Coord.	Concierge Service	COPD	Dermatology	Diabetes Management
Medicare	Toxicology	Urgent Care	Abandoned Markets	Benefits Selection - Health, Dental
Charity Care	Crisis / Outbreak / State of Emergency	Ergonomics/Safety Assessments	Fitness Programs	Gene Therapy
Hospice/Caregiver Assistance	Physical Therapy	Sexual Health	Smoking Cessation	Wellness Programs

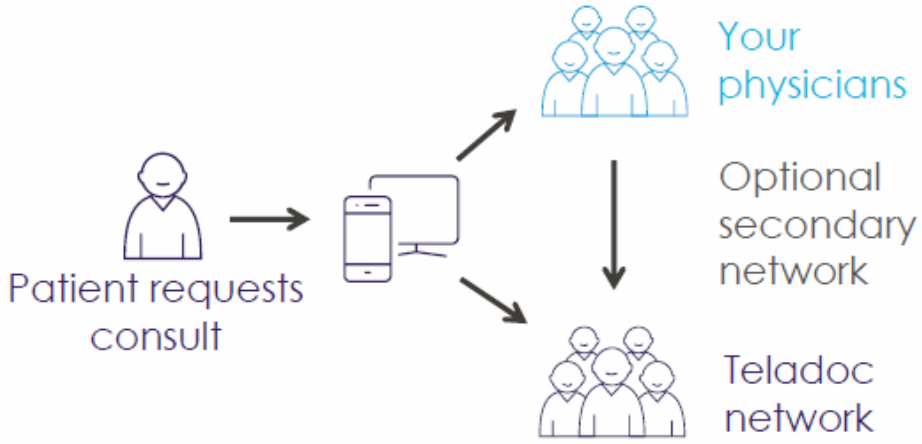
Proposed MCHS Teladoc Specialty Focus


TELADOC
Behavioral Health issues
on the rise...driving up costs
Over Half
of those suffering from behavioral health issues do not receive treatment. 45% because of cost.5
1 in 5
americans suffer from a mental health condition.1
$$
56%
$201,000,000,000
spent on mental health in 2016.3
201 B
2-3X Higher Costs
when physical and mental health issues are combined.2
Half of Americans
will meet the criteria for a diagnosable mental health condition sometime in their life.
Age for mental illness
75% by the age of 24 and 25% after 24.
Sources: 1. Mental Health America, 2. National Council for Behavioral Health, 3. Huffington Post, 4. Robert Wood Johnson Foundation, 5. Substance Abuse and Mental Health Services Administration

Clinical Infrastructure

Hybrid Network

Configurable network routing



Clinical Governance

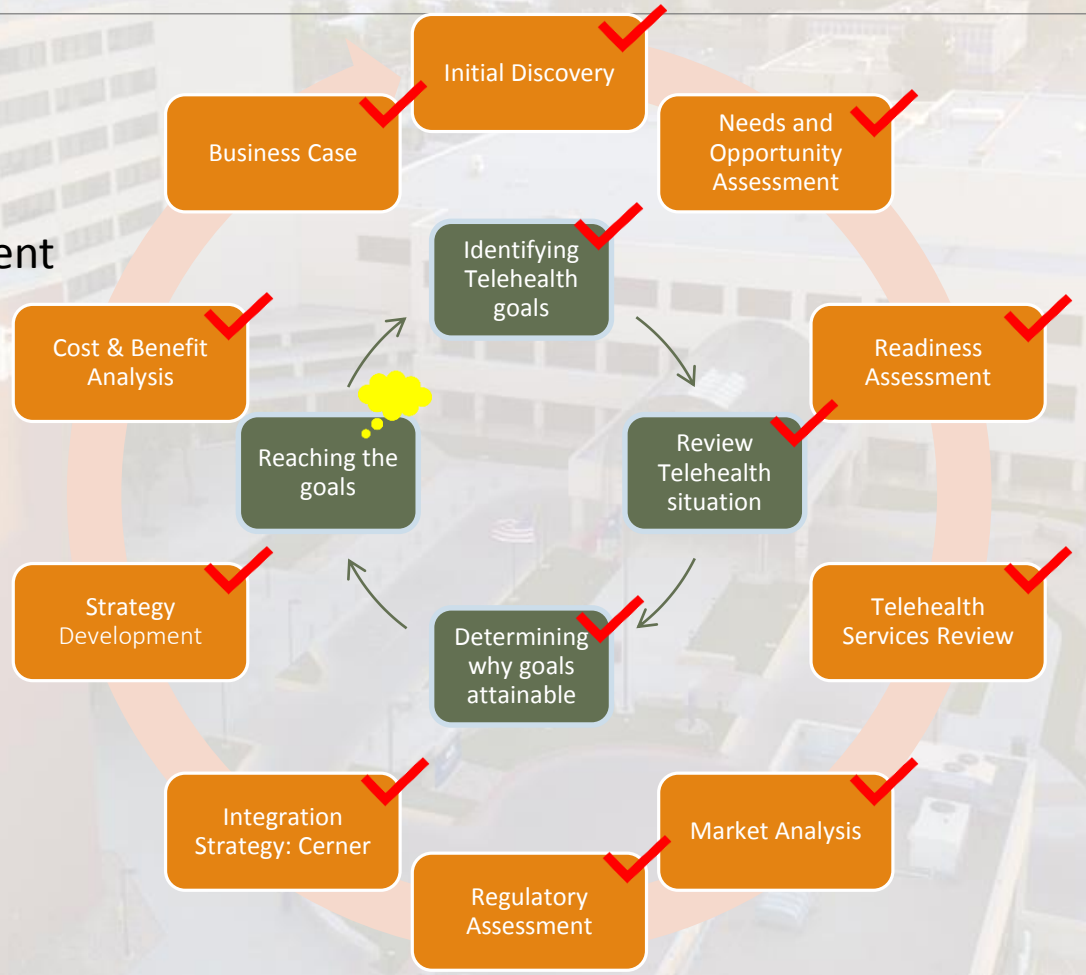
Quality measures & oversight

- Proprietary clinical guidelines
- Board sub-committees
- Monitoring & QA
- Patient Safety Organization

Teladoc Deep Dive Cont'd

MCHS Business Development & Strategy

- Complete
- Work in Progress
- Business Development & Strategy
- Goal Process



3 YEAR PHASE OUT STRATEGY

DTC: MCHS Employees

0 MONTH MARK

Small, Regional Employers

6 MONTH MARK

Full Service Area Rollout; Mental Health

12 MONTH MARK

Chronic, Complex Care Management, Specialty Clinics

24 MONTH MARK

Regional Adoption of Live Video Conference

36 MONTH MARK

Teladoc HEALTH | InTouch Health

Teladoc Utilization Proforma – Summary

Major Assumptions

- Regional healthcare cost savings not factored in
  - Estimated at over $500,000 every year
- Overall conservative
- Funding not factored into revenue therefore not into net present value (NPV) at 5% discount rate
- YR1-2: cash only system
- YR3-5: cash + insurance reimbursement
- Physician breakdown:
  - 80% Telehealth
  - 20% MCHS
- Payer Mix:
  - Medicare 20%
  - Medicaid 35%
  - Commercial 20%
  - Self-Pay 25%
- 20% of Telehealth visits will result in a follow up
  - 30% of this number will create an ancillary service

MEDICAL CENTER HEALTH SYSTEM
OFFICE OF HEALTH SYSTEM AFFAIRS
MCH TELECARE

Source(s): Wise Health, US Census Bureau, MCHS Procare, THA, eVisit, Teladoc, MCHS Finance, Optum, Advisory Board, HHS, NIH, THRS, Reach Health, MCHS Chief Strategy Officer, CMS

Telemedicine Platform	Year 1	Year 2	Year 3	Year 4	Year 5
Telemedicine Platform					
Total Teladoc Encounters	2,288	3,891	7,003	9,923	12,883
Total Encounters	2,746	4,670	8,403	11,908	15,459
Total External Funding	$ 293,000	$ 138,500	$ 138,500	$ 20,000	$ -
Total Revenue	$ 149,942	$ 243,393	$ 599,375	$ 917,836	$ 1,238,750
Total Expenses	$ 184,054	$ 252,948	$ 451,381	$ 750,199	$ 953,347
Net Margin	$ (34,112)	$ (9,555)	$ 147,993	$ 167,637	$ 285,403

NPV	$448,224.03

Teladoc Utilization Proforma – Breakdown, Volume

Total Visits						
1. Employees & Ben.	1,000	2,000	3,000	3,300	3,630	*50% YOY growth YR1-3; 10% YR4-5; YR1 based on 3% increase from Wise Health Ymonth 1 findings annualized (114,1368)*
2. Non-employees	0	500	2,500	5,000	7,500	*YR1 = 0; YR2-3, 250% inc; YR3-4, 100% inc.; YR4-5, 50% inc.*
3. ED Decompression	1,288	1,391	1,503	1,623	1,753	*8% YOY inc.; based on 15% LWBS, 8% triage 5, 3% triage 4*
Total Teladoc Encounters	2,288	3,891	7,003	9,923	12,883	
4. Referral Visits	458	778	1,401	1,985	2,577	*20% of total teladoc encounters YOY*
Total Encounters	2,746	4,670	8,403	11,908	15,459	
Financial Breakdown by Stat						
1. Reimbursement per Cash Visit	$ -	$ 49.29	$ 49.29	$ 49.29	$ 49.29	*if cash only system; all should come down to avg net blended rate per visit*
2. Reimbursement per Cash + Ins. Visit	$				84.55	*reimburseable amount + co-pay; CPT + co-pay*
3. Incremental Difference	$				35.26	*incremental difference once insurance starts*

Teladoc Utilization Proforma – Breakdown, Volume

Total Visits						
1. Employees & Ben.	1,000	2,000	3,000	3,300	3,630	*50% YOY growth YR1-3; 10% YR4-5; YR1 based on 3% increase from Wise Health Ymonth 1 findings annualized (114,1368)*
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Total Encounters	2,746	4,670	8,403	11,908	15,459	
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1. Reimbursement per Cash Visit	$ -	$ 49.29	$ 49.29	$ 49.29	$ 49.29	*if cash only system; all should come down to avg net blended rate per visit*
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3. Incremental Difference	$				35.26	*incremental difference once insurance starts*

Teladoc Utilization Proforma – Breakdown, Revenue

Revenue						
1. Payer Mix (Cash Only)						*Medicare&Medicaid --> only using telemedicine specific E/M codes*
a. Medicare	$ -	$ 3,975	$ 19,875	$ 39,750	$ 59,625	*20%; based on 99446-99449 CPT/HCPCS code reimbursement model for physician fee schedule via CMS*
b. Medicaid	$ -	$ 6,261	$ 31,303	$ 62,606	$ 93,909	*35%; 90% of medicare; based on 99446-99449 CPT/HCPCS code reimbursement model for physician fee schedule via CMS*
c. Commercial	$ -	$ 6,956	$ 34,781	$ 69,563	$ 104,344	*20%; 175% of medicaid, 40% of billable rate reimbursed*
d. Self Pay	$ -	$ 7,453	$ 37,266	$ 74,531	$ 111,797	*25%; for now, 150% of medicaid*
e. Other	$ -	$ -	$ -	$ -	$ -	*0%*
f. Employees	$ 12,500	$ 25,000	$ 37,500	$ 41,250	$ 45,375	*$25 from 50% cash basis from employees*
Total	$ 12,500	$ 49,645	$ 160,725	$ 287,700	$ 415,050	
2. Insurance Reimbursement	$ -	$ -	$ 88,140	$ 176,280	$ 264,420	*insurance reimbursement based on values*
3. ED Decompression	$ 64,421	$ 69,574	$ 127,056	$ 137,220	$ 148,198	*YR1-2 based on cash only system; YR3-5 based on reimburseable amount+co-pay*
4. Regional Impact - Ancillery Services	$ 73,021	$ 124,174	$ 223,454	$ 316,636	$ 411,082	*20% of our teladoc encournters generate a follow/up; 30% of the 20% of those visits have ancillery services attached; $15 inc. to the incremental revenue, physician visit*
5. Other Revenue - Funding						
a. MCHS Foundation	$ 293,000	$ 138,500	$ 138,500	$ 20,000	$ -	*confirmed via Alison (up to $500k)*
Total	$ 293,000	$ 138,500	$ 138,500	$ 20,000	$ -	
Total Revenue	**$149,942**	**$243,393**	**$599,375**	**$917,836**	**$1,238,750**	does not include funding/grants

Teladoc Utilization Proforma – Breakdown, Revenue

Revenue						
1. Payer Mix (Cash Only)						*Medicare&Medicaid --> only using telemedicine specific E/M codes*
a. Medicare	$ -	$ 3,975	$ 19,875	$ 39,750	$ 59,625	*20%; based on 99446-99449 CPT/HCPCS code reimbursement model for physician fee schedule via CMS*
b. Medicaid	$ -	$ 6,261	$ 31,303	$ 62,606	$ 93,909	*35%; 90% of medicare; based on 99446-99449 CPT/HCPCS code reimbursement model for physician fee schedule via CMS*
c. Commercial	$ -	$ 6,956	$ 34,781	$ 69,563	$ 104,344	*20%; 175% of medicaid, 40% of billable rate reimbursed*
d. Self Pay	$ -	$ 7,453	$ 37,266	$ 74,531	$ 111,797	*25%; for now, 150% of medicaid*
e. Other	$ -	$ -	$ -	$ -	$ -	*0%*
f. Employees	$ 12,500	$ 25,000	$ 37,500	$ 41,250	$ 45,375	*$25 from 50% cash basis from employees*
Total	$ 12,500	$ 49,645	$ 160,725	$ 287,700	$ 415,050	
2. Insurance Reimbursement	$ -	$ -	$ 88,140	$ 176,280	$ 264,420	*insurance reimbursement based on values*
3. ED Decompression	$ 64,421	$ 69,574	$ 127,056	$ 137,220	$ 148,198	*YR1-2 based on cash only system; YR3-5 based on reimburseable amount+co-pay*
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Teladoc Utilization Proforma – Breakdown, Expenses

Expenses						
1. License Fee	$ 138,500	$ 138,500	$ 138,500	$ 138,500	$ 138,500	*annual Teladoc utilization fee*
a. Cerner Integration	$ 40,000	$ -	$ -	$ -	$ -	*one-time Cerner integration fee*
b. Teladoc IT Bundle Package	$ 50,000	$ -	$ -	$ -	$ -	*one-time Cerner|Teladoc SSO, bi-directional, etc. bundle IT package*
c. Teladoc Installation Fee	$ 64,500	$ -	$ -	$ -	$ -	*one-time installation fee*
d. Funding Offset	$ (293,000)	$ (138,500)	$ (138,500)	$ (20,000)	$ -	*funding offset*
Total	$ -	$ -	$ -	$ 118,500	$ 138,500	
2. Marketing	$ 10,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	*50% decrease YR1 TO YR2; facebook ads, newspaper, magazine, banners, billboard, flyers, discharge papers*
2. Regional Outreach						
a. Conferences	$ 1,500	$ 1,500	$ 1,500	$ 1,500	$ 1,500	*local, state, and national conferences centered around Telehealth*3 attendees/year*
b. Travel - West Texas	$ 8,000	$ 7,200	$ 6,480	$ 5,832	$ 5,249	*10% decrease YOY; can be subcomponent of marketing*
Total	$ 9,500	$ 8,700	$ 7,980	$ 7,332	$ 6,749	
3. Physicians						
a. Teladoc Physicians	$ 82,383	$ 140,093	$ 252,101	$ 357,229	$ 463,783	*80% of YR 1 volume at $45 per visit; must be MD*
a. MCHS Physicians	$ 16,660	$ 28,330	$ 50,980	$ 72,240	$ 93,787	*20% of YR 1 volume at $36.40 for 0.97 WORK RVU, CPT 99447 via CMS physician fee schedule*
Total	$ 99,042	$ 168,423	$ 303,081	$ 429,469	$ 557,571	
4. Salaries and Benefits	$ -	$ -	$ -	$ -	$ -	*originally thought director needed, businces case does not call for it*
a. Administrative Fees	$ 18,605	$ 27,323	$ 63,909	$ 91,845	$ 120,059	*20% of tot. rev. payer mix; 25% of tot. rev. ED decomp.*
b. Incremental Expenses for Referrals	$ 21,906	$ 37,252	$ 67,036	$ 94,991	$ 123,325	*30% of F/U&ancillery services line item*
Total	$ 40,512	$ 64,575	$ 130,945	$ 186,836	$ 243,384	
5. Start-up Expenses	$ 25,000	$ 6,250	$ 4,375	$ 3,063	$ 2,144	*OT; productivity increase/reallocation; misc.; 75% decrease after YR1, 30% YOY dec. post YR2*
Total Expenses	**$184,054**	**$252,948**	**$451,381**	**$750,199**	**$953,347**	

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Teladoc Utilization Proforma – Summary

Major Assumptions

- Regional healthcare cost savings not factored in
  - Estimated at over $500,000 every year
- Overall conservative
- Funding not factored into revenue therefore not into net present value (NPV) at 5% discount rate
- YR1-2: cash only system
- YR3-5: cash + insurance reimbursement
- Physician breakdown:
  - 80% Telehealth
  - 20% MCHS
- Payer Mix:
  - Medicare 20%
  - Medicaid 35%
  - Commercial 20%
  - Self-Pay 25%
- 20% of Telehealth visits will result in a follow up
  - 30% of this number will create an ancillary service

MEDICAL CENTER HEALTH SYSTEM
OFFICE OF HEALTH SYSTEM AFFAIRS
MCH TELECARE

Source(s): Wise Health, US Census Bureau, MCHS Procare, THA, eVisit, Teladoc, MCHS Finance, Optum, Advisory Board, HHS, NIH, THRS, Reach Health, MCHS Chief Strategy Officer, CMS

Telemedicine Platform	Year 1	Year 2	Year 3	Year 4	Year 5
Telemedicine Platform					
Total Teladoc Encounters	2,288	3,891	7,003	9,923	12,883
Total Encounters	2,746	4,670	8,403	11,908	15,459
Total External Funding	$ 293,000	$ 138,500	$ 138,500	$ 20,000	$ -
Total Revenue	$ 149,942	$ 243,393	$ 599,375	$ 917,836	$ 1,238,750
Total Expenses	$ 184,054	$ 252,948	$ 451,381	$ 750,199	$ 953,347
Net Margin	$ (34,112)	$ (9,555)	$ 147,993	$ 167,637	$ 285,403

NPV	$448,224.03

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mch
TeleCare
A Member of Medical Center Health System

MEDICAL CENTER HEALTH SYSTEM

OFFICE OF HEALTH SYSTEM AFFAIRS

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Telemedicine Platform	Year 1	Year 2	Year 3	Year 4	Year 5	Assumptions/Notes
Telemedicine Platform						
Total Visits						
1. Employees & Ben.	1,000	2,000	3,000	3,300	3,630	*50% YOY growth YR1-3; 10% YR4-5; YR1 based on 3% increase from Wise Health Ymonth 1 findings annualized (114,1368)*
2. Non-employees	0	500	2,500	5,000	7,500	*YR1 = 0; YR2-3, 250% inc; YR3-4, 100% inc.; YR4-5, 50% inc.*
3. ED Decompression	1,288	1,391	1,503	1,623	1,753	*8% YOY inc.; based on 15% LWBS, 8% triage 5, 3% triage 4*
Total Teladoc Encounters	2,288	3,891	7,003	9,923	12,883	
4. Referral Visits	458	778	1,401	1,985	2,577	*20% of total teladoc encounters YOY*
Total Encounters	2,746	4,670	8,403	11,908	15,459	
Financial Breakdown by Stat						
1. Reimbursement per Cash Visit	$ -	$ 49.29	$ 49.29	$ 49.29	$ 49.29	*if cash only system; all should come down to avg net blended rate per visit*
2. Reimbursement per Cash + Ins. Visit	$				84.55	*reimburseable amount + co-pay; CPT + co-pay*
3. Incremental Difference	$				35.26	*incremental difference once insurance starts*
Revenue						
1. Payer Mix (Cash Only)						*Medicare&Medicaid --> only using telemedicine specific E/M codes*
a. Medicare	$ -	$ 3,975	$ 19,875	$ 39,750	$ 59,625	*20%; based on 99446-99449 CPT/HCPCS code reimbursement model for physician fee schedule via CMS*
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Total Expenses	**$184,054**	**$252,948**	**$451,381**	**$750,199**	**$953,347**	
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Telemedicine Platform	Year 1	Year 2	Year 3	Year 4	Year 5	Assumptions/Notes

May Board Report

Traveling has remained within Ector county for the last 30 days due to COVID-19. Some traveling and close communication with over 50 clinics in Ector County (including both MCHS Procare and all non Procare clinics), home health agencies, and nursing homes is occurring daily, assuring they are up to date with all MCHS COVID-19 processes/ updates. Daily close communication also still occurring with all regional partners. Education is also being shared with these organizations for medication administration, discharge information for COVID-19 patients, and infection prevention tools. MCHS is hosting a weekly regional call Thursday at 1:30 pm, this call includes discussion around the following items listed below

- Active cases
- Current census
- Transfers
- Supplies/ PPE
- Surge plans

We have discussed with our regional partners the need to exchange patients if volume were to exceed capacity, several are in agreeance to help if that becomes the case.

General physician education is also being created at this time for our regional partners. As previously mentioned in the last few months, Dr Pinnow traveled to Crane to provide physician education, this was greatly appreciated. This is something we are going to continue to create and share with the region, whether it ends up being virtual or in person we will continue to proceed with this project.

Upcoming

- Mr. Tippin and I will be traveling to Stanton to meet new CEO Nancy Cook
- Introduction of Dr. Babbel (hand orthopedic surgeon) and Dr Garcia (Pediatric Medical Director) to the region
- Resume traveling in May