FY2026

Business Plan Strategies

Exceptional Care. Always.

Strengths, Weaknesses, Opportunities, and Threats

	Moore County Hospital District	BSA	Northwest Texas
Strengths (I)	1. Employee and Physician Engagement creates a unified, loyal, stable, optimistic, and forward-thinking culture capable of overcoming tremendous challenges. Tremendous talent and breadth of care for a rural hospital. 2. Community partnerships have created tremendous educational and career opportunities for those desiring healthcare careers. 3. New facility and Moore County's geographic location and economic diversity propel future development and prosperity. 4. High quality, personalized care. Low infection rates. 5. Strategic ability to manage populations (ACO, PHO) positions MCHD for long-term viability. 6. Employment opportunities contribute to local economy & retain talent in the community 7. Updated EHR 8. Flexibility and speed in decision-making due to smaller size 9. Stable clinical staff in acute care, low RN turnover, steady pipeline of nursing through RNEC	1. Positive community perception 2. Diverse product lines 3. Nice facilities 4. BSA Insurance Network 5. Access to Specialists 6. New Level 3 Trauma Designation. 7. Reliance on Rural Facilities for referrals	1. Designated Trauma Center 2. Diverse product lines 3. Texas Panhandle Clinical Partners ACO 4. Access to Specialists 5. Reliance on Rural Facilities for referrals
Weaknesses (I)	1. Lack of public transportation for patient transport 2. Challenges in staffing in certain disciplines & departments outside of nursing (finance, therapy, lab, surgical tech) 3. Lack of engagement with Concord Hospitalist Group 4. No depth in Concord pool of APP and/or Physicians to schedule at MCHD 5. Lack of MD to serve the volume of pediatric needs 6. Lack of mental health providers 7. Limited specialty coverage after hours/PTO 8. Unable to meet surgical demands 24/7 or include all procedures (i.e. general surgery when Agle out, elective total hips or traumas after hours)	1. Understaffed. 2. Infection Rates 3. Potential for Impersonal Service 4. Poor communication and lack of relationship with area hospitals and providers.	1. Understaffed. Poor employee relationships. 2. Potential for Impersonal Service 3. Currently without a permanent CEO. Former leadership left regional relationships in a mess. 4. Ruptured relationships have caused physicians to flee to other hospitals (including MCHD).
Opportunities (E)	1. Modelled after the RNEC, expanding partnership with Amarillo College for Lab Techs could be modeled on the same concept. 2. Partnerships with DISD for CTE opportunities 3. Improve Community Image and Patients Perceptions of Care 4. Improve access to quality of care 5. Need for mental health services & available funding to develop products. 6. Provide counseling services / support group for mental health issues 7. Telehealth opportunities to reach technology-driven market share and outlying market share 8. Expansion of services to include pediatrics & counseling	1. Development of Freestanding ERs/Urgent Care Centers.	1. Development of Freestanding ERs/Urgent Care Centers. Direct employment of rural physicians.
Threats (E)	1. Outmigration from Moore County to Amarillo - Only have 46% of inpatient market share according to Chartis (CMS data) 2. Increasing concentration of revenue streams from governmental programs 3. Limited labor pool 4. Lack of digital care resources (telehealth)	1. Rural hospitals affiliating with NWTHS. 2. High turnover in administration.	1. Strategy to employ rural physicians has fractured relationships with several rural hospitals and reduced the trust others once had in Northwest. 2. BSA achieving Level 3 Trauma Designation will move volume from Northwest. 3. High turnover in administration.

GROWTH

- Analysis of MCHD transfer data indicates patients are being transferred due to a lack of inpatient dialysis capability and others due to need for general nephrology care.
- Kidney disease is an increasing phenomenon among the Moore County patient population.
- Dr. Corbin's resignation creates a leadership vacuum in MCHD's largest employed clinic.
- Local Primary Care Providers are seeing increasing volumes of patients with complex mental health diagnoses.
- MCHD is missing revenue in non-RHC licensed primary care practices.
- Given volumes, clinic structures inhibit personnel and throughput efficiencies.
- Following the end of major construction, smaller renovation projects remain unfinished.

SERVICE

- Engaging physicians in operational decisions is always a strategic imperative.
- Having engaged Custom Learning Systems, MCHD must now implement a comprehensive strategy to address Patient Perceptions of Care.

EMPLOYEES

- MCHD needs to find new paths to engage with community partners to develop future workforce entrants.
- DISD's loss of their CNA educator can effect Moore County's RNEC program.

QUALITY

- A hospitalist program comprised of purely non-MCHD employed providers is not likely to align with MCHD long-term goals. MCHD should move toward hiring our own providers and using an external group to fill remaining open shifts.
- Quality reporting is a core component of modern medicine. MCHD must use quality data reporting processes to produce real outcome improvement.
- Improving Sepsis response, Patient Perceptions of Care, and Maintaining a Top 100 Ranking are identified as focus areas by the Board Quality Committee.

FINANCE

- Continued downward pressure on revenues demands that MCHD find replacement resources through grants and gifts.
- Governmental programs are the replacement revenue source for fee-for-service.

COMMUNITY

- MCHF will lead funding efforts for needed capital equipment and workforce development.
- As a community hospital, MCHD Leaders need to volunteer and serve in the community.

MEDICAL STAFF

- Current and aspiring medical staff leaders need leadership training. Once elected, leadership requires a significant donation of personal time.
- Now that a CMO has been selected, MCHD must now integrate that role into existing administrative and medical staff decision making processes.

GROWTH

"Constantly seek new and innovative ways to grow MCHD"

1. Open Inpatient Dialysis Program
2. Physician Recruiting:
    a. Open Moore County Nephrology (Dr. Shashank Singh)
    b. Start Dr. Chance Pack (to replace Dr. Corbin)
    c. Start Dr. Khushbu Patel (Employed Hospitalist)
    d. Recruit Pediatrics (Subject to Go Forward on New MOB)(2025 Forward Thinking #2)
3. Develop Mental Health Community Case Management Program (2025 Forward Thinking #4)
    a. Employ Clinical Psychologist (Dr. Sandra Yankah)
    b. Begin Counselling Services
4. Facility Projects:
    a. Go/No Go on New Consolidated Primary Care RHC Office Building (2025 Forward Thinking #1)
    b. Complete Chapel, Courtyard, Cafeteria, Corridor, Patient rooms to office conversions
5. Equipment Upgrades

GROWTH STRATEGY 1 | OPEN/EXPAND NEW PRACTICES/PROGRAMS

Goal: To expand access to care and create new health-related products.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Begin Inpatient Dialysis Program	Yessenia			
2. Physician Recruiting: a. Open Moore County Nephrology (Dr. Shashank Singh) b. Start Dr. Chance Pack (to replace Dr. Corbin) c. Start Dr. Khushbu Patel (Employed Hospitalist) d. Recruit Pediatrics (Subject to Go Forward on New MOB) (2025 Forward Thinking #2)	Jeff/Connie/Shawn Connie Jeff/John Jeff			
3. Grow Mental Health Services: a. Employ Clinical Psychologist (Dr. Sandra Yankah) b. Employ/Contract Counselors, Begin Counselling Services	Jeff/Yessenia Jeff/Yessenia	→ →	→ →	

Estimated Impact	**2026**	**2027**	**2028**
Capital Requests ($ in 000s)			
Incremental Admissions	12		
Incremental Surgeries			
Incremental Clinic Visits	100		
Incremental OP Visits			
Incremental Net Revenue			

NATIONAL CENTER FOR HEALTH STATISTICS
Health E-Stats
SEPTEMBER 2024

Visit Rates for Adolescents and Adults With Mental Health Disorders, Substance Use Disorders, or Both Disorders at Health Centers, by Age: United States 2022

by Loredana Santo, M.D., M.P.H., Lello Guluma, M.P.H., and Jill J. Ashman, Ph.D.

In 2022, 84.2 million adults and 6.1 million adolescents were diagnosed with a mental health disorder (MHD) or substance use disorder (SUD) (1). Health centers are community-based clinics that offer primary care to underserved communities. In 2022, health centers offered MHD services to 2.7 million patients and SUD services to about 299,000 patients (2). This report presents rates for MHDs, SUDs, and both MHDs and SUDs by age group for visits to health centers by people age 12 and older, based on the 2022 National Ambulatory Medical Care Survey Health Center Component.

In 2022, the health center visit rate for people age 12 and older with an MHD only was 50.5 visits per 1,000 people. This was higher than rates for people with an SUD only (10.3 visits) and both an MHD and SUD (12.8) (Figure). Similar patterns were observed across all age groups, with rates for MHD only higher than rates for SUD only and both MHD and SUD. Rates for adolescents ages 12–17 with an SUD only (0.6) and with both an MHD and SUD (1.1) were the lowest. Rates for adults ages 26–49 (13.3) and 50 and older (11.9) with an SUD only were higher than rates for young adults ages 18–25 (3.2). Similarly, rates for adults ages 26–49 (19.0) and 50 and older (12.0) with both an MHD and SUD were higher than rates for young adults ages 18–25 (6.2). Rates for MHD only were not significantly different across age groups.

Data source and methods

The 2022 National Ambulatory Medical Care Survey Health Center Component includes visit data from electronic health records from federally qualified health centers and federally qualified health center look-alikes (health centers that meet federally qualified health center eligibility requirements but do not receive program funding) (3). Sampled health centers submitted data for more than 5.6 million visits (unweighted). Sampling design details for the National Ambulatory Medical Care Survey Health Center Component are described elsewhere (4). Weighting, which accounts for sampling probabilities and nonresponse, was conducted to produce national visit-level estimates of health centers from all 50 U.S. states and the District of Columbia (5). Visit

weights were normalized to account for excluded health centers due to complete absence (missingness) of diagnosis variables (5).

Visit rates were calculated by dividing the number of health center visits by population estimates from the U.S. Census Bureau (6). Data analyses were performed using SAS-callable SUDAAN software (7). Reliability of estimates was assessed using National Center for Health Statistics data presentation standards for rates and counts (8). Differences in the distribution were based on chi-square tests ($p < 0.05$). This report uses the restricted-use file (5), and the population includes all visits by people age 12 and older, with age categories defined based on previous reports (1,9). Visits with any of the following codes in any of the diagnosis fields from the *International Classification of Diseases, 10th Revision, Clinical Modification* (10) were used to define MHD only: F01–F09 or F20–F99; and SUD only: F10–F19. MHD only and SUD only are mutually exclusive categories.

References

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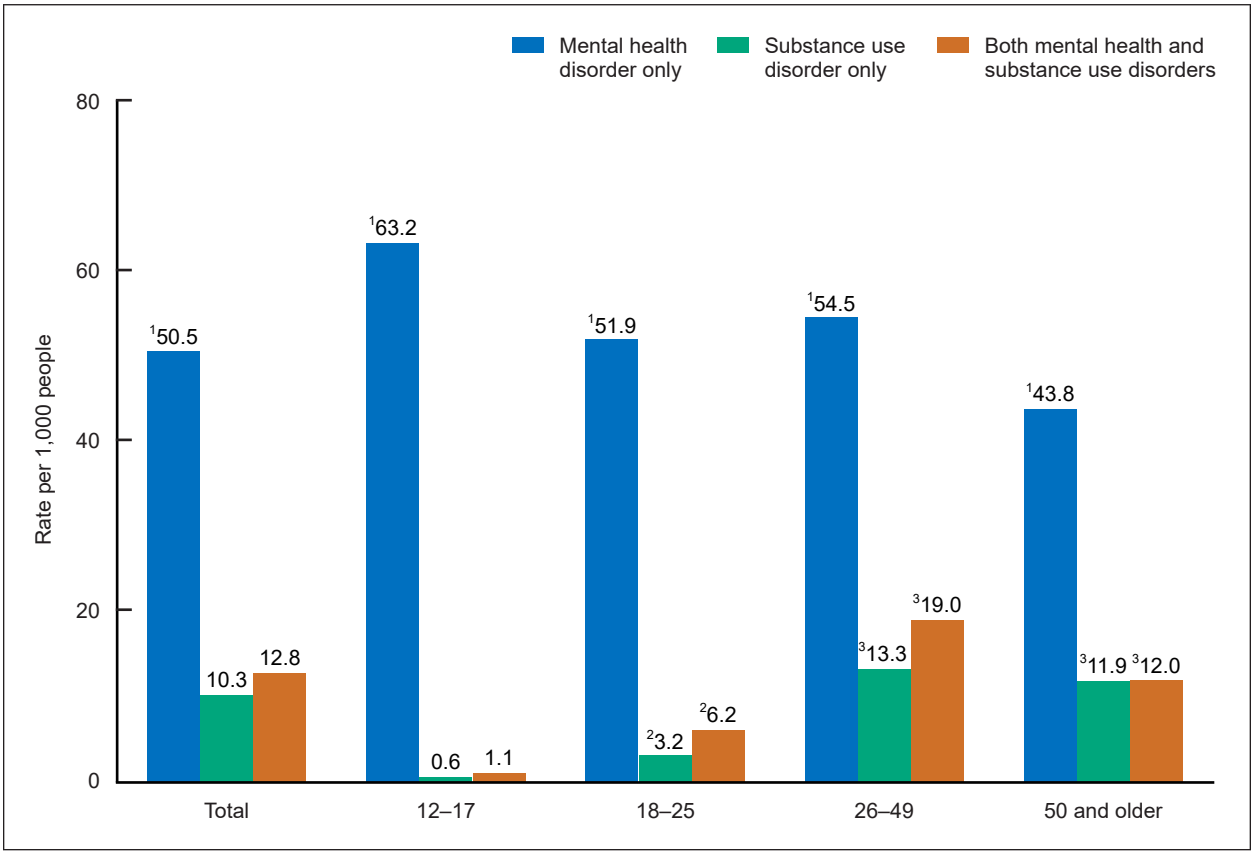
Suggested citation

Santo L, Guluma L, Ashman JJ. Visit rates for adolescents and adults with mental health disorders, substance use disorders, or both disorders at health centers, by age: United States, 2022. NCHS Health E-Stats. 2024. DOI: https://dx.doi.org/10.15620/cdc/160501.

Figure. Visit rate for adolescents and adults with mental health disorders, substance use disorders, or both disorders at health centers, by age group: United States 2022



[1]Rate significantly higher than rates for substance use disorder only and both mental health and substance use disorders, overall and among all age groups.
[2]Rate significantly higher than rate for adolescents ages 12–17.
[3]Rate significantly higher than rates for adolescents ages 12–17 and adults ages 18–25.
NOTES: Rates are based on a sample of 95.8 million visits by adolescents and adults age 12 and older. Mental health disorders are defined as visits with an *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD–10–CM) code between F01 and F09 or F20 and F99. Substance use disorders are defined as visits with an ICD–10–CM code between F10 and F19. Mental health disorder only and substance use disorder only are mutually exclusive categories.
SOURCE: National Center for Health Statistics, National Ambulatory Medical Care Survey Health Center Component, 2022.

Table. Visit rate for adolescents and adults with mental health disorders, substance use disorders, or both disorders at health centers, by age group: United States, 2022

Disorder and age group	Rate per 1,000 people	95% confidence interval
Total:		
Mental health disorder only	50.5	36.0–64.9
Substance use disorder only	10.3	7.1–13.6
Both disorders	12.8	6.5–19.2
12–17:		
Mental health disorder only	63.2	41.1–85.4
Substance use disorder only	0.6	0.3–0.9
Both disorders	1.1	0.5–1.6
18–25:		
Mental health disorder only	51.9	35.9–68.0
Substance use disorder only	3.2	2.0–4.5
Both disorders	6.2	3.0–9.4
26–49:		
Mental health disorder only	54.5	39.2–69.8
Substance use disorder only	13.3	8.7–17.9
Both disorders	19.0	8.6–29.5
50 and older:		
Mental health disorder only	43.8	30.5–57.0
Substance use disorder only	11.9	8.0–15.8
Both disorders	12.0	6.1–17.9

NOTES: Rates are based on a sample of 95.8 million visits by adolescents and adults age 12 and older. Visit rates are based on the July 1, 2022, set of estimates of the U.S. civilian noninstitutionalized population, as developed by the U.S. Census Bureau Population Division. Mental health disorders are defined as visits with an *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD–10–CM) code between F01 and F09 or F20 and F99. Substance use disorders are defined as visits with an ICD–10–CM code between F10 and F19. Health centers where all the diagnoses were missing for any visits were excluded, and visit weights for the remaining health centers were normalized to account for the health centers that were excluded. Mental health disorder only and substance use disorder only are mutually exclusive categories.

SOURCE: National Center for Health Statistics, National Ambulatory Medical Care Survey Health Center Component, 2022.

MENTAL HEALTH & Access to Care in RURAL AMERICA

People from all communities are affected by mental illness, but rural Americans often experience unique barriers to managing their mental health.

AMONG U.S. ADULTS IN NONMETROPOLITAN AREAS, 2020:

21% experienced mental illness

6% experienced serious mental illness

13% experienced a substance use disorder

5% had serious thoughts of suicide

ACCESS TO TREATMENT IS SEVERELY LIMITED

Among U.S. adults in nonmetropolitan areas, 2020:

48% with a mental illness received treatment

62% with a serious mental illness received treatment

Compared to suburban and urban residents, rural Americans:

must travel **2x** as far to their nearest hospital

are **2x** as likely to lack broadband internet, limiting access to telehealth

25+ MILLION rural Americans live in Mental Health Professional Shortage Areas, where there are too few providers to meet demand

SOME POPULATIONS FACE ADDITIONAL CHALLENGES

53% of rural adults say the COVID-19 pandemic has affected their mental health:

66% of farmers and farmworkers

71% of younger adults aged 18-34

Many rural states have a postpartum depression rate higher than the national average of 13%:

AL 21%

MS 22%

AR 23%

Rural youth are at an increased risk of suicide, but highly rural areas have fewer youth suicide prevention services

Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats

NAMI HelpLine 800-950-NAMI (6264) | NAMI | NAMICommunicate | NAMICommunicate | www.nami.org

NAMI National Alliance on Mental Illness

Mental Health Care MATTERS

Mental health treatment — therapy, medication, self-care — have made recovery a reality for most people experiencing mental illness. Although taking the first steps can be confusing or difficult, it's important to start exploring options.

The average delay between symptom onset and treatment is

11 YEARS

PEOPLE WHO GET TREATMENT IN A GIVEN YEAR

47% of adults with mental illness

65% of adults with serious mental illness

51% of youth (6-17) with a mental health condition

Adults with a mental health diagnosis who received treatment or counseling in the past year

25% of Asian adults

36% of Hispanic or Latino adults

39% of Black adults

52% of White adults

52% of adults who report mixed/multiracial

56% of lesbian, gay and bisexual adults

For therapy to work, you have to be open to change. I'm proud to say that I changed. ***Therapy saved my life.***

– NAMI Program Leader

Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats

NAMI HelpLine 800-950-NAMI (6264) | NAMI | NAMICommunicate | NAMICommunicate | www.nami.org

NAMI National Alliance on Mental Illness

Common WARNING SIGNS of Mental Illness

Diagnosing mental illness isn't a straightforward science. We can't test for it the same way we can test blood sugar levels for diabetes. Each condition has its own set of unique symptoms, though symptoms often overlap. Common signs and/or symptoms can include:

- Feeling very sad or withdrawn for more than two weeks
- Trying to harm or end one's life or making plans to do so
- Severe, out-of-control, risk-taking behavior that causes harm to self or others
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or difficulty breathing
- Significant weight loss or gain

- Seeing, hearing or believing things that aren't real*
- Excessive use of alcohol or drugs
- Drastic changes in mood, behavior, personality or sleeping habits
- Extreme difficulty concentrating or staying still
- Intense worries or fears that get in the way of daily activities

*Various communities and backgrounds might view this sign differently based on their beliefs and experiences. Some people within these communities and cultures may not interpret hearing voices as unusual.

WORRIED ABOUT YOURSELF OR SOMEONE YOU CARE ABOUT?

If you notice any of these symptoms, it's important to ask questions

Try to understand what they're experiencing and how their daily life is impacted

Making this connection is often the first step to getting treatment

50% of all lifetime mental illness begins by age **14**

75% by age **24**

KNOWLEDGE IS POWER

Talk with a health care professional

Learn more about mental illness

Take a mental health education class

Call the NAMI HelpLine at 800-950-NAMI (6264)

Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats

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NAMI National Alliance on Mental Illness

You are NOT ALONE

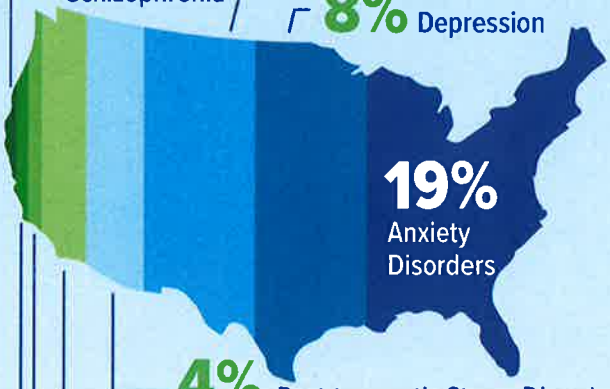
Millions of people are affected by mental illness each year. Across the country, many people just like you work, perform, create, compete, laugh, love and inspire every day.

1 in 5 U.S. adults experience mental illness

1 in 20 U.S. adults experience serious mental illness

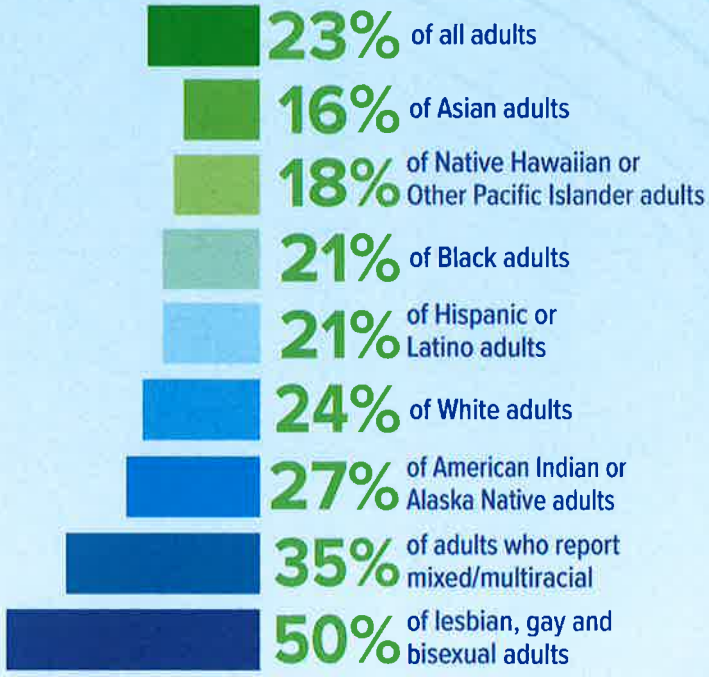
17% of youth (6-17 years) experience a mental health disorder

12 MONTH PREVALENCE OF COMMON MENTAL ILLNESSES (ALL U.S. ADULTS)



- 4% Post-traumatic Stress Disorder
- 3% Bipolar Disorder
- 1% Borderline Personality Disorder
- 1% Obsessive Compulsive Disorder

12 MONTH PREVALENCE OF ANY MENTAL ILLNESS (ALL U.S. ADULTS)



WAYS TO REACH OUT AND GET HELP

- Talk with a health care professional
- Call the NAMI HelpLine at 800-950-NAMI (6264)
- Connect with friends and family
- Join a support group

Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats

NAMI HelpLine 800-950-NAMI (6264) | NAMI | NAMICommunicate | NAMICommunicate | www.nami.org

NAMI National Alliance on Mental Illness

The RIPPLE EFFECT of Mental Illness

Having a mental illness can make it challenging to live everyday life and maintain recovery. Beyond the individual, these challenges ripple out through our families, our communities, and our world.

PERSON

People with serious mental illness have an increased risk for chronic disease, like diabetes or cancer

Rates of cardiometabolic disease are twice as high in adults with serious mental illness

34% of U.S. adults with mental illness also have a substance use disorder

FAMILY

At least **8.4 million** Americans provide care to an adult with an emotional or mental illness

Caregivers spend an average of **32 hours** per week providing unpaid care

COMMUNITY

21% of unhoused people experience serious mental illness

Depressive disorders are the #1 cause of hospitalization for people aged <18 *after excluding those related to pregnancy and birth*

Psychosis spectrum and mood disorders lead to nearly 600k hospitalizations per year for people aged 18-44

20% of U.S. Veterans experience mental illness

WORLD

Depression is a leading cause of disability worldwide

Depression and anxiety disorders cost the global economy **$1 trillion** each year in lost productivity

Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats

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NAMI National Alliance on Mental Illness

Mental Illness and the CRIMINAL JUSTICE SYSTEM

People with mental illness deserve help, not handcuffs. Yet people with mental illness are overrepresented in our nation's jails and prisons. We need to reduce criminal justice system involvement and increase investments in mental health care.

About **2 million times** each year, people with serious mental illness are booked into jails.

About **2 in 5** people who are incarcerated have a **history of mental illness** (37% in state and federal prisons and 44% held in local jails).

66% of women in prison reported having a history of mental illness, **almost twice the percentage of men** in prison.

Nearly **1 in 4 people shot and killed** by police officers between 2015–2020 had a mental health condition.

Suicide is the **leading cause of death** for people held in local jails.

An estimated **4,000 people** with serious mental illness are held in solitary confinement inside U.S. prisons.

COMMUNITIES

70% of youth in the juvenile justice system have a diagnosable mental health condition.

Youth in detention are **10x more likely** to suffer from psychosis than youth in the community.

About **50,000 veterans** are held in local jails — 55% report experiencing mental illness.

Among incarcerated people with a mental health condition, **non-white individuals** are more likely to be held in solitary confinement, be injured and **stay longer in jail.**

ACCESS TO CARE

About **3 in 5 people** (63%) with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons.

45%

Less than half of people with a history of mental illness **receive mental health treatment** while held in local jails.

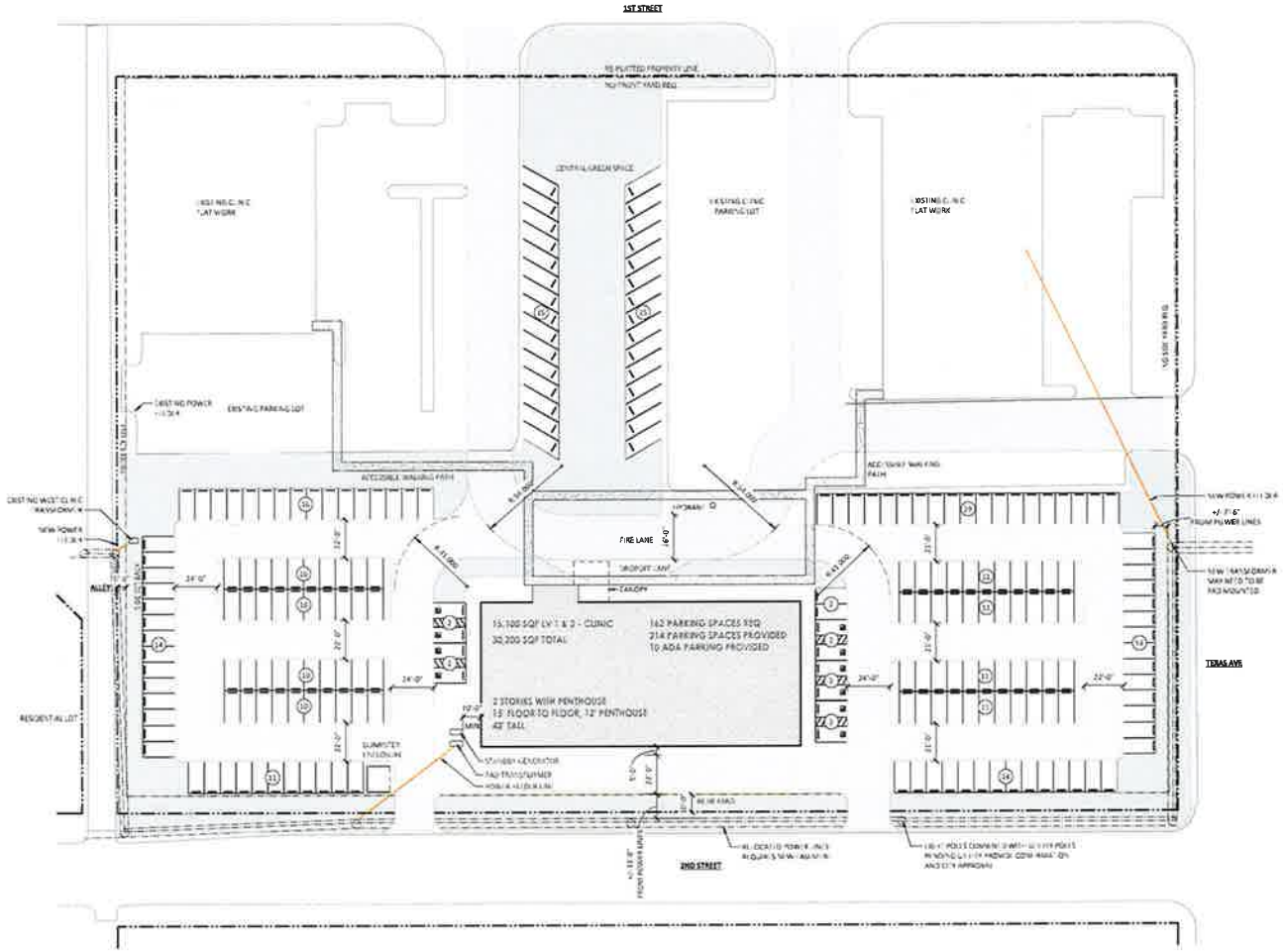
People who **have health care coverage** upon release from incarceration are more likely to **engage in services that reduce recidivism.**

Data from the U.S. Department of Justice and other select sources. Find citations for this resource at **nami.org/mhstats**

Goal: Develop facilities and environments that support the provision of care.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Go/No Go Decision on Consolidated Primary Care Medical Office Building (2025 Forward Thinking #1) a. If Go: i. Secure Financing ii. Finalize Plans iii. Begin Construction	Jeff/John	→	→	→
2. Complete: a. Chapel b. Courtyard c. Corridor d. Patient rooms to office conversions e. Cafeteria (If successful in ending Hospital project and retaining USDA funds) i. Unidine Service Enhancement – Fresh Market, Dining Options	Jeff/Shawn Jeff/Committee Jeff/Shawn Jeff/Shawn Jeff/Shawn/Terrance	→ →		

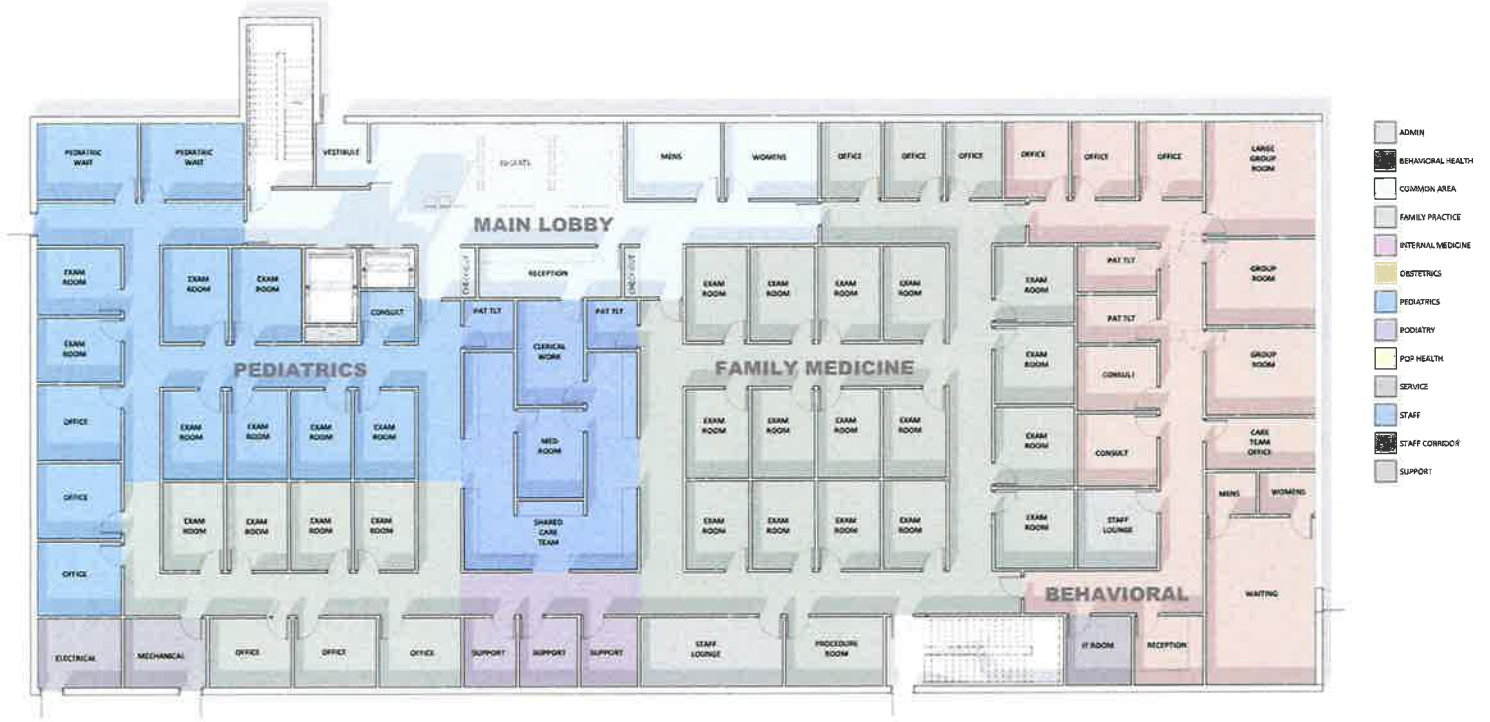
Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)			
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue			



05/06/2025

SITE PLAN

Guide ARCHITECTURE



1 LEVEL 1 - FLOOR PLAN
1/8" = 1'-0"

1 LEVEL 2 - FLOOR PLAN
1/8" = 1'-0"

05/06/2025

SITE PLAN

Guide
ARCHITECTURE

05/06/2025

AERIAL VIEW

Guide
ARCHITECTURE

05/06/2025

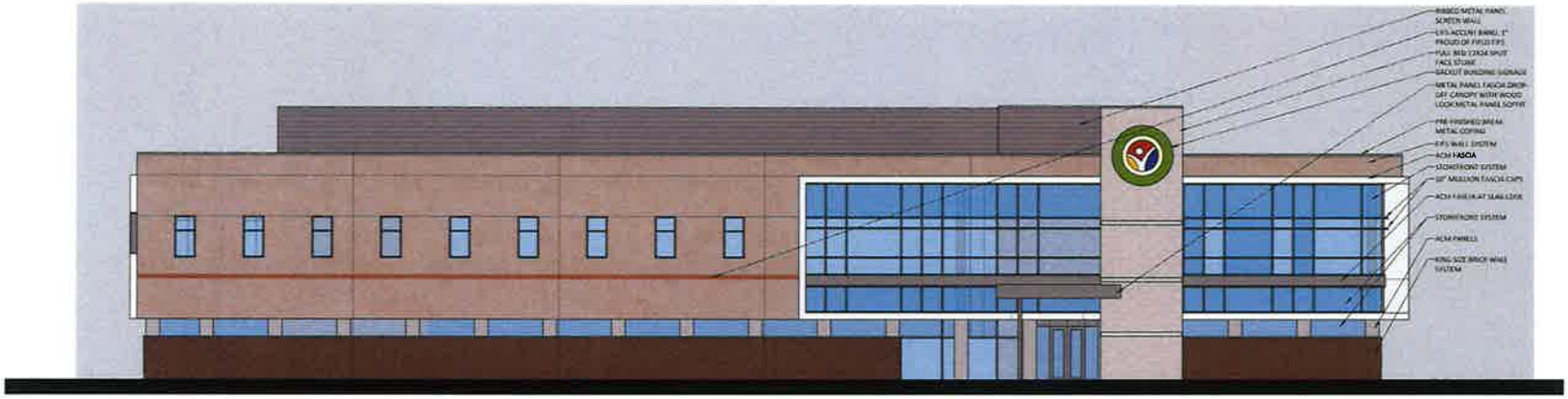
PERSPECTIVE VIEW 1

Guide
ARCHITECTURE

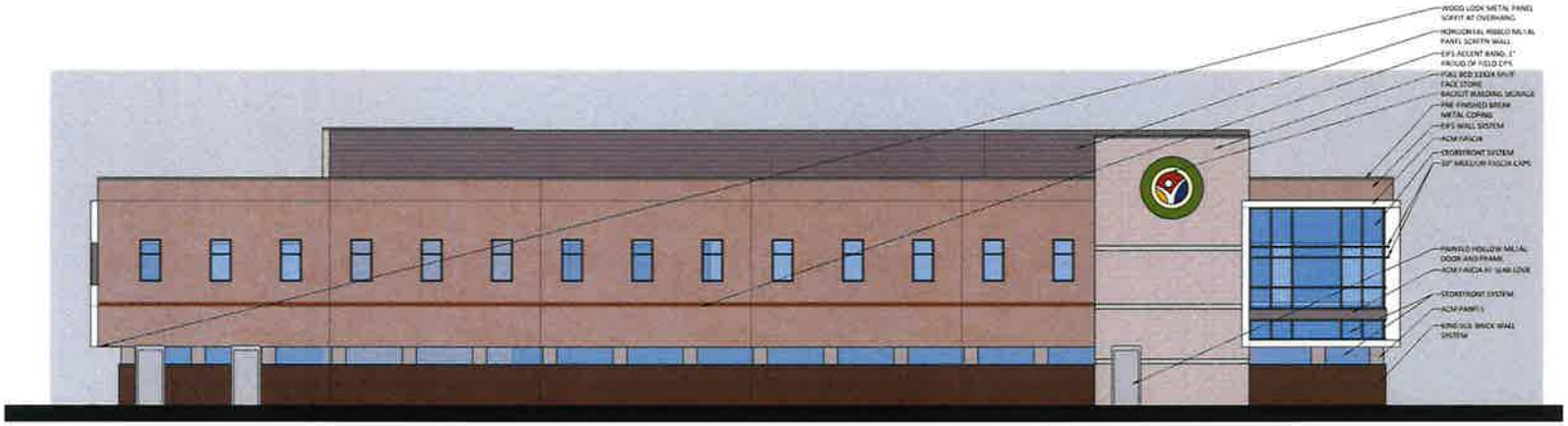
05/06/2025

PERSPECTIVE VIEW 2

Guide
ARCHITECTURE



2 EXTERIOR ELEVATION - NORTH
1/8" = 1'-0"



1 EXTERIOR ELEVATION - SOUTH
1/8" = 1'-0"

05/06/25

EXTERIOR ELEVATIONS

Guide ARCHITECTURE

2 EXTERIOR ELEVATION - WEST
1/8" = 1'-0"

1 EXTERIOR ELEVATION - EAST
1/8" = 1'-0"

05/06/25

EXTERIOR ELEVATIONS

Guide
ARCHITECTURE

PRELIMINARY PROFORMA

DATE OPENED: 06/17/25
PROJECT: Moore County RHC
APPROVAL DATE:
Developer Katie Newman High Point
PROJECT MANAGER: Charles Watkins OGA
NEW BUDGET:
APPROVED AMOUNT:
REVISED BUDGET:
DATE CLOSED:

SITE INFORMATION

PROJECT NAME: MCHD Dumas, TX - MOB
ADDRESS: TBD East 1st Street
CITY, STATE, ZIP: Dumas, TX
PROJECT MANAGER: Charles Watkins
Project Gross Square Feet: 30,000

DRAFT

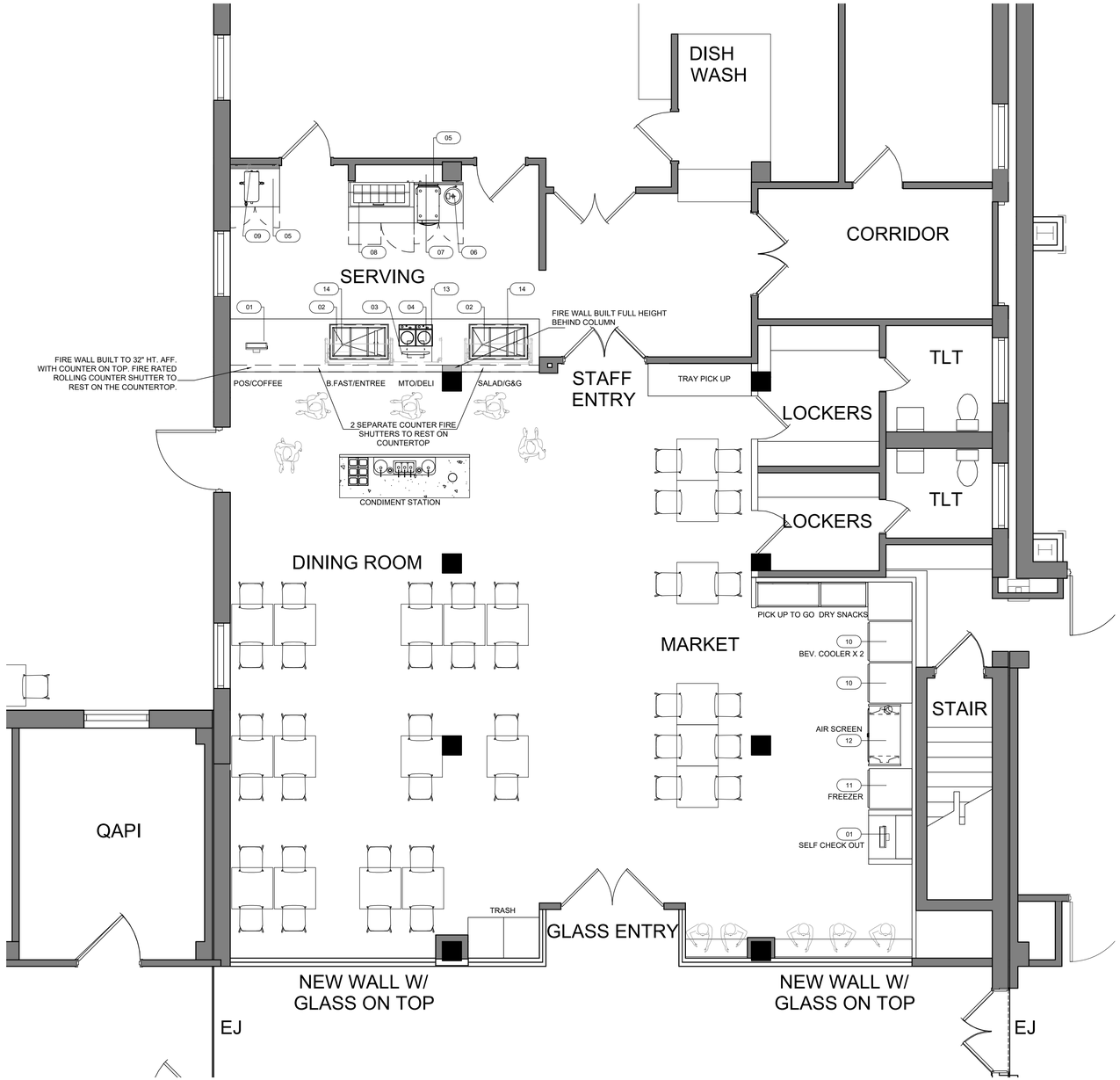
LAND ACREAGE: 1.81

PROJECT DESCRIPTION Ground-up, 2 story MOB development to include IM, FP, OB, Pedi, Podiatry, Mental Health, & Pop Health.

Phase Code - Phase Description Phase Job Cost	Preliminary Budget 6.17.25	Preliminary Comments
MCHD DUMAS, TX - MOB		
G01 - LAND		
G01.01 Land	$0.00	Owned by MCHD
Total G01	**$0.00**	
G02 - LAND ACQUISITION		
G02.01 Land Closing	$25,000.00	Legal, Title, Insurances
G02.02 Loan/Grant Closing	$150,000.00	Lender, Recording, Appraisal, Legal
Total G02	**$175,000.00**	$5.83
G03 - LAND ENTITLEMENTS/DEVELOPMENT		
G03.01 Sub-platting	$5,000.00	Minor Subdivision
G03.02 Fees, Studies, Etc.	$2,500.00	Blueprinting, Site Plan, Etc.
Total GO3	**$7,500.00**	$0.25
G04 - HARD		
G04.01 Permits	$0.00	Building Permit/Plan Review
G04.02 Site & Shell	$6,750,000.00	$225.00
G04.03 Tenant Improvements	$6,750,000.00	$225.00
G04.03 FFE	$0.00	By Owner
Total G04	**$13,500,000.00**	$450.00
G05 - SOFT		
G05.01 Geotech/Soils	$10,000.00	Includes Private Utility Locate
G05.02 ALTA Survey	$12,500.00	Includes ALTA, Foundation & As-Built
G05.03 Phase I ESA	$3,000.00	
G05.04 Phase I Update	$0.00	Assume no update required
G05.05 Civil	$80,000.00	
G05.06 Architectural	$617,500.00	
G05.07 Arch Reimb.	$20,000.00	Reimburseables
G05.08 Structural	$0.00	Incl. in Architect
G05.09 MPE	$0.00	Incl. in Architect
G05.10 Landscaping Design	$0.00	Incl. in Civil
G05.11 Impact Fees	$0.00	Not Included
G05.12 Tap/Capacity Fees	$25,000.00	Water & Sewer
G05.13 Materials Testing	$35,000.00	
G05.14 Traffic Impact Study	$10,000.00	If Required
G05.15 MRI RF Enclosure (Imaging)	$0.00	
G05.16 Utility Fees/Deposits	$75,000.00	Electric/Gas
G05.17 Tax Expense	$0.00	None Assumed
G05.18 Lender Inspection Fees	$18,000.00	Includes Down Date Endorsement
G05.19 HVAC Commissioning	$25,000.00	
G05.20 Equipment Planning	$35,000.00	By Tenant
Total G05	**$966,000.00**	$32.20
G06 - OTHER		
G06.01 Development Fee	$684,000.00	4%
G06.02 Travel Expenses	$12,500.00	
G06.03 Contingency	$675,000.00	5%
G06 04 Escalations	$1,080,000.00	8%
Total G06	**$2,451,500.00**	$81.72
G07 - FINANCING		
G07.01 Construction Period Interest	$0.00	Financing Dependent
Total G06	**$0.00**	
BUDGET TOTALS:	**$17,100,000.00**	$570.00

FOODSERVICE EQUIPMENT SCHEDULE

ITEM NO.	QTY.	DESCRIPTION	REMARKS
01	2	POS	
02	2	3-PAN DROP-IN HOT / COLD WELL	DELFIELD - N8643P
03		DOWNDRAFT AIR FILTER SYSTEM	SPRING USA - AF350
04	2	COUNTERTOP INDUCTION RANGE	SPRING USA - SM 181C
05	2	REFRIGERATED WORK TABLE	TRUE MFG. - TWT-36-HC
06	1	SOUP WELL	COOKTEK - 11QT. SINAQUA SOUPER
07	1	TURBOCHEF SOTA	
08	1	MAKE STATION	TRUE MFG. - TSSU-48-12D-2-HC
09	1	BUNN COFFEE MAKER	BUNN-O-MATIC 531.0101 FILTERED WATER LINE REQUIRED. REFER CUT SHEETS FOR DETAILS
		MARKET EQUIPMENT	
10	2	BEVERAGE COOLER	MINUS FORTY - 22-USGR-F2-BL
11	1	FREEZER	MINUS FORTY - 22-USGF-F2-BL
12	1	REFRIGERATED SELF SERVICE CASE	STRUCTURAL CONCEPTS - B4524
13	1	40" FULL-SERVE SNEEZE GUARD	#04 INDUCTION RANGE
14	2	50" FULL-SERVE SNEEZE GUARD W/HEAT & LIGHT	#02 3-PAN DROP-IN HOT/COLD WELL

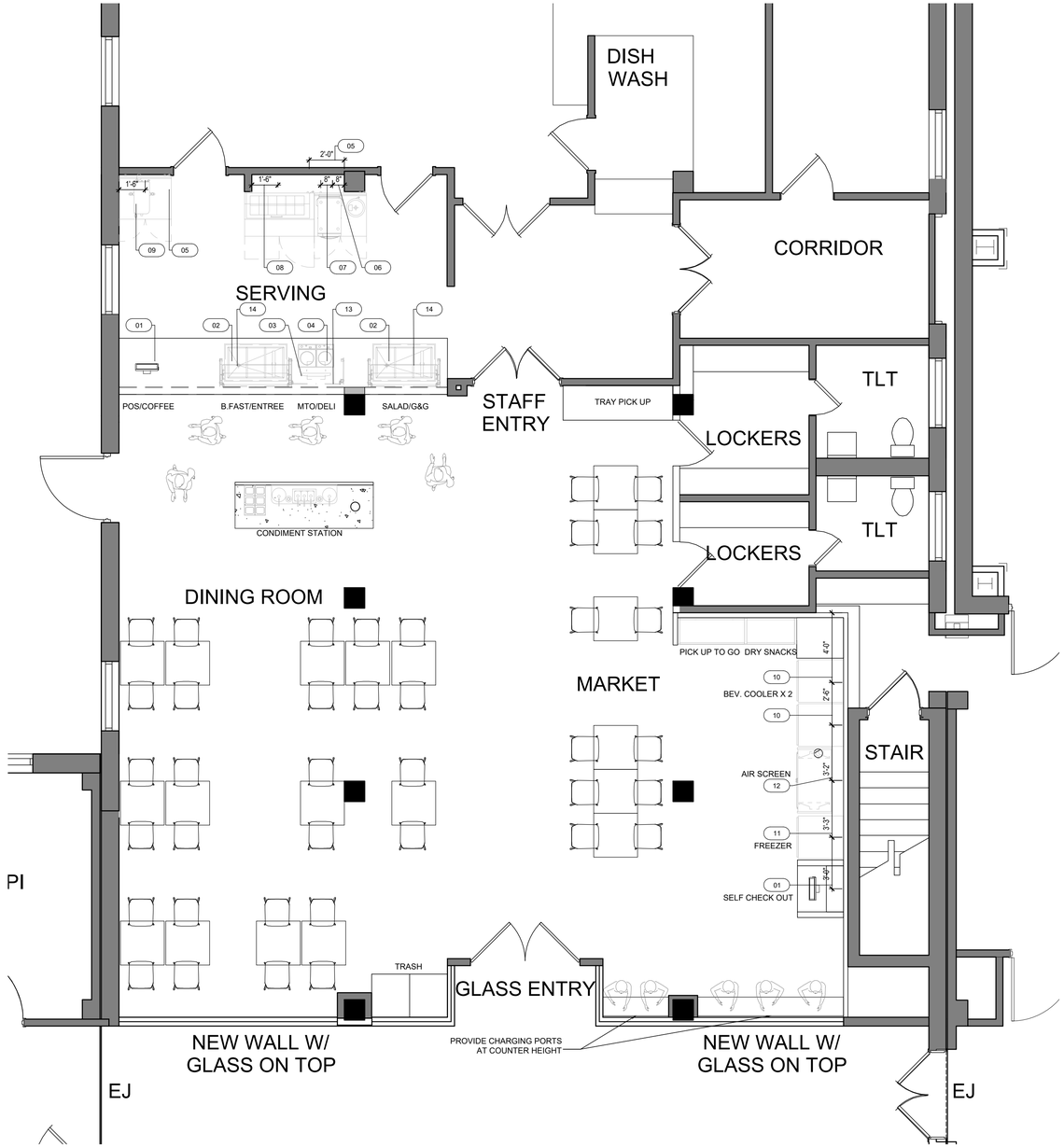


1 / ID-2 FS EQUIPMENT PLAN
SCALE: 1/4" = 1'-0"

PROJECT: SERVERY/ DINING HALL REFRESH MOORE COUNTY HOSPITAL DISTRICT TEXAS	DATE: JAN 19, 2022	
	SCALE: (PDF NTS)	
DRAWING: EQUIPMENT PLAN	PROJECT: 2022046	NORTH:
FILE NAME:	DRAWN BY: _	PAGE: ID-2

FOODSERVICE ELECTRICAL SCHEDULE

ITEM NO.	QTY	DESCRIPTION	VOLTS	CYCLE	PHASE	KW	AMP	TYPE	NEMA	REMARKS
01	2	POS	-	-	-	-				
02	2	3-PAN DROP-IN HOT/COLD WELL	120	60	1		21			
03	1	DOWNDRAFT AIR FILTER SYSTEM	110-120	60	1	350	3		5-15P	
04	2	COUNTERTOP INDUCTION RANGE	120	60	1		15		5-15P	
05	2	REFRIGERATED WORK TABLE	115	60	1		2.0		5-15P	
06	1	11QT DROP-IN SOUP WELL	120	60	1	0.5	4.2			
07	1	TURBOCHEF SOTA	208	60	1	6.2	30		6-30P	
08	1	MAKE STATION	115	60	1		5.8		5-15P	
09	1	BUNN-O-MATIC	120	60	1	1.7	14		5-15P	
10	1	BEVERAGE COOLER	115	60	1	.37	4.6		5-15P	
11	1	FREEZER	115	60	1	.37	4.6		5-15P	
12	1	REFRIGERATED SELF SERVICE CASE	208	60	1		10.82		6-15P	
14	2	50" FULL-SERVE SNEEZE GUARD W/HEAT & LIGHT								REF. MANUFACTURER'S CUT SHEETS FOR DETAILS



1/ID-2 FS ELECTRICAL PLAN
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	SCALE: (PDF NTS)	
DRAWING: FS ELECTRICAL PLAN	PROJECT: 2022046	NORTH:
FILE NAME:	DRAWN BY: _	PAGE: ID-2

FOODSERVICE EQUIPMENT SCHEDULE

ITEM NO.	QTY.	DESCRIPTION	REMARKS
01	2	POS	
02	2	3-PAN DROP-IN HOT / COLD WELL	DELFIELD - N8643P
03		DOWNDRAFT AIR FILTER SYSTEM	SPRING USA - AF350
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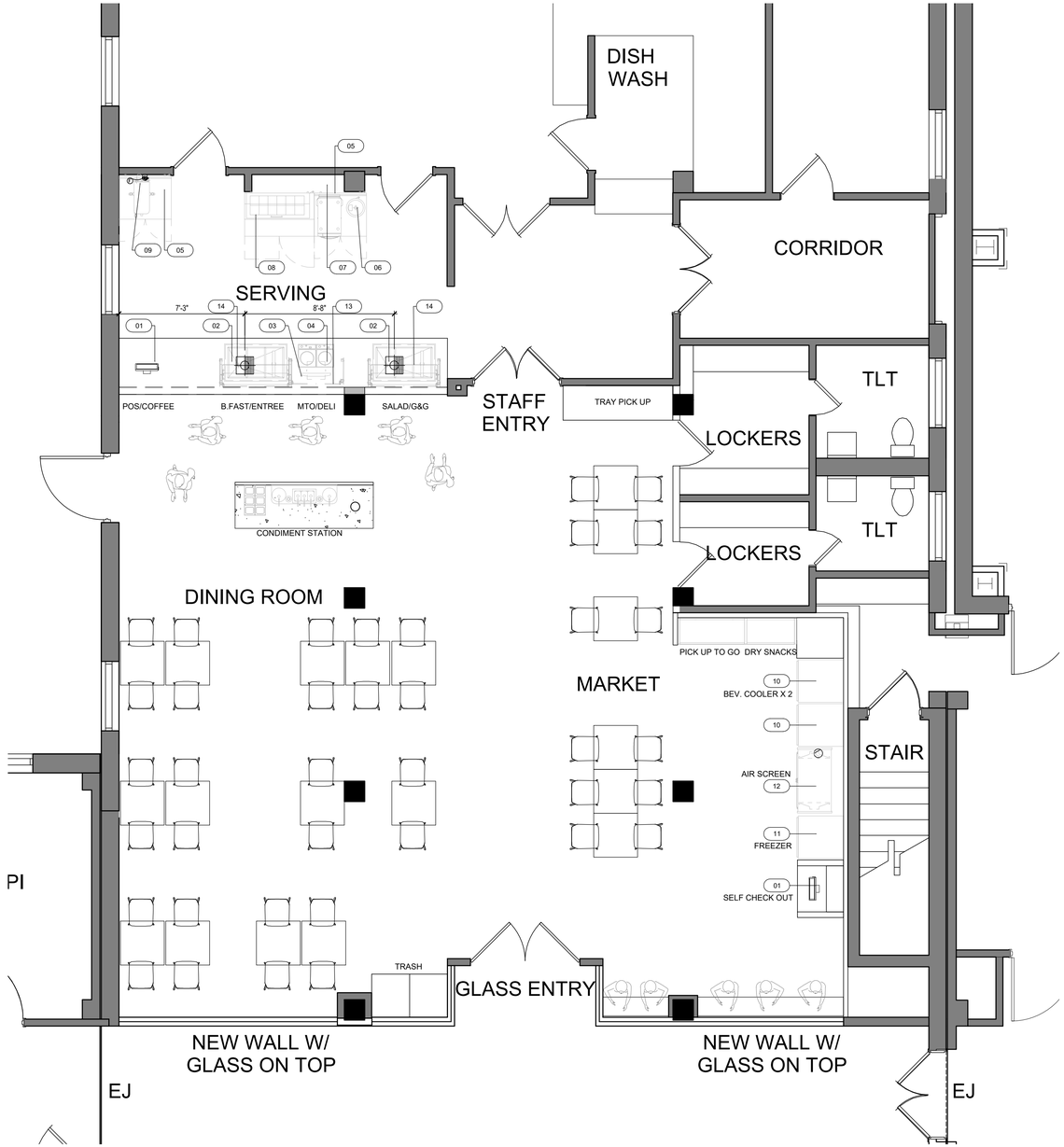
06	1	SOUP WELL	COOKTEK - 11QT. SINAQUA SOUPER
07	1	TURBOCHEF SOTA	
08	1	MAKE STATION	TRUE MFG. - TSSU-48-12D-2-HC
09	1	BUNN COFFEE MAKER	BUNN-O-MATIC 531.0101 FILTERED WATER LINE REQUIRED. REFER CUT SHEETS FOR DETAILS
		MARKET EQUIPMENT	
10	2	BEVERAGE COOLER	MINUS FORTY - 22-USGR-F2-BL
11	1	FREEZER	MINUS FORTY - 22-USGF-F2-BL
12	1	REFRIGERATED SELF SERVICE CASE	STRUCTURAL CONCEPTS - B4524
13	1	40" FULL-SERVE SNEEZE GUARD	#04 INDUCTION RANGE
14	2	50" FULL-SERVE SNEEZE GUARD W/HEAT & LIGHT	#02 3-PAN DROP-IN HOT/COLD WELL

PLUMBING LEGEND

- FLOOR SINK - FULL GRATE
- FLOOR SINK - PARTIAL GRATE
- FILTERED WATER



1 / ID-2 FS PLUMBING PLAN
SCALE: 1/4" = 1'-0"

PROJECT: SERVERY/ DINING HALL REFRESH MOORE COUNTY HOSPITAL DISTRICT TEXAS	DATE: JAN 19, 2022	
	SCALE: (PDF NTS)	
DRAWING: FS PLUMBING PLAN	PROJECT: 2022046	NORTH:
FILE NAME:	DRAWN BY: _	PAGE: ID-2

ESTIMATE

NEW CAFE RESET

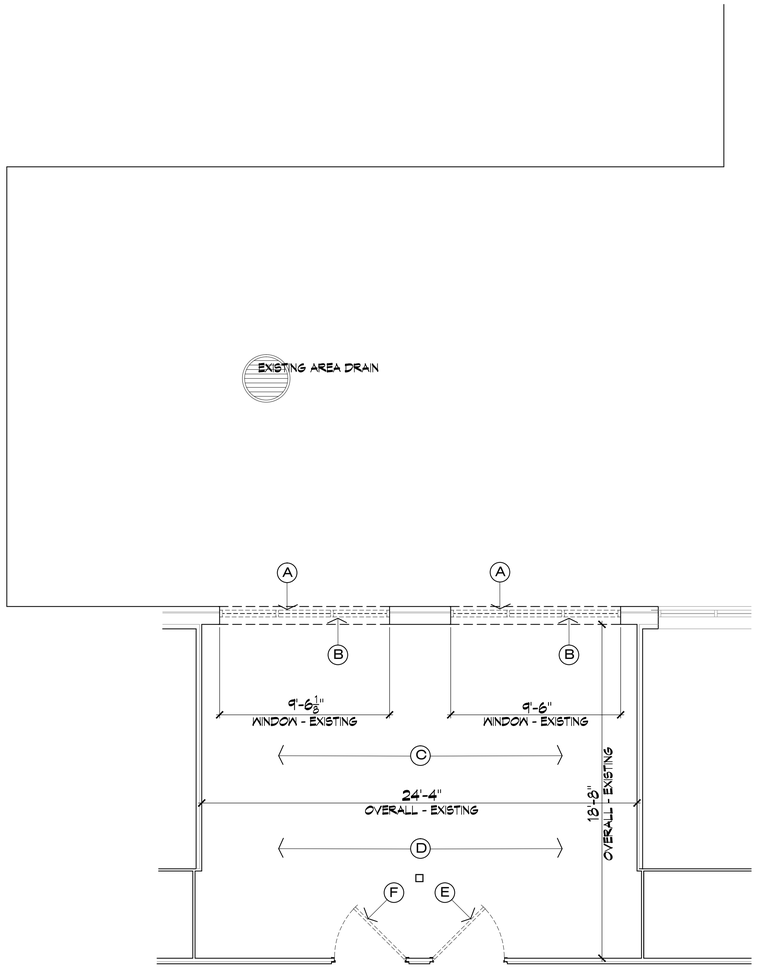
DATE: 2/27/2023
ESTIMATE:

ACCOUNT:	Moore County Hospital District			TOTAL PROJECT
ADDRESS:	224 East 2nd Street			
CITY:	Dumas	STATE: TX	ZIP CODE:	79029
Cost Center:				Unidine
Vendor ID				

QUANTITY	DESCRIPTION	UNIT PRICE	TOTAL
	Millwork Package		
	Front Counter	21,390.00	
	Tray Pick Up	6,715.00	
	Condiment	8,556.00	
	Trash Units	4,657.00	
	Poser Bar	6,210.00	
	Market Wall	21,217.00	
	(5) Bar Height Chairs	2,825.00	
	Subtotal Millwork Package	**71,570.00**	**$ 71,570.00**
	Equipment Package		
	Drop In (3 pan) Hot/ Cold	19,740.00	
	Induction Coutnertop Cook Station	5,005.00	
	Refrigerated Work Table	4,620.00	
	Soup Rethermalizer (countertop	1,370.00	
	Turbo Chef Sota	15,805.00	
	Make Station	7,740.00	
	Coffee Brewer/ Dual	Exising	
	(2) Minus40 Bev Coolers	4,935.00	
	(1) Minus40 Freezer	4,335.00	
	Refrigerated Self Service Air Screen	13,030.00	
	Sneeze Guard Package	14,425.00	
	Subtotal Equipment Package	**91,005.00**	**$ 91,005.00**
	Graphics/ Design Elements-		
	Graphics Signage allowance	7,500.00	
	Video Menu Signage (2)	3,400.00	
	Subtotal Graphics Package	**10,900.00**	**$ 10,900.00**
	Services		
	Design Services	6,500.00	
	PM Services	9,500.00	
	Site Visits for Verifications	5,800.00	
	Millwork & Equipment Installation	17,500.00	
	Punch Trip	4,250.00	
	Burn In and Start Up	3,200.00	
	Shipping & Handling (Dedicated & LTL)	19,900.00	
	Contingency (not billed if not used)	10,000.00	
	Project Fee	15,095.00	
	Subtotal Services	**91,745.00**	**$ 91,745.00**
	Construction Services-	**365,300.00**	**$ 368,395.00**
	Demo/Drywall/Acoustical		
	DFH/Fire Shutters		
	Painting		
	Flooring/Base		
	Glass/Glazing		
	Millwork		
	Electrical		
	HVAC		
	Plumbing		
	Fire Alarm		
	Fire Sprinkler		
	Contingency		
	General Conditions		
	HUB project/program management fee		**$ 10,000.00**
	All work Done During Regular Hours		

SUBTOTAL	$	643,615.00
EST SALES TAX		53,098.24
TOTAL	**$**	**696,713.24**

PAYMENT	TERMS	
DOWN	Upon acceptance	$348,356.62
PROGRESS	At Install	$313,520.96
FINAL	Completion	$34,835.66



EXISTING CORRIDOR

demolition floor plan

SCALE : 1/4" = 1'-0"

NORTH

DEMOLITION NOTES

(A) REMOVE EXISTING ALUMINUM / GLASS WINDOW IN ITS ENTIRETY; PREP EXISTING MASONRY HEAD, JAMBS AND SILL AS REQUIRED TO INSTALL NEW ALUMINUM CURTAIN WALL AS DETAILED.

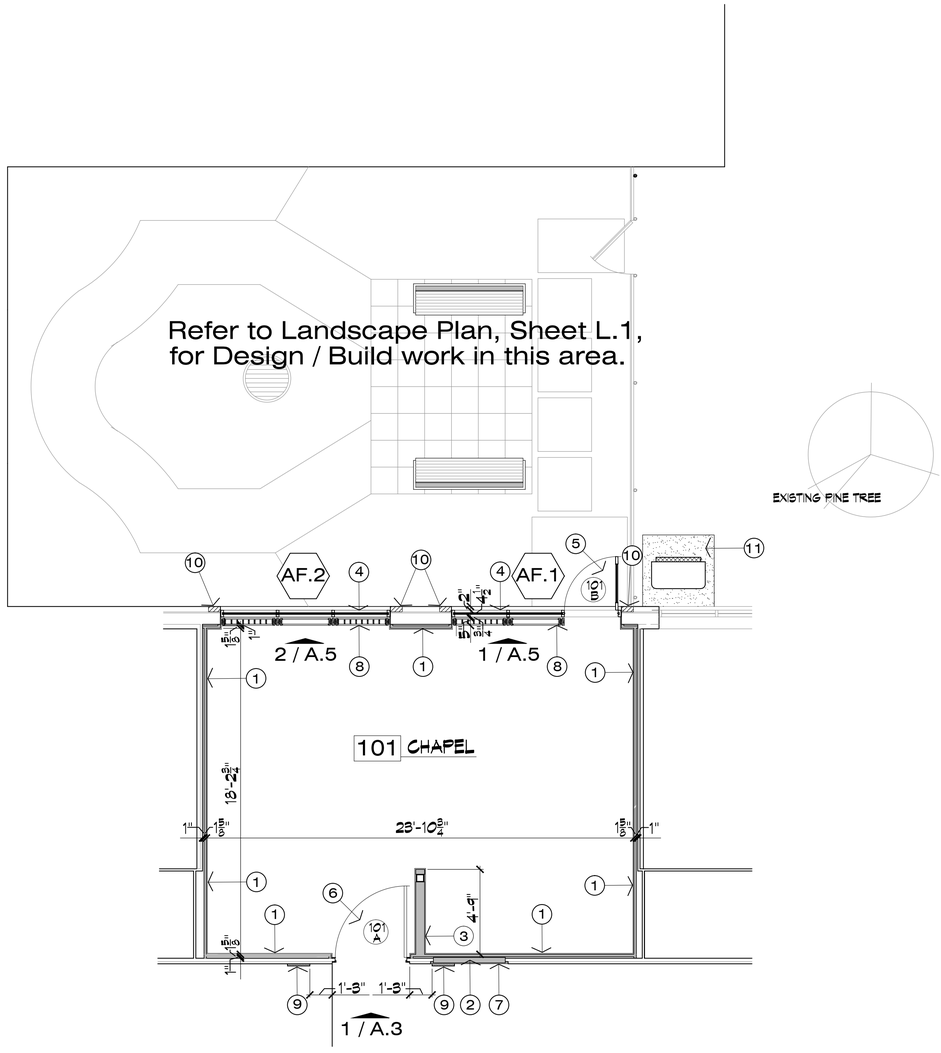
(B) REMOVE EXISTING MASONRY WALL FROM THE WINDOW SILLTO THE FLOOR IN ITS ENTIRETY; PREP JAMBS AND FLOOR AS REQUIRED TO INSTALL NEW ALUMINUM CURTAIN WALL AS DETAILED.

(C) EXISTING PLASTER SUB-CEILING TO REMAIN; PATCH ANY EXISTING HOLES AND OPENINGS IN CEILING.

(D) REMOVE EXISTING FLOORING IN ITS ENTIRETY; PREP FLOOR (REMOVE HIGH SPOTS / LEVEL LOW SPOTS) AS REQUIRED TO RECEIVE NEW FLOORING.

(E) REMOVE EXISTING 4'-0" X 7'-0" DOOR AND HM FRAME IN ITS ENTIRETY; PREP ADJACENT SURFACES AS REQUIRED FOR NEW CONSTRUCTION.

(F) REMOVE EXISTING 4'-0" X 7'-0" DOOR AND HARDWARE IN ITS ENTIRETY; PREP FRAME AS REQUIRED FOR INSTALLATION OF NEW DOOR.



floor plan

SCALE : 1/4" = 1'-0"

NORTH

CONSTRUCTION NOTES:

(1) FURR OUT EXISTING WALL WITH 5/8" GYPSUM BOARD ON ONE SIDE OF 1 5/8" METAL STUDS AT 16" OC; INSTALL 2 1/2" SOUND ATTENUATING INSULATION BATTS IN WALL CAVITY;FINISH WALL AS SCHEDULED, SHEET A.3.

(2) FILL OPENING IN EXISTING WALL WHERE DOOR AND FRAME WAS REMOVED; INSTALL 5/8" GYPSUM BOARD ON ONE SIDE OF 3 5/0" METAL STUDS AT 16" OC; FINISH WALL AS SCHEDULED, SHEET A.3 AND AS NOTED ON THIS SHEET, NOTE 7.

(3) INSTALL NEW DRYWALL PARTITION (5/8" GYPSUM BOARD ON BOTH SIDES OF 6" METAL STUDS AT 16" O.C.); EXTEND STUDS FROM FLOOR TO 6" ABOVE FINISHED CEILING; FINISH AS SCHEDULED, SHEET A.3.

(4) INSTALL NEW ALUMINUM CURTAIN WALL (KAWNEER TRI-FAB 451) AS DETAILED ON SHEET A.4; REFER TO DETAILS FOR GLASS TYPE AND COLOR AND FRAME FINISH; REFER TO SHEET A.3 FOR DOOR TYPE AND COLOR.

(5) INSTALL NEW 5'-0" X 7'-0" ALUMINUM / GLASS DOOR (KAWNEER MEDIUM STILE) AS DETAILED ON ON ALUMINUM FRAME ELEVATIONS, SHEET A.4.

(6) INSTALL NEW 4'-0" X 7'-0" X 1 3/4" THICK SOLID CORE WOOD DOOR IN EXISTING HOLLOW METAL FRAME; REFER TO DOOR SCHEDULE, SHEET A.3.

(7) INSTALL VINYL WALL COVERING AND VINYL COVE BASE WHERE DOOR / FRAME WAS REMOVEED AND PATCHED AS PER NOTE 2; REFER TO ROOM FINISH SCHEDULE, SHEET A.3.

(8) INSTALL DECORATVE WOOD SCREENS AS DETAILED AND NOTED ON SHEET A.5; REFER TO ELEVATIONS 1/A.5 AND 2/A.5 FOR BASE BID AND ELEVATIONS 3/A.5 AND 4/A.5 FOR ALTERNATE NO. 1.

(9) INSTALL STAINED GLASS LED WALL SCOUNCE AS SHOWN ON INTERIOR ELEVATION 1 / A.3; REFER TO ELECTRICAL, SHEET E.1.

(10) PATCH FACE BRICK AT JAMB WITH BRICK FROM DEMOLITION SALVGE AS REUIRED AT EACH JAMB WHERE EXISTING MASONRY WALL WAS REMOVED.

(11) INSTALL NEW 4'-0" X 4'-0" CONCRETE PAD FOR NEW MINI-SPLIT CONDENSING UNIT.

2024

CHAPEL

FOR

MOORE COUNTY HOSPITAL DISTRICT

224 East 2nd Street Dumas, Texas

ARCHITECT

BROOKSarchitecture
architecture
planning
graphic design

R. Stephen Brooks, Architect
1203 W 5th Avenue, Suite B
Amarillo, Texas 79101
email: stevebrooks53@yahoo.com
phone:806.372.5144 / fax:806.373.4031

HD&D DESIGN
(1977 - 2008)

REGISTERED ARCHITECT
R. Stephen Brooks
10836
STATE OF TEXAS

License Expires 11 . 30 . 2024

CONSULTANTS :

Mechanical Design / Build :

Plumbing Design / Build :

Electrical Design / Build :

Structural Engineering :

REVISIONS :

DATE : 11 . AUGUST . 2024

SHEET TITLE :

Demolition Plan & Notes
Floor Plan & Notes

SHEET NUMBER :

A.2

PROJECT NUMBER : 24.04

GENERAL NOTES :

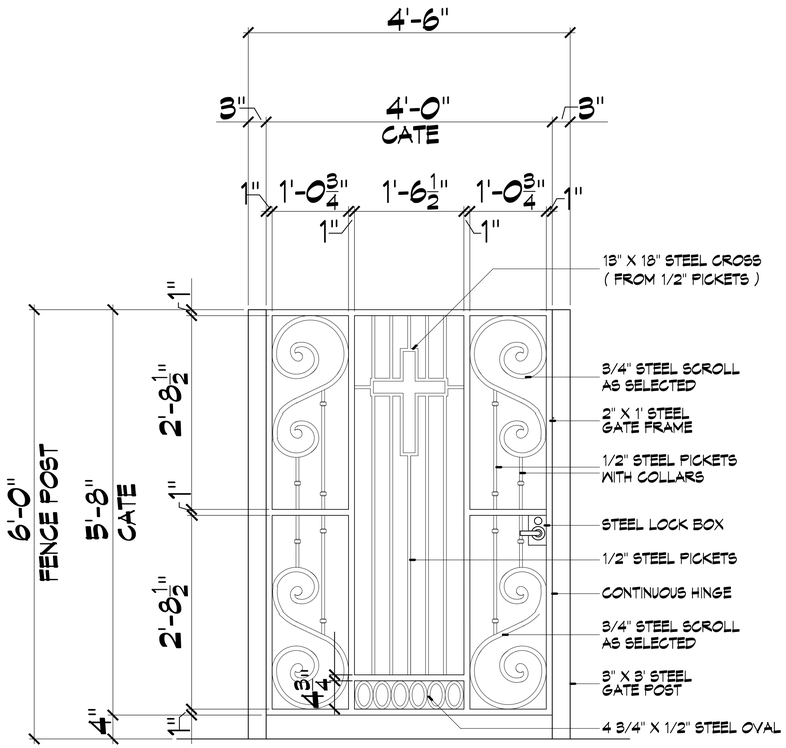
THIS DRAWING IS A SCHEMATIC ONLY. THE "PRAYER GARDEN" LANDSCAPE WORK FOR THIS FACILITY IS TO BE STRUCTURED AS A DESIGN / BUILD PROJECT.

THE SUCCESSFUL CONTRACTOR MUST HAVE THE ABILITY TO OBTAIN ALL PERMITS AND ALL DESIGN MUST MEET ALL STANDARDS AND CODES WHICH ARE CURRENTLY USED BY THE CITY OF DUMAS CODE ENFORCEMENT DEPARTMENT.

THE SUCCESSFUL CONTRACTOR MUST PROVIDE ALL NECESSARY DOCUMENTATION AND SUPPLEMENTAL DRAWINGS AS REQUIRED BY THE CITY OF DUMAS CODE ENFORCEMENT DEPARTMENT.

GENERAL NOTE: LANDSCAPE DESIGN

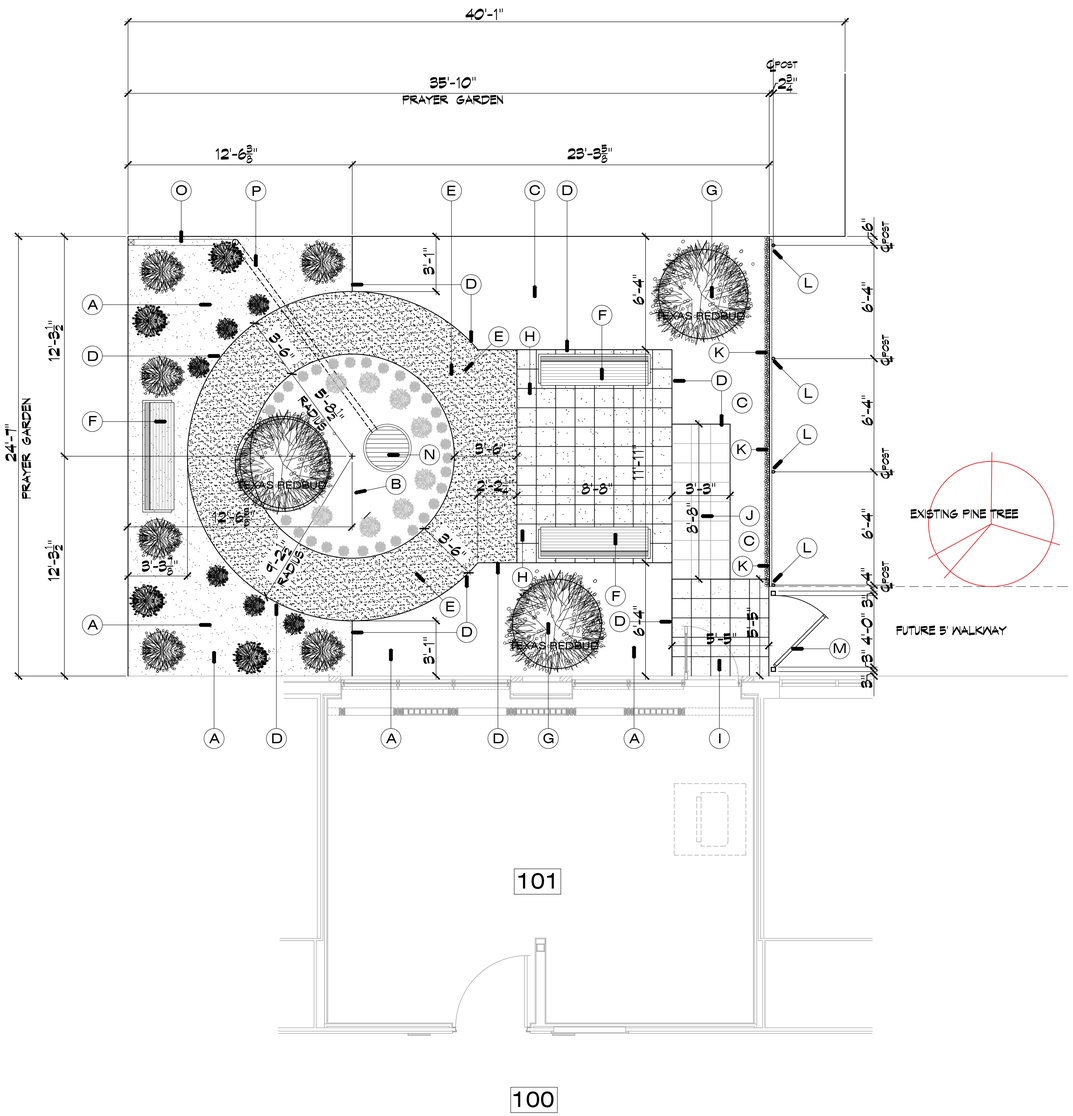
THE LANDSCAPE CONTRACTOR IS RESPONSIBLE TO DESIGN AND SIZE ALL PLANTING ITEMS AND BE RESPONSIBLE FOR THE DESIGN OF THE LANDSCAPE IRRIGATION SYSTEMS. THE CONTRACTOR SHALL BE REQUIRED TO FURNISH ALL LABOR AND MATERIAL PROVIDE TO THE OWNER A COMPLETE PROJECT.



1 / L.1 gate celevation

SCALE : 1" = 1'-0"

NOTE: POWDERCOAT FINISH, COLOR AS SELECTED



landscape plan

SCALE : 1/4" = 1'-0"

NORTH

LANDSCAPE NOTES:

(A) XERISCAPE PLANTING BED:
PLANT DROUGHT RESISTANT MATERIAL AS SELECTED BY THE LANDSCAPE CONTRACTOR; IRRIGATE AREA WITH A DRIP SYSTEM; INSTALL WEED BARRIER ABOVE SOIL AND COVER DECOMPOSED GRANITE.

(B) FLOWER PLANTING BED:
PLANT FLOWERING MATERIAL (PERENNIALS / ANNUALS) AS SUITED FOR OUR AREA AND APPROVED BY THE OWNER; IRRIGATE AREA WITH A DRIP SYSTEM;

(C) LAWN AREA:
INSTALL THIN BLADE FESCUE SOD; IRRIGATE WITH A LAWN SPRINKLER SYSTEM; CONNECT TO WATER SOURCE AS DIRECTED BY THE HOSPITAL.

(D) INSTALL NEW 6" DEEP STEEL LANDSCAPE EDGING AS SHOWN ON THE DRAWINGS.

(E) INSTALL NEW 4" DEEP COMPACTED DECOMPOSED GRANITE WALKWAY; STABILIZE EXISTING SUB-GRADE AS REQUIRED.

(F) 6' GRADE A TEAK BENCH; MFR: ASH & EMBER; STYLE: HAWTHORNE

(G) INSTALL SMALL 3" CALIPER ORNAMENTAL TREE (TEXAS REDBOUD / DESERT WILLOW) AS SELECTED BY THE LANDSCAPE CONTRACTOR AND APPROVED BY THE OWNER.

(H) PATIO: 13" X 13" X3 1/8" CONCRETE PAVERS OVER 4" COMPACTED SAND CUSHION; MFR: TECHNO BLOCK; TYPE: BLU 80 SMOOTH COMMERCIAL; COLOR A AS SELECTED; PROVIDE 6" STEEL EDGING AT ENTIRE PERIMETER OF PATIO.

(I) DOOR STOOP: 13" X 13" X3 1/8" CONCRETE PAVERS OVER 4" COMPACTED SAND CUSHION; MFR: TECHNO BLOCK; TYPE: BLU 80 SMOOTH COMMERCIAL; COLOR A AS SELECTED; PROVIDE 6" STEEL EDGING AT ENTIRE PERIMETER OF PATIO.

(J) SIDEWALK: 13" X 13" X3 1/8" CONCRETE PAVERS OVER 4" COMPACTED SAND CUSHION; MFR: TECHNO BLOCK; TYPE: BLU 80 SMOOTH COMMERCIAL; COLOR B AS SELECTED; PROVIDE 6" STEEL EDGING AT ENTIRE PERIMETER OF PATIO.

(K) INSTALL EXPANDING PREMIUM LEAVES PRIVACY WALL TRELIS FENCING OVER 3/4" PLYWOOD PANELS; MFR: NATURAL HEDGE; TYPE: FAUX ENGLISH LAUREL; SIZE: 3'-2" X 6'-0"

(L) FENCE: 6'-0" HIGH WOOD FENCE; 2" DIAMETER STEEL POSTS @ 6'4" CC MAX; THREE 2 X 4 VERTICAL RAILS; INSTALL 3/4" EXTERIOR GRADE PLYWOOD OVER RAILING; PROVIDE 12" DIAMETER X 24" DEEP CONCRETE FOOTINGS AT EACH POST

(M) GATE: 4'-0" WIDE X 6'-0" HIGH DECORATIVE STEEL GATE AS DETAILED; 3" X 3" STEEL POSTS @ EACH SIDE; POWDERCOAT FINISH; REFER TO ELEVATION 1 / L.1.

(N) EXISTING 32" AREA DRAIN; SLOPE PLANTING AREAS TO DRAIN AS REQUIRED.

(O) EXISTING METAL DOWNSPOUT TO REMAIN; REWORK AS PER NOTE O.

(P) FURNISH AND INSTALL TRANSITIONAL BUTT FROM END OF DOWNSPOUT TO A 6" PVC; DRAIN LINE; EXTEND UNDERGROUND DRAIN LINE TO EXISTING AREA DRAIN AND CONNECT THRU SIDE OF AREA DRAIN AS REQUIRED.

2024

CHAPEL

FOR

MOORE COUNTY HOSPITAL DISTRICT

224 East 2nd Street Dumas, Texas

ARCHITECT

BROOKSarchitecture
architecture
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graphic design

R. Stephen Brooks, Architect
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REGISTERED ARCHITECT
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CONSULTANTS :

Mechanical Design / Build :

Plumbing Design / Build :

Electrical Design / Build :

Structural Engineering :

REVISIONS :

DATE : 20 . AUGUST . 2024

SHEET TITLE :

Landscape Plan & Notes
Floor Plan & Notes

SHEET NUMBER :

L.1

PROJECT NUMBER : 24.04

GROWTH STRATEGY 3 | EQUIPMENT UPGRADES

Goal: Provide quality equipment to support quality care.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Fulfil needs on the capital list as funds become available	Exec Team	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)			
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue			

CAPITAL BUDGET REQUEST $1,225,000 (TOTAL REQUESTED $2.1M)

Qty	Description	Dept Rank	Qtr	Total	Department
	Cafeteria Renovation Estimate	2		$ 600,000	Dietary
	Kitchen Roof	3		$ 200,000	Dietary
1	Ambulance Remount	1	1	$ 182,000	EMS
	Roof			$ 128,681	MNRC
2	Anesthesia Workstation	1		$ 122,148	Pharmacy
	Chapel Renovation 32K from PY and 53K for FFE			$ 85,000	Admin
1	MagTrace System	1		$ 79,112	Surg Svcs
5	Smart Bed	2		$ 53,500	Med/Surg
	Exam Room Furniture Est			$ 50,000	Nephrology Clinic
	Roof			$ 46,283	Ortho/OB
	10 Ton AC Unit			$ 45,000	Therapy
	Roof			$ 38,668	IM/Gen Surg
1	Phillips Interface for V/S	2		$ 34,267	Med/Surg/ER
1	FX40 BACTEC x 2	1	1	$ 33,800	Lab
3	Tec850 SEV/ Tec 6&7 Vaporizers	2		$ 28,292	Surg Svcs
	Overbed Lighting for 55 beds	1		$ 26,486	MNRC
1	Hamilton Ventilator	1	1	$ 26,166	Pulmonary
	Flooring			$ 19,342	Nephrology Clinic
10	IV pumps	3		$ 18,000	Med/Surg
1	Glidescope	3		$ 15,768	Surg Svcs
	Roof, Painting External & Internal including Facia Replacement			$ 14,821	Nephrology Clinic
4	Patient Recliner (2 standard, 2 wide)	1		$ 14,000	Med/Surg
1	Sophos Firewalls	1	1	$ 13,000	IT
	Old patient room renovation			$ 12,000	Admin
1	Blood Bank Refrigerator	2	4	$ 11,026	Lab
	Concrete work			$ 10,821	Nephrology Clinic
	Corridor floors and wall resurface			$ 10,000	Admin

Breakdown of capital request:

- $500,000 Equipment
- $725,000 Renovation Budget

Breakdown of funding sources:

- $625,000 Operations
- $600,000 USDA Remaining Funds including LD

SERVICE

"Provide exceptional customer service to all we serve"

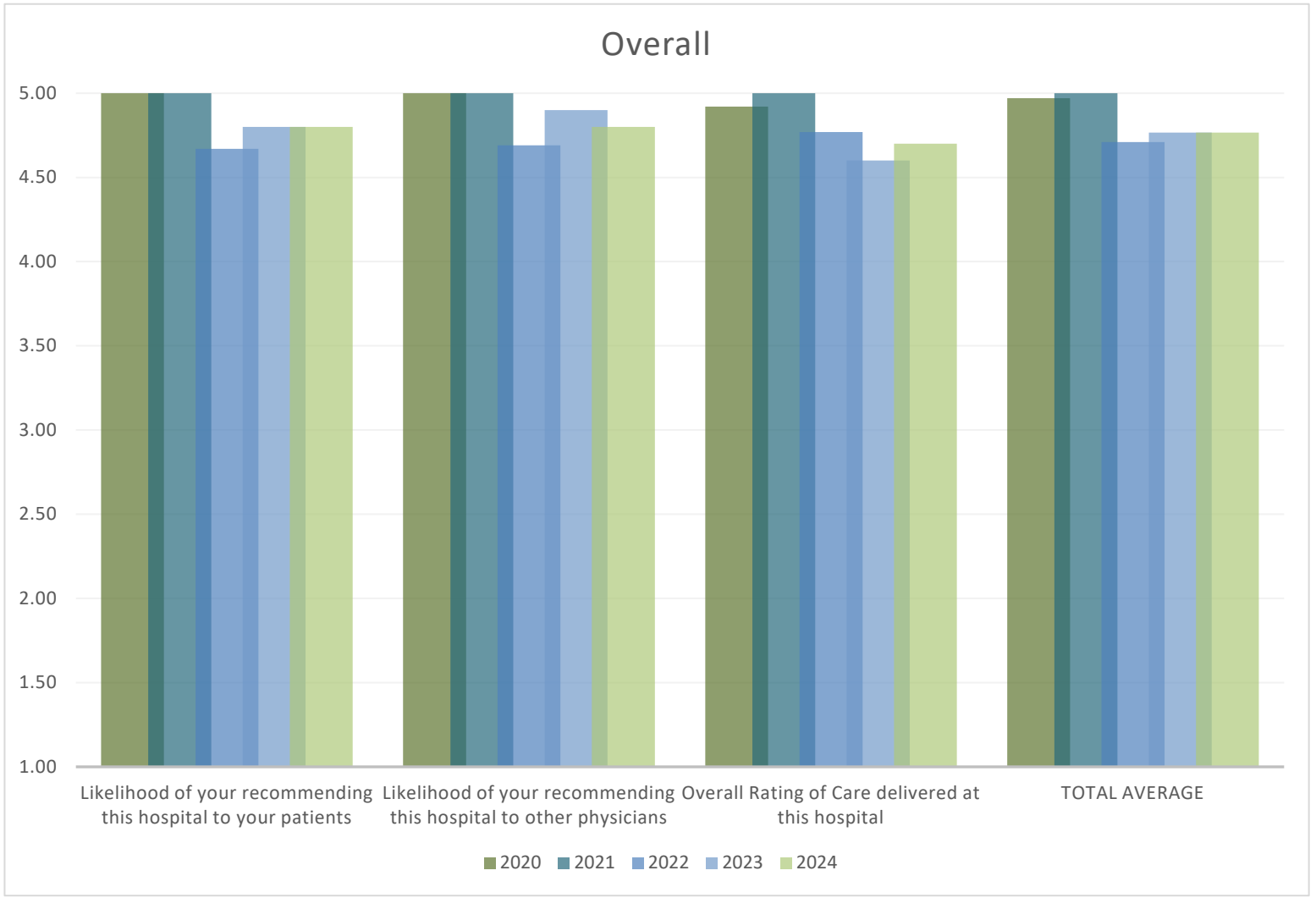
1. Physician Engagement Survey
2. Custom Learning Systems 5-star Initiative
    a. Clinics
    b. ER Academy
    c. Hospital
    d. Nursing Home

Goal: Integrate physician perspectives into District decisions.

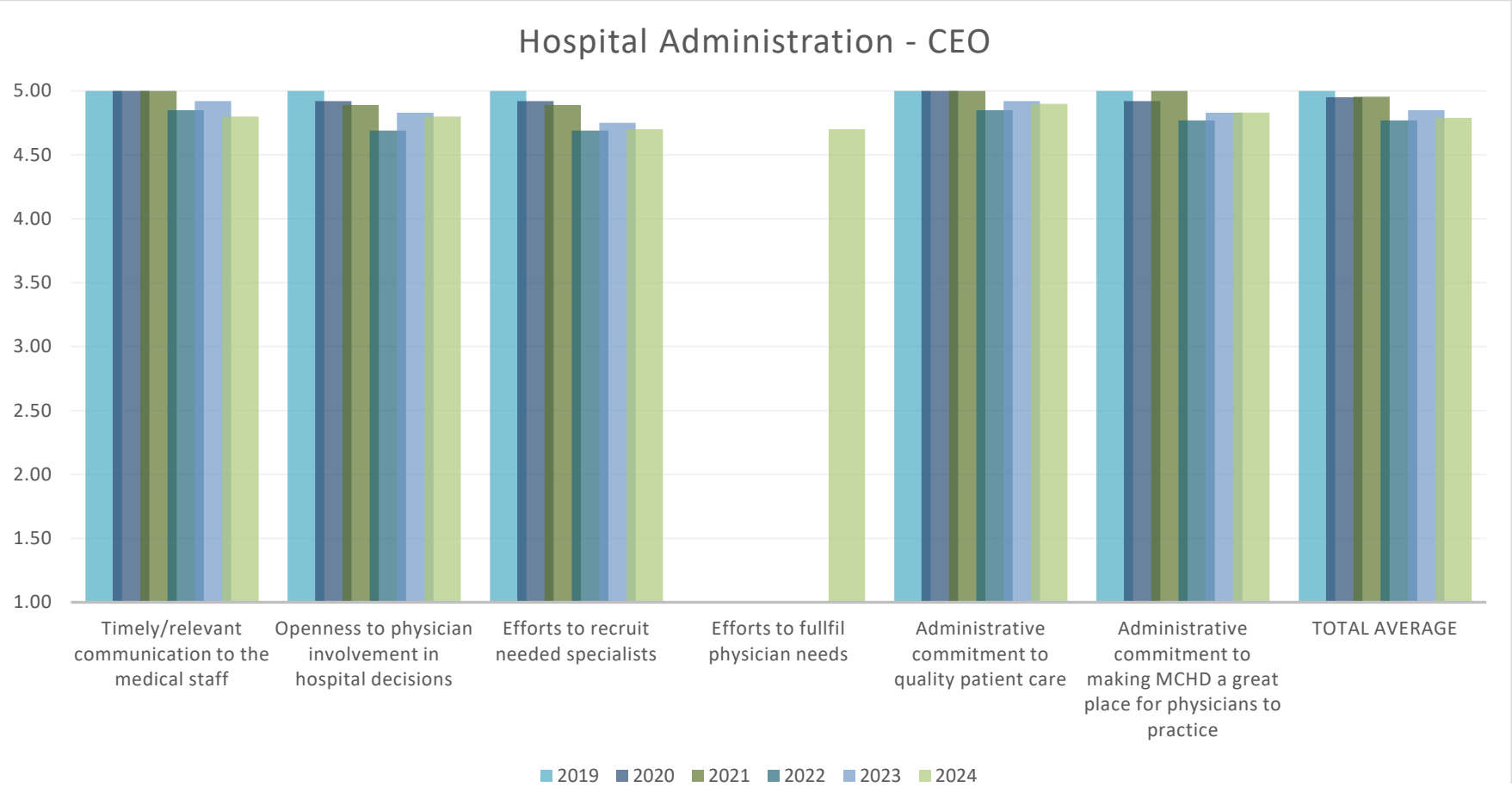
ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Conduct Physician Engagement Survey. 2. See also Medical Staff Strategies.	Ashley, Jeff Dr. Tan, Jeff	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

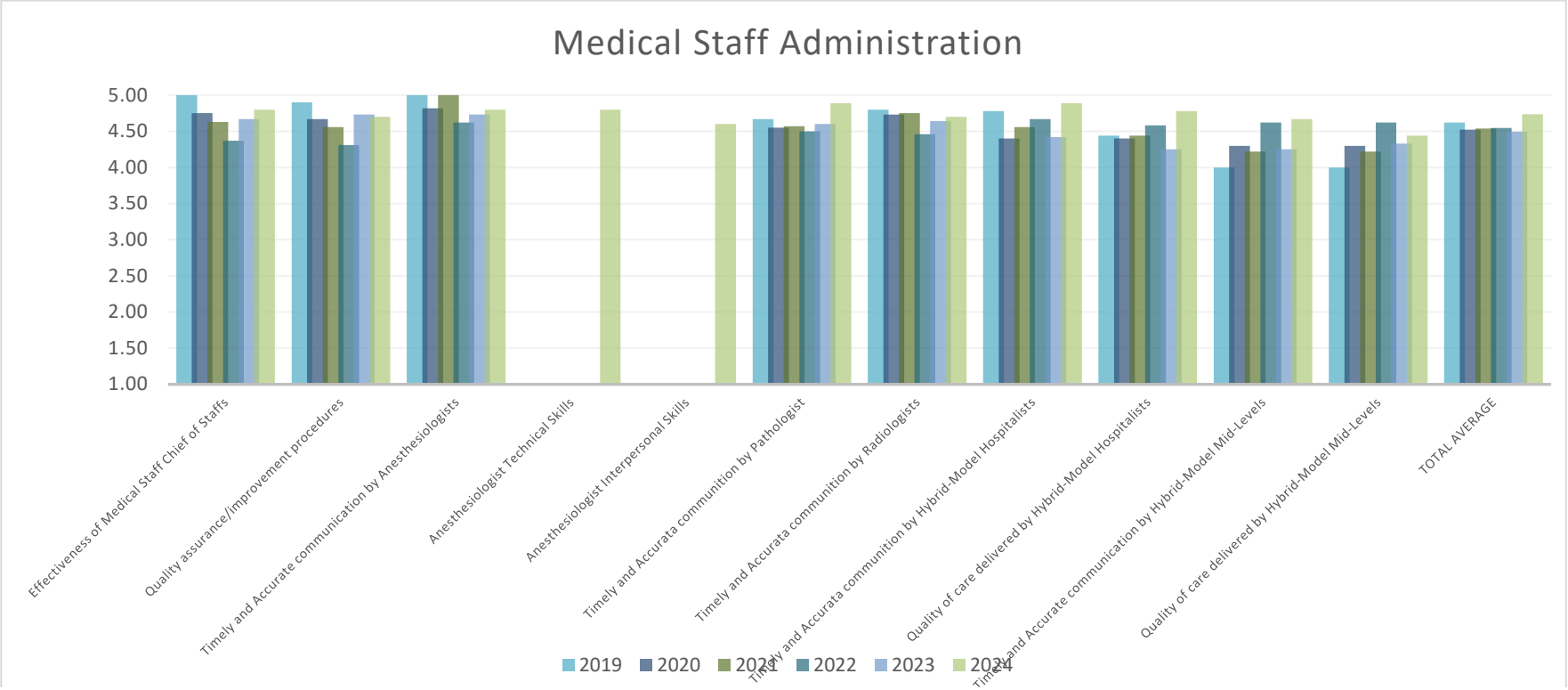
FINAL EVALUATIONS	2020	2021	2022	2023	2024
Likelihood of your recommending this hospital to your patients	**5.00**	**5.00**	**4.67**	**4.80**	**4.80**
Likelihood of your recommending this hospital to other physicians	**5.00**	**5.00**	**4.69**	**4.90**	**4.80**
Overall Rating of Care delivered at this hospital	**4.92**	**5.00**	**4.77**	**4.60**	**4.70**
TOTAL AVERAGE	**4.97**	**5.00**	**4.71**	**4.77**	**4.77**



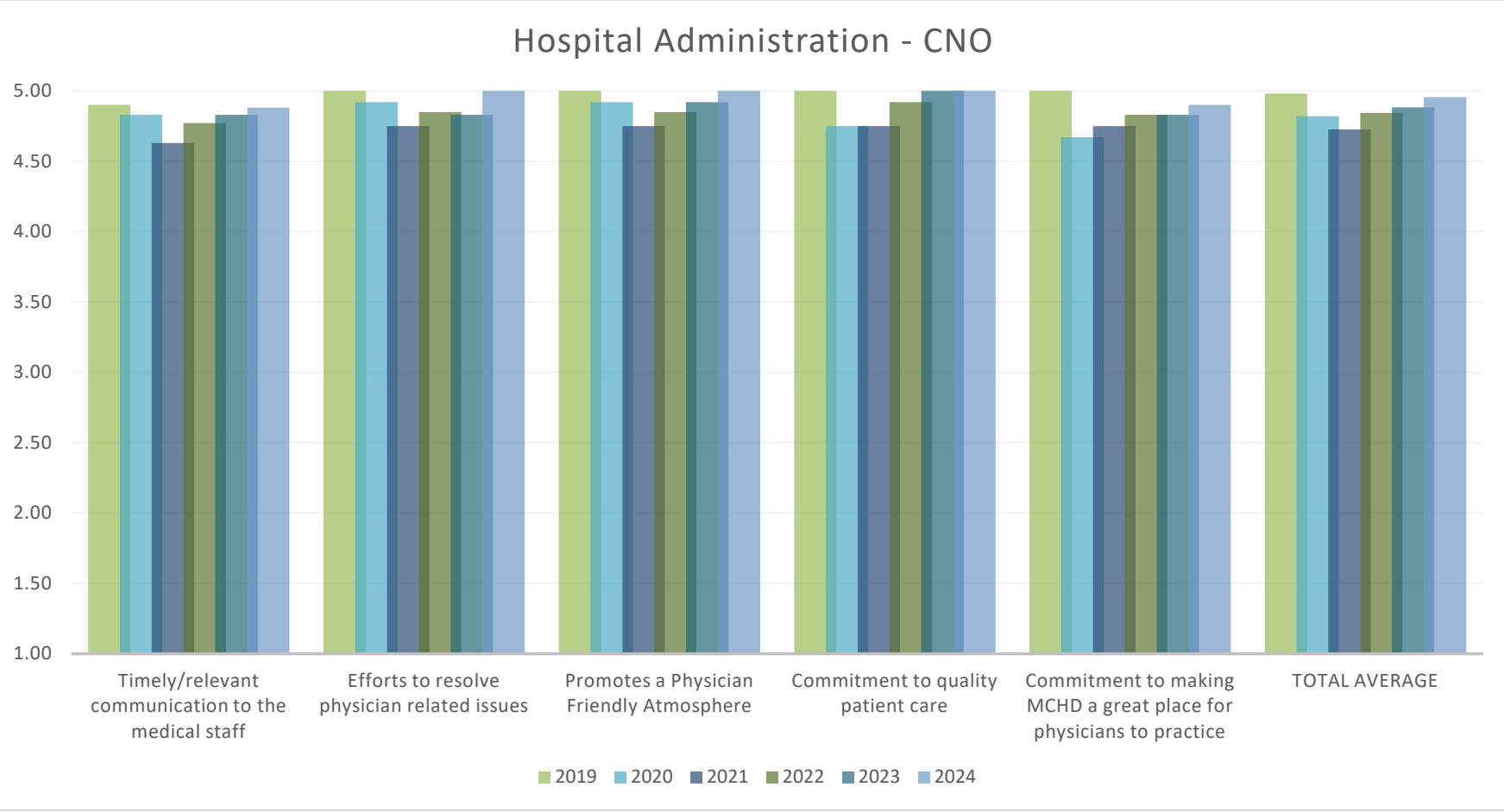
HOSPITAL ADMINISTRATION - CEO						
	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	5.00	5.00	5.00	4.85	4.92	4.80
Openness to physician involvement in hospital decisions	5.00	4.92	4.89	4.69	4.83	4.80
Efforts to recruit needed specialists	5.00	4.92	4.89	4.69	4.75	4.70
Efforts to fullfil physician needs						4.70
Administrative commitment to quality patient care	5.00	5.00	5.00	4.85	4.92	4.90
Administrative commitment to making MCHD a great place for physicians to practice	5.00	4.92	5.00	4.77	4.83	4.83
TOTAL AVERAGE	5.00	4.95	4.96	4.77	4.85	4.79



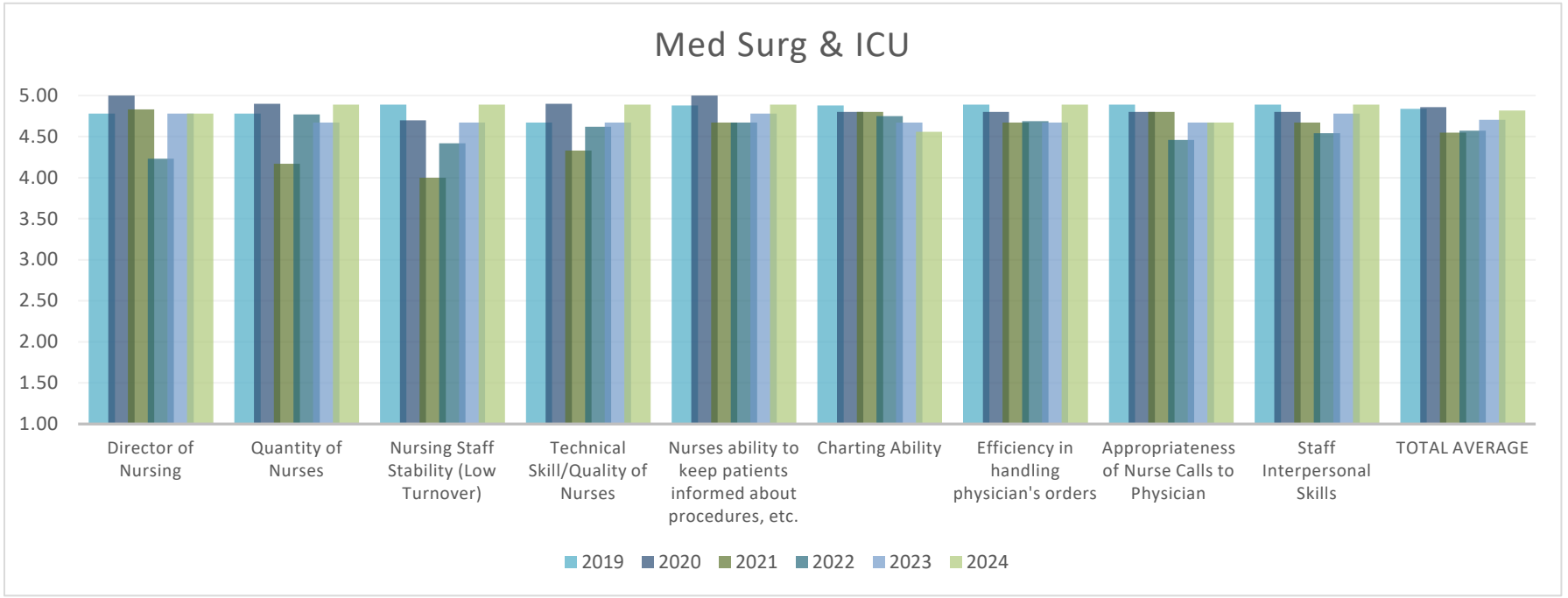
MEDICAL STAFF ADMINISTRATION						
	2019	2020	2021	2022	2023	2024
Effectiveness of Medical Staff Chief of Staffs	**5.00**	**4.75**	**4.63**	**4.37**	**4.67**	**4.80**
Quality assurance/improvement procedures	**4.90**	**4.67**	**4.56**	**4.31**	**4.73**	**4.70**
Timely and Accurate communication by Anesthesiologists	**5.00**	**4.82**	**5.00**	**4.62**	**4.73**	**4.80**
Anesthesiologist Technical Skills						**4.80**
Anesthesiologist Interpersonal Skills						**4.60**
Timely and Accurata communition by Pathologist	**4.67**	**4.55**	**4.57**	**4.50**	**4.60**	**4.89**
Timely and Accurata communition by Radiologists	**4.80**	**4.73**	**4.75**	**4.46**	**4.64**	**4.70**
Timely and Accurata communition by Hybrid-Model Hospitalists	**4.78**	**4.40**	**4.56**	**4.67**	**4.42**	**4.89**
Quality of care delivered by Hybrid-Model Hospitalists	**4.44**	**4.40**	**4.44**	**4.58**	**4.25**	**4.78**
Timely and Accurate communication by Hybrid-Model Mid-Levels	**4.00**	**4.30**	**4.22**	**4.62**	**4.25**	**4.67**
Quality of care delivered by Hybrid-Model Mid-Levels	**4.00**	**4.30**	**4.22**	**4.62**	**4.33**	**4.44**
TOTAL AVERAGE	**4.62**	**4.52**	**4.54**	**4.55**	**4.49**	**4.73**



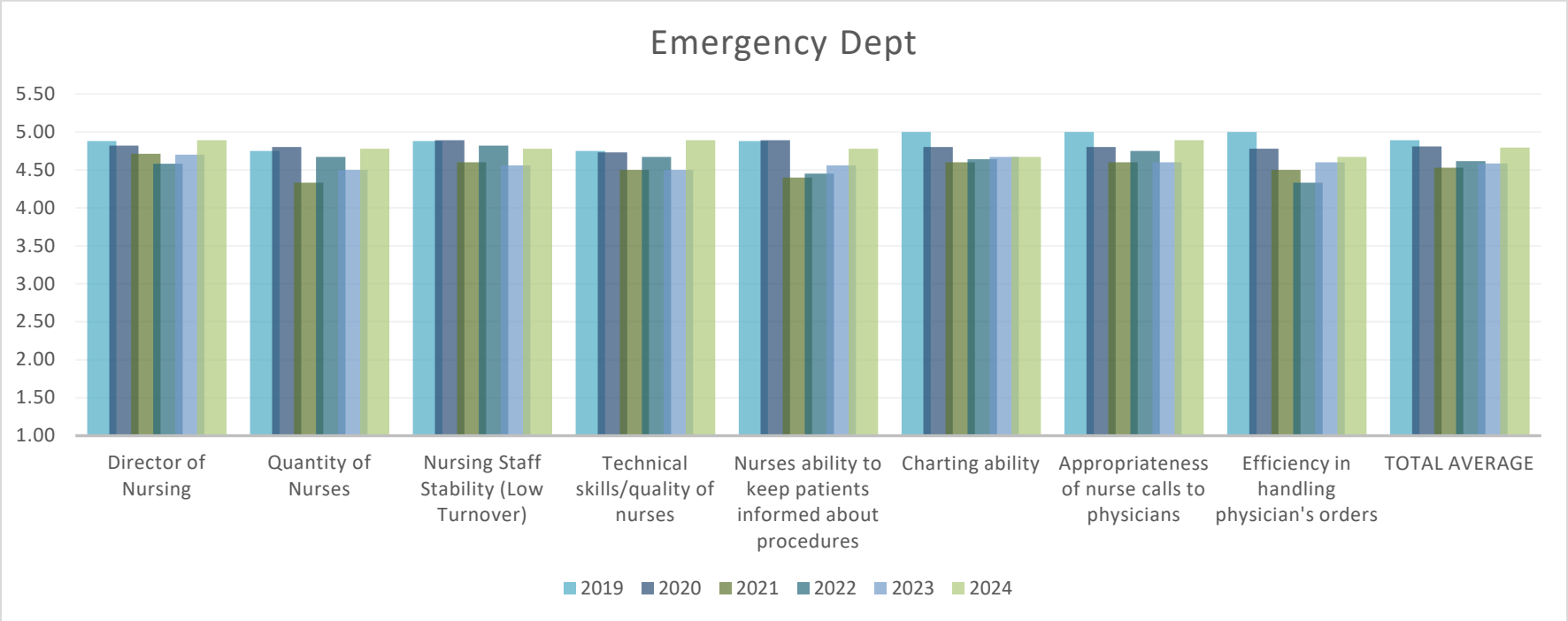
HOSPITAL ADMINISTRATION - CNO						
	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	4.90	4.83	4.63	4.77	4.83	4.88
Efforts to resolve physician related issues	5.00	4.92	4.75	4.85	4.83	5.00
Promotes a Physician Friendly Atmosphere	5.00	4.92	4.75	4.85	4.92	5.00
Commitment to quality patient care	5.00	4.75	4.75	4.92	5.00	5.00
Commitment to making MCHD a great place for physicians to practice	5.00	4.67	4.75	4.83	4.83	4.90
TOTAL AVERAGE	4.98	4.82	4.73	4.84	4.88	4.96



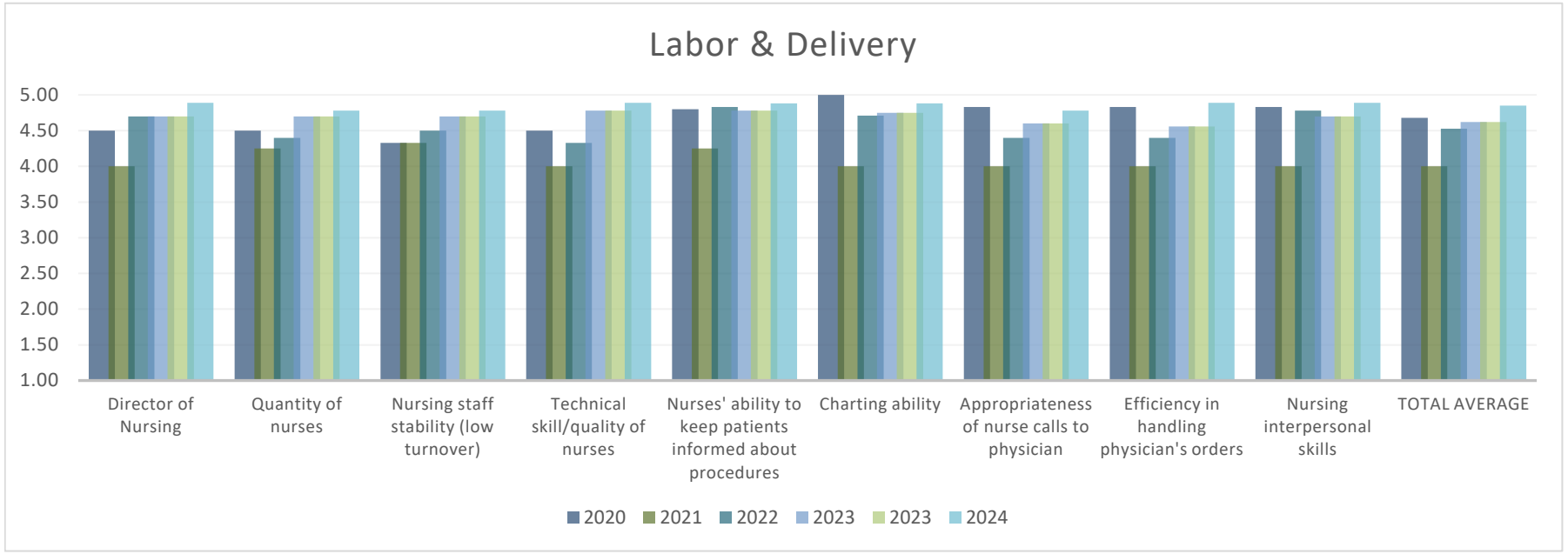
NURSING (Med Surg & ICU)						
	2019	2020	2021	2022	2023	2024
Director of Nursing	4.78	5.00	4.83	4.23	4.78	4.78
Quantity of Nurses	4.78	4.90	4.17	4.77	4.67	4.89
Nursing Staff Stability (Low Turnover)	4.89	4.70	4.00	4.42	4.67	4.89
Technical Skill/Quality of Nurses	4.67	4.90	4.33	4.62	4.67	4.89
Nurses ability to keep patients informed about procedures, etc.	4.88	5.00	4.67	4.67	4.78	4.89
Charting Ability	4.88	4.80	4.80	4.75	4.67	4.56
Efficiency in handling physician's orders	4.89	4.80	4.67	4.69	4.67	4.89
Appropriateness of Nurse Calls to Physician	4.89	4.80	4.80	4.46	4.67	4.67
Staff Interpersonal Skills	4.89	4.80	4.67	4.54	4.78	4.89
TOTAL AVERAGE	4.84	4.86	4.55	4.57	4.71	4.82



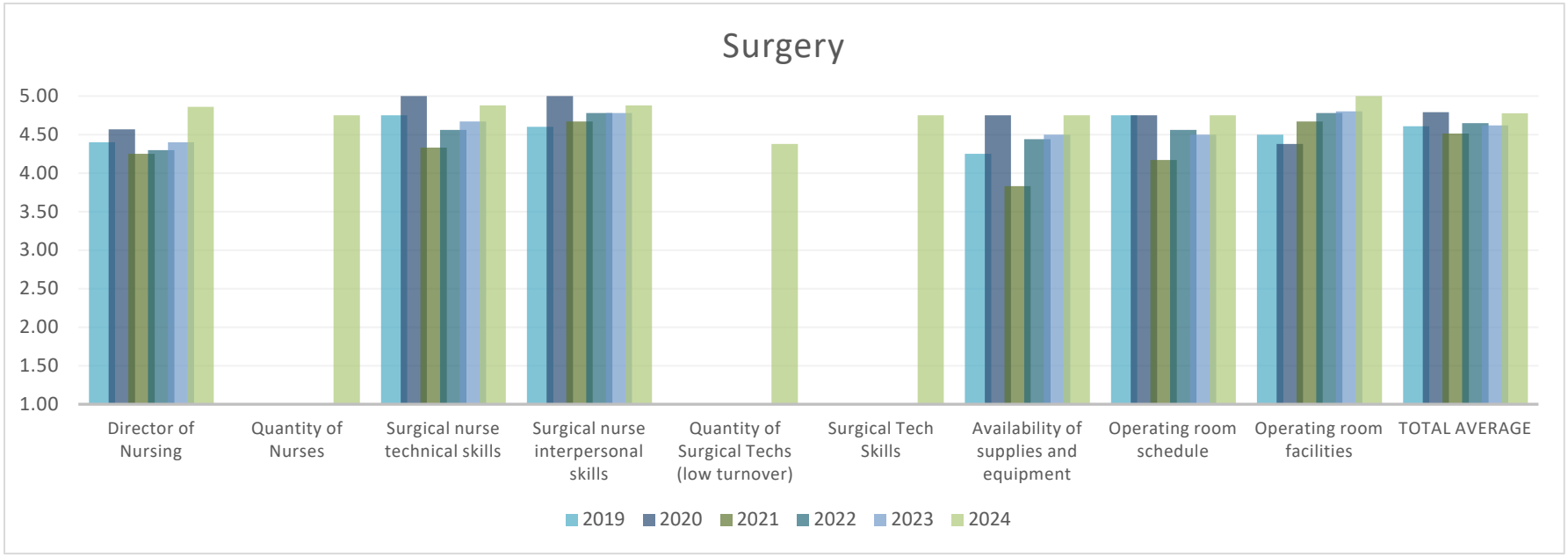
NURSING (ED)	2019	2020	2021	2022	2023	2024
Director of Nursing	**4.88**	**4.82**	**4.71**	**4.58**	**4.70**	**4.89**
Quantity of Nurses	**4.75**	**4.80**	**4.33**	**4.67**	**4.50**	**4.78**
Nursing Staff Stability (Low Turnover)	**4.88**	**4.89**	**4.60**	**4.82**	**4.56**	**4.78**
Technical skills/quality of nurses	**4.75**	**4.73**	**4.50**	**4.67**	**4.50**	**4.89**
Nurses ability to keep patients informed about procedures	**4.88**	**4.89**	**4.40**	**4.45**	**4.56**	**4.78**
Charting ability	**5.00**	**4.80**	**4.60**	**4.64**	**4.67**	**4.67**
Appropriateness of nurse calls to physicians	**5.00**	**4.80**	**4.60**	**4.75**	**4.60**	**4.89**
Efficiency in handling physician's orders	**5.00**	**4.78**	**4.50**	**4.33**	**4.60**	**4.67**
TOTAL AVERAGE	**4.89**	**4.81**	**4.53**	**4.61**	**4.59**	**4.79**



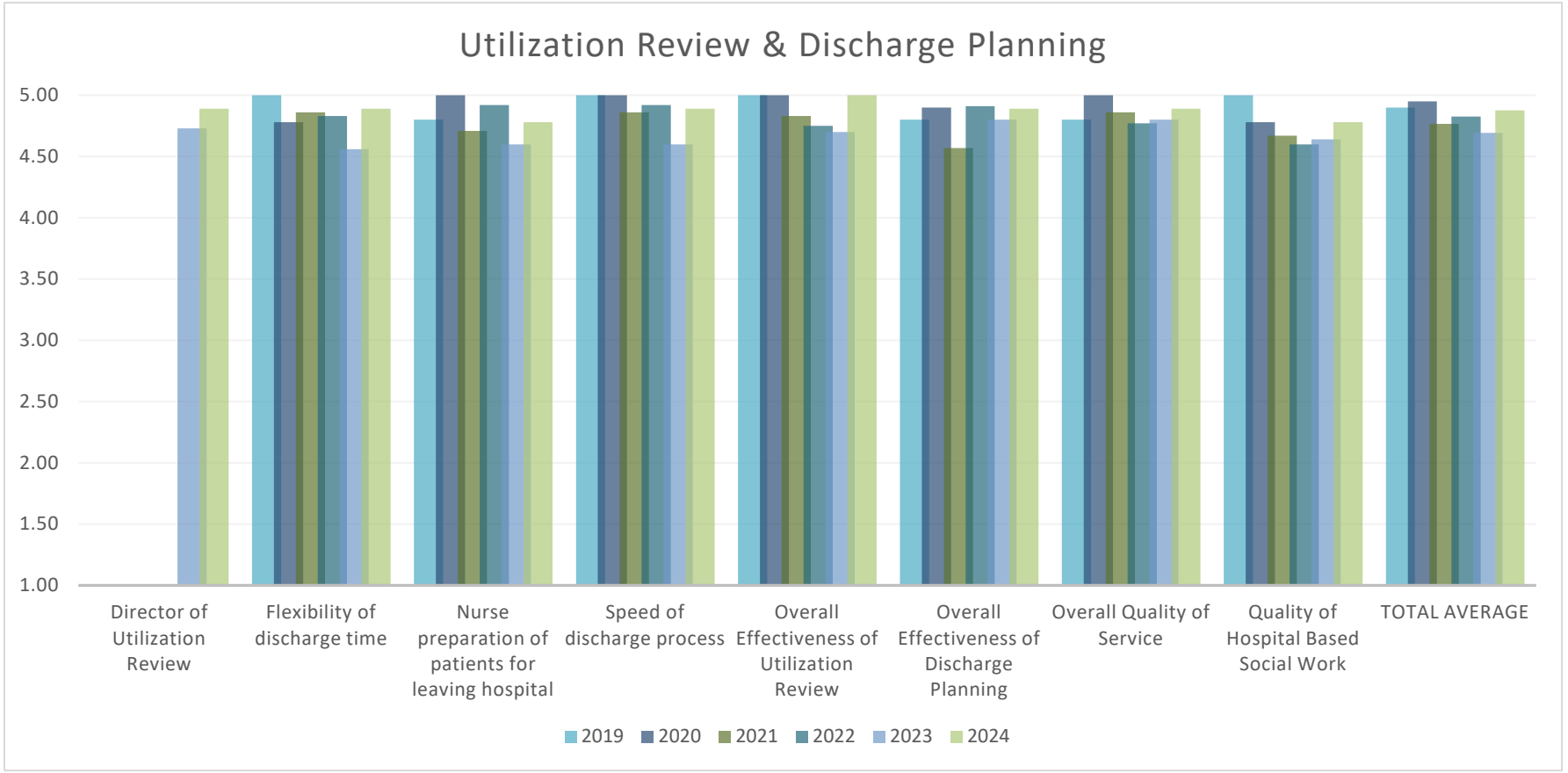
SPECIALTY NURSING UNITS (Women's Services)						
	2020	2021	2022	2023	2023	2024
Director of Nursing	4.50	4.00	4.70	4.70	4.70	4.89
Quantity of nurses	4.50	4.25	4.40	4.70	4.70	4.78
Nursing staff stability (low turnover)	4.33	4.33	4.50	4.70	4.70	4.78
Technical skill/quality of nurses	4.50	4.00	4.33	4.78	4.78	4.89
Nurses' ability to keep patients informed about procedures	4.80	4.25	4.83	4.78	4.78	4.88
Charting ability	5.00	4.00	4.71	4.75	4.75	4.88
Appropriateness of nurse calls to physician	4.83	4.00	4.40	4.60	4.60	4.78
Efficiency in handling physician's orders	4.83	4.00	4.40	4.56	4.56	4.89
Nursing interpersonal skills	4.83	4.00	4.78	4.70	4.70	4.89
TOTAL AVERAGE	4.68	4.00	4.53	4.62	4.62	4.85



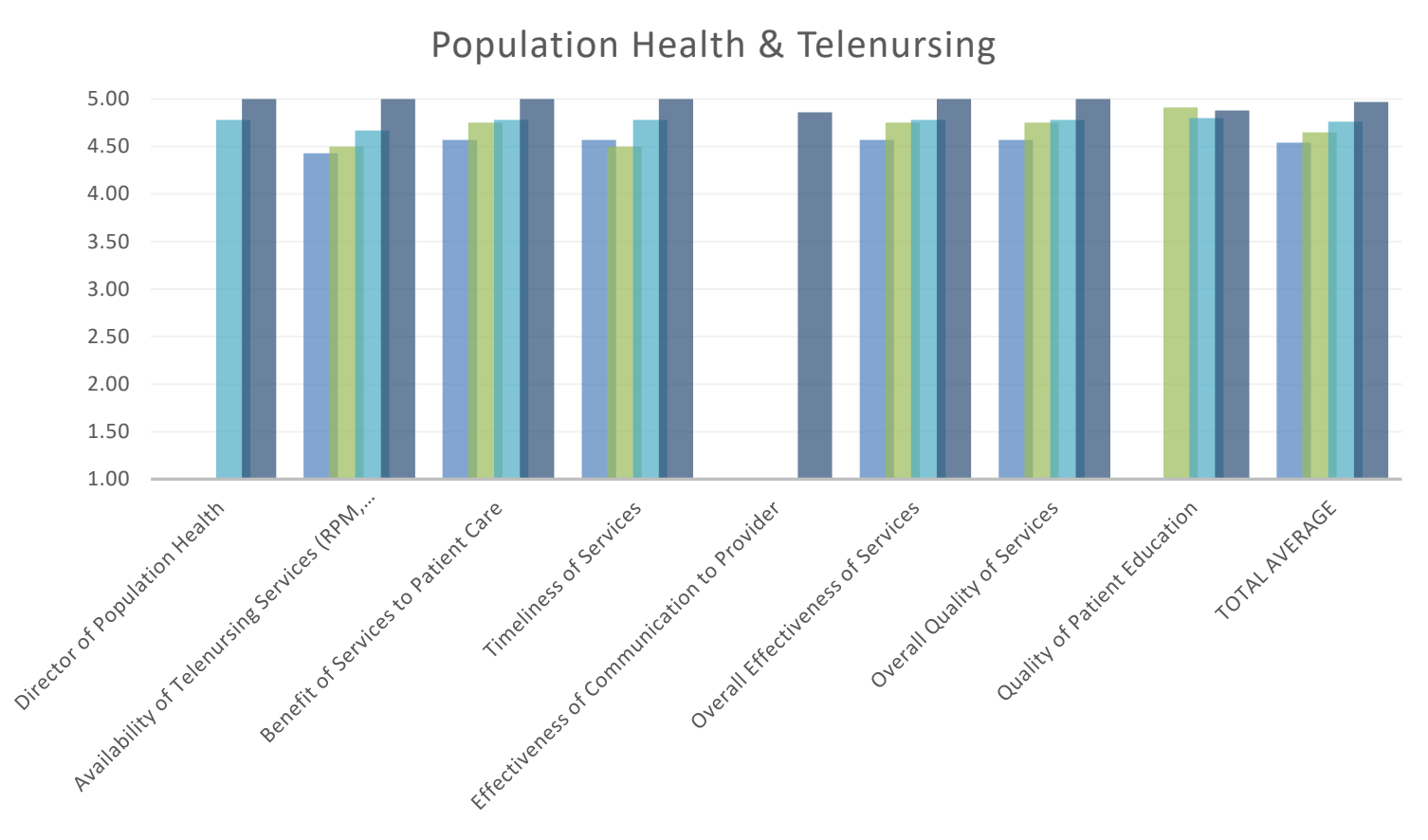
SURGERY	2019	2020	2021	2022	2023	2024
Director of Nursing	**4.40**	**4.57**	**4.25**	**4.30**	**4.40**	**4.86**
Quantity of Nurses						**4.75**
Surgical nurse technical skills	**4.75**	**5.00**	**4.33**	**4.56**	**4.67**	**4.88**
Surgical nurse interpersonal skills	**4.60**	**5.00**	**4.67**	**4.78**	**4.78**	**4.88**
Quantity of Surgical Techs (low turnover)						**4.38**
Surgical Tech Skills						**4.75**
Availability of supplies and equipment	**4.25**	**4.75**	**3.83**	**4.44**	**4.50**	**4.75**
Operating room schedule	**4.75**	**4.75**	**4.17**	**4.56**	**4.50**	**4.75**
Operating room facilities	**4.50**	**4.38**	**4.67**	**4.78**	**4.80**	**5.00**
TOTAL AVERAGE	**4.61**	**4.79**	**4.51**	**4.65**	**4.62**	**4.78**



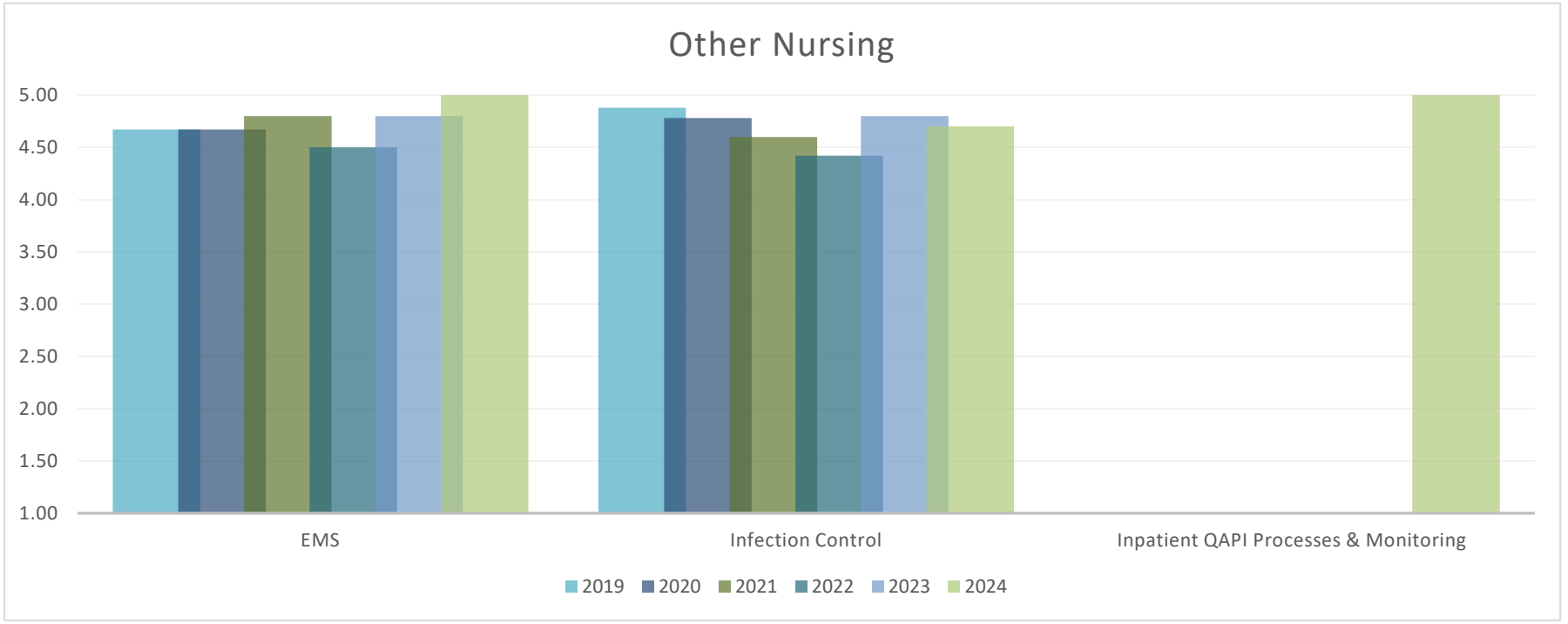
Utilization Review & Discharge Planning						
	2019	2020	2021	2022	2023	2024
Director of Utilization Review					4.73	4.89
Flexibility of discharge time	5.00	4.78	4.86	4.83	4.56	4.89
Nurse preparation of patients for leaving hospital	4.80	5.00	4.71	4.92	4.60	4.78
Speed of discharge process	5.00	5.00	4.86	4.92	4.60	4.89
Overall Effectiveness of Utilization Review	5.00	5.00	4.83	4.75	4.70	5.00
Overall Effectiveness of Discharge Planning	4.80	4.90	4.57	4.91	4.80	4.89
Overall Quality of Service	4.80	5.00	4.86	4.77	4.80	4.89
Quality of Hospital Based Social Work	5.00	4.78	4.67	4.60	4.64	4.78
TOTAL AVERAGE	4.90	4.95	4.77	4.83	4.69	4.88



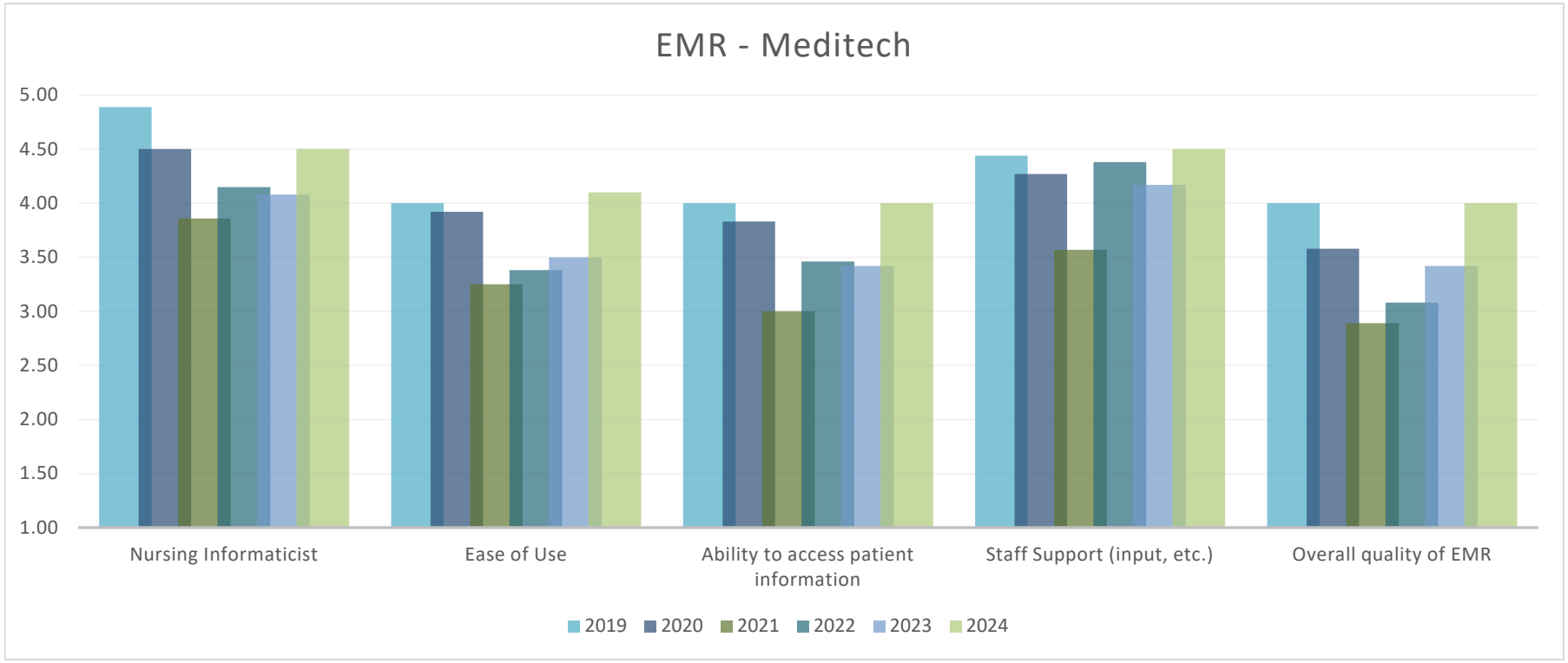
POPULATION HEALTH & TELENURSING	2021	2022	2023	2024
Director of Population Health			4.78	5.00
Availability of Telenursing Services (RPM, CCM, BHM)	4.43	4.50	4.67	5.00
Benefit of Services to Patient Care	4.57	4.75	4.78	5.00
Timeliness of Services	4.57	4.50	4.78	5.00
Effectiveness of Communication to Provider				4.86
Overall Effectiveness of Services	4.57	4.75	4.78	5.00
Overall Quality of Services	4.57	4.75	4.78	5.00
Quality of Patient Education		4.91	4.80	4.88
TOTAL AVERAGE	4.54	4.65	4.76	4.97



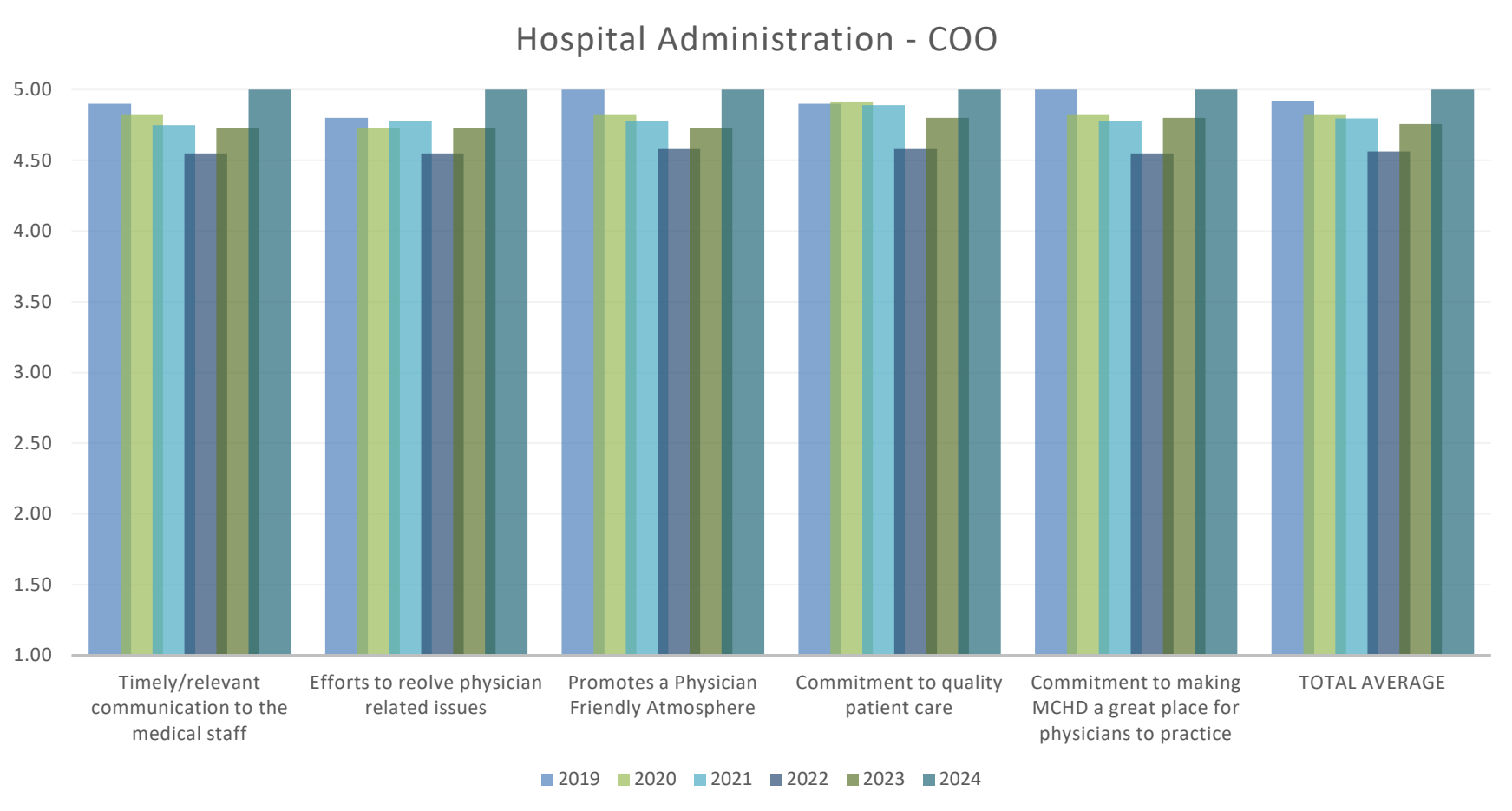
Other Nursing	2019	2020	2021	2022	2023	2024
EMS	**4.67**	**4.67**	**4.80**	**4.50**	**4.80**	**5.00**
Infection Control	**4.88**	**4.78**	**4.60**	**4.42**	**4.80**	**4.70**
Inpatient QAPI Processes & Monitoring						**5.00**



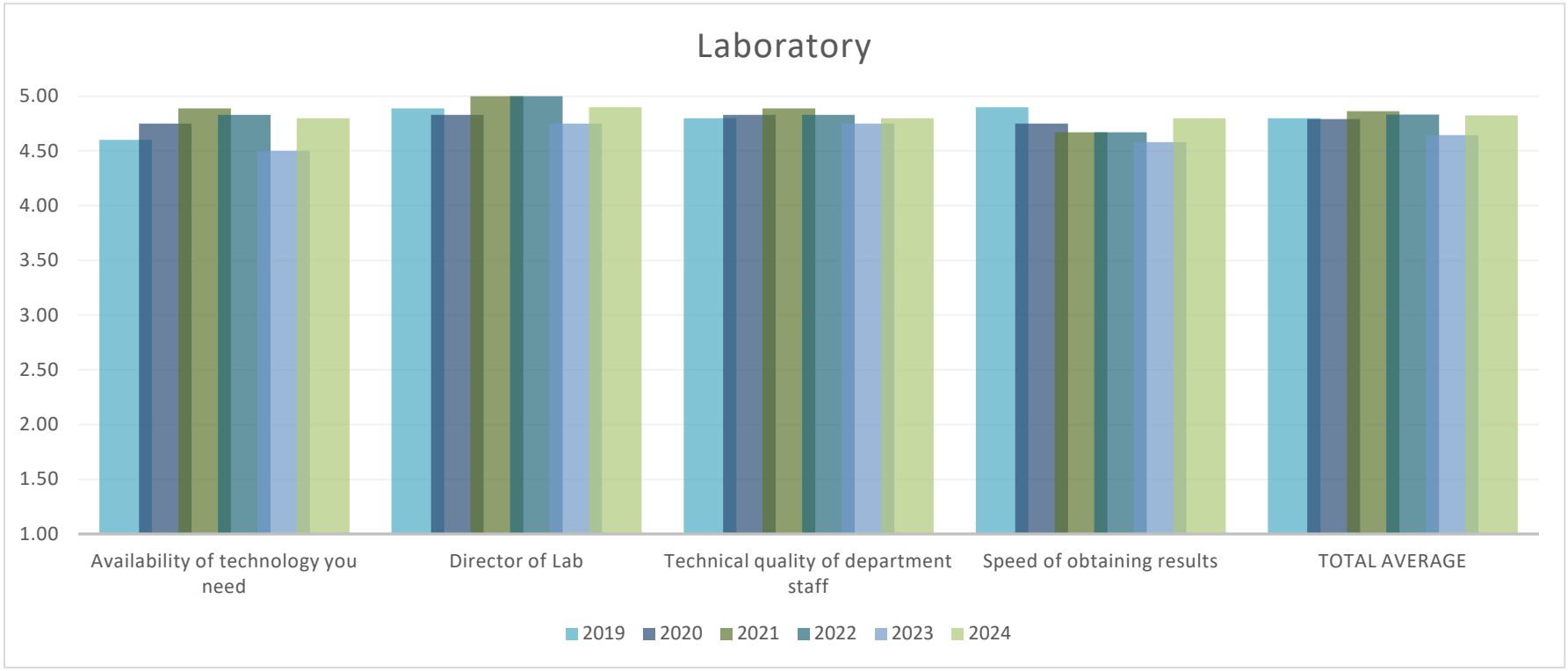
EMR - Meditech	2019	2020	2021	2022	2023	2024
Nursing Informaticist	**4.89**	**4.50**	**3.86**	**4.15**	**4.08**	**4.50**
Ease of Use	**4.00**	**3.92**	**3.25**	**3.38**	**3.50**	**4.10**
Ability to access patient information	**4.00**	**3.83**	**3.00**	**3.46**	**3.42**	**4.00**
Staff Support (input, etc.)	**4.44**	**4.27**	**3.57**	**4.38**	**4.17**	**4.50**
Overall quality of EMR	**4.00**	**3.58**	**2.89**	**3.08**	**3.42**	**4.00**



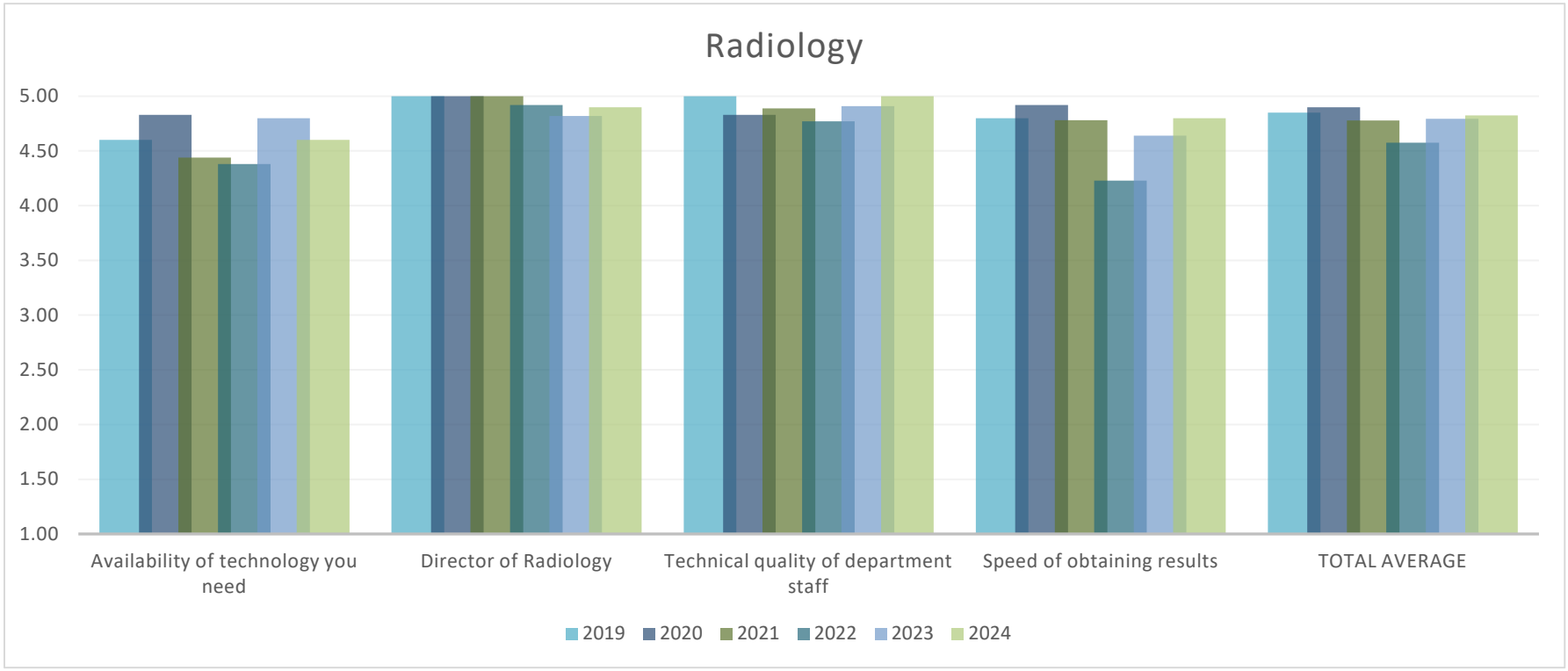
HOSPITAL ADMINISTRATION - COO						
	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	4.90	4.82	4.75	4.55	4.73	5.00
Efforts to reolve physician related issues	4.80	4.73	4.78	4.55	4.73	5.00
Promotes a Physician Friendly Atmosphere	5.00	4.82	4.78	4.58	4.73	5.00
Commitment to quality patient care	4.90	4.91	4.89	4.58	4.8	5.00
Commitment to making MCHD a great place for physicians to practice	5.00	4.82	4.78	4.55	4.8	5.00
TOTAL AVERAGE	4.92	4.82	4.80	4.56	4.76	5.00



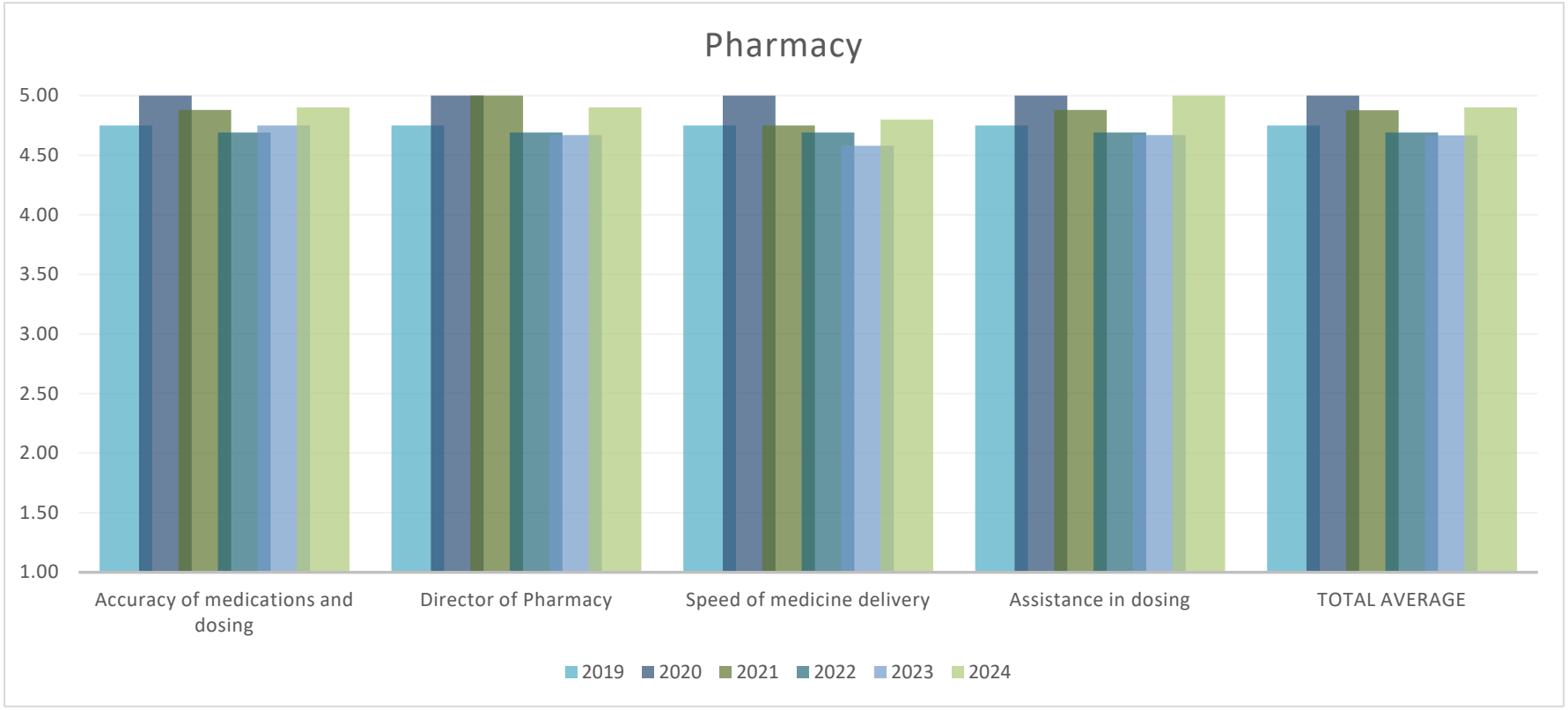
ANCILLARY CLINICAL DEPARTMENTS (Laboratory)						
	2019	2020	2021	2022	2023	2024
Availability of technology you need	**4.60**	**4.75**	**4.89**	**4.83**	**4.50**	**4.80**
Director of Lab	**4.89**	**4.83**	**5.00**	**5.00**	**4.75**	**4.90**
Technical quality of department staff	**4.80**	**4.83**	**4.89**	**4.83**	**4.75**	**4.80**
Speed of obtaining results	**4.90**	**4.75**	**4.67**	**4.67**	**4.58**	**4.80**
TOTAL AVERAGE	**4.80**	**4.79**	**4.86**	**4.83**	**4.65**	**4.83**



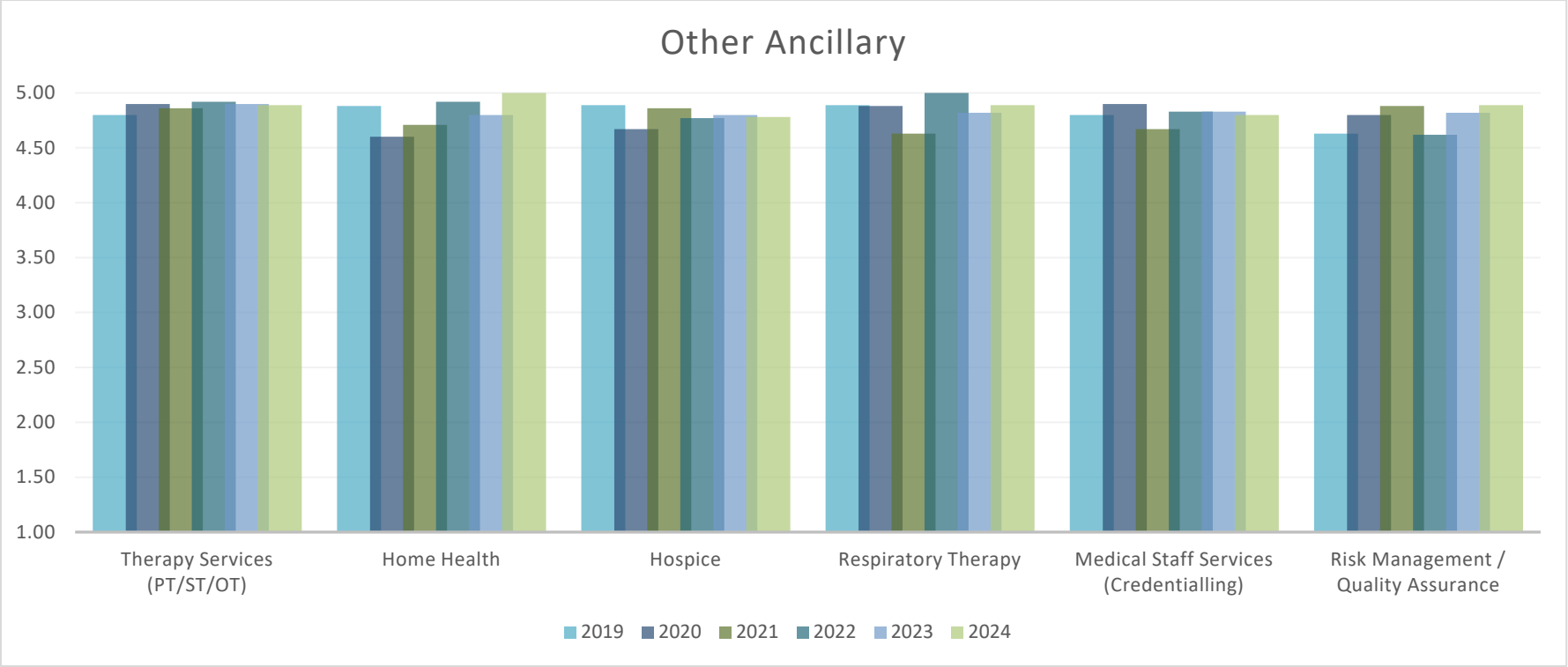
ANCILLARY CLINICAL DEPARTMENTS (Radiology)						
	2019	2020	2021	2022	2023	2024
Availability of technology you need	**4.60**	**4.83**	**4.44**	**4.38**	**4.80**	**4.60**
Director of Radiology	**5.00**	**5.00**	**5.00**	**4.92**	**4.82**	**4.90**
Technical quality of department staff	**5.00**	**4.83**	**4.89**	**4.77**	**4.91**	**5.00**
Speed of obtaining results	**4.80**	**4.92**	**4.78**	**4.23**	**4.64**	**4.80**
TOTAL AVERAGE	**4.85**	**4.90**	**4.78**	**4.58**	**4.79**	**4.83**



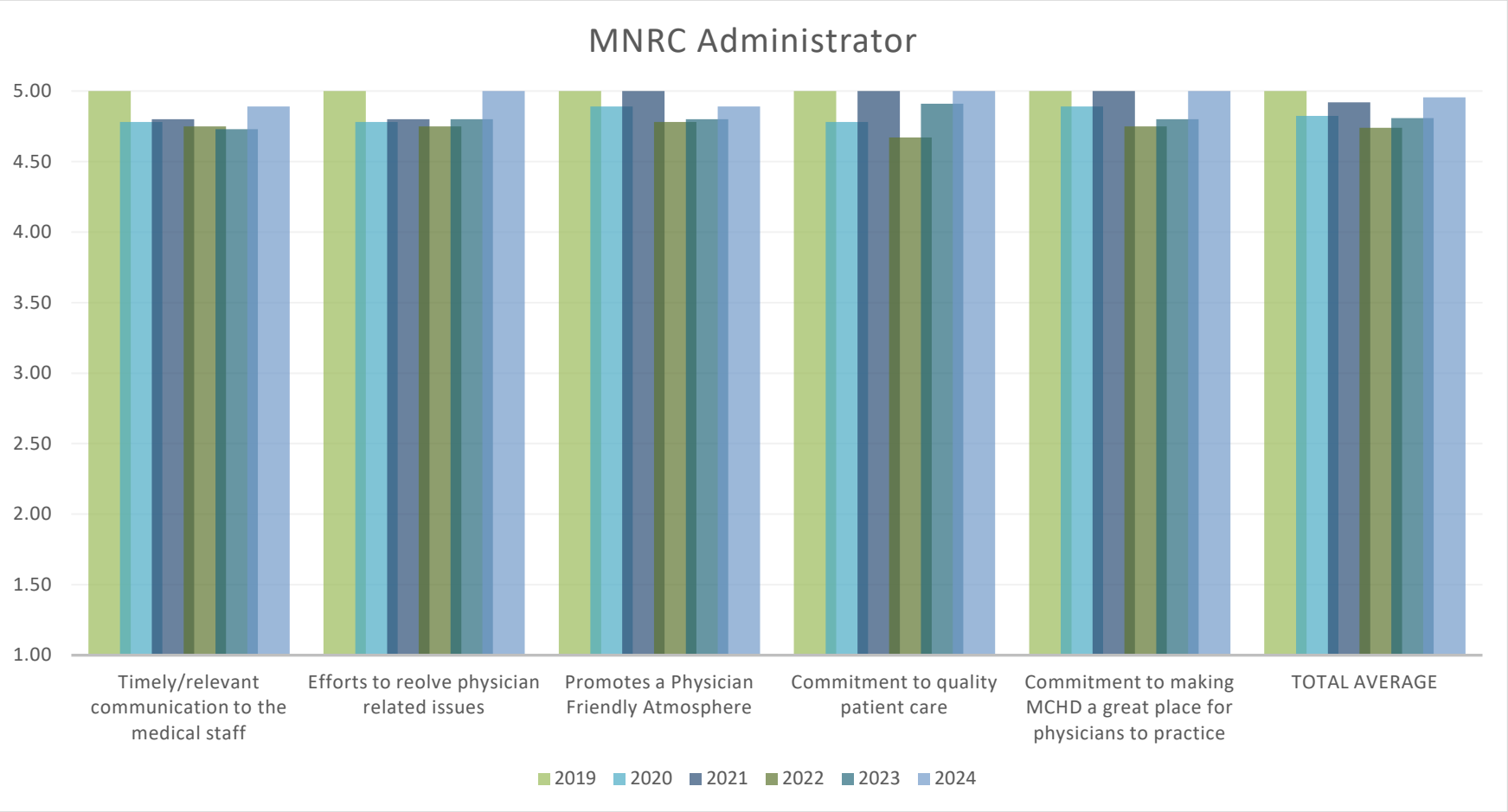
ANCILLARY CLINICAL DEPARTMENTS (Pharmacy)						
	2019	2020	2021	2022	2023	2024
Accuracy of medications and dosing	**4.75**	**5.00**	**4.88**	**4.69**	**4.75**	**4.90**
Director of Pharmacy	**4.75**	**5.00**	**5.00**	**4.69**	**4.67**	**4.90**
Speed of medicine delivery	**4.75**	**5.00**	**4.75**	**4.69**	**4.58**	**4.80**
Assistance in dosing	**4.75**	**5.00**	**4.88**	**4.69**	**4.67**	**5.00**
TOTAL AVERAGE	**4.75**	**5.00**	**4.88**	**4.69**	**4.67**	**4.90**



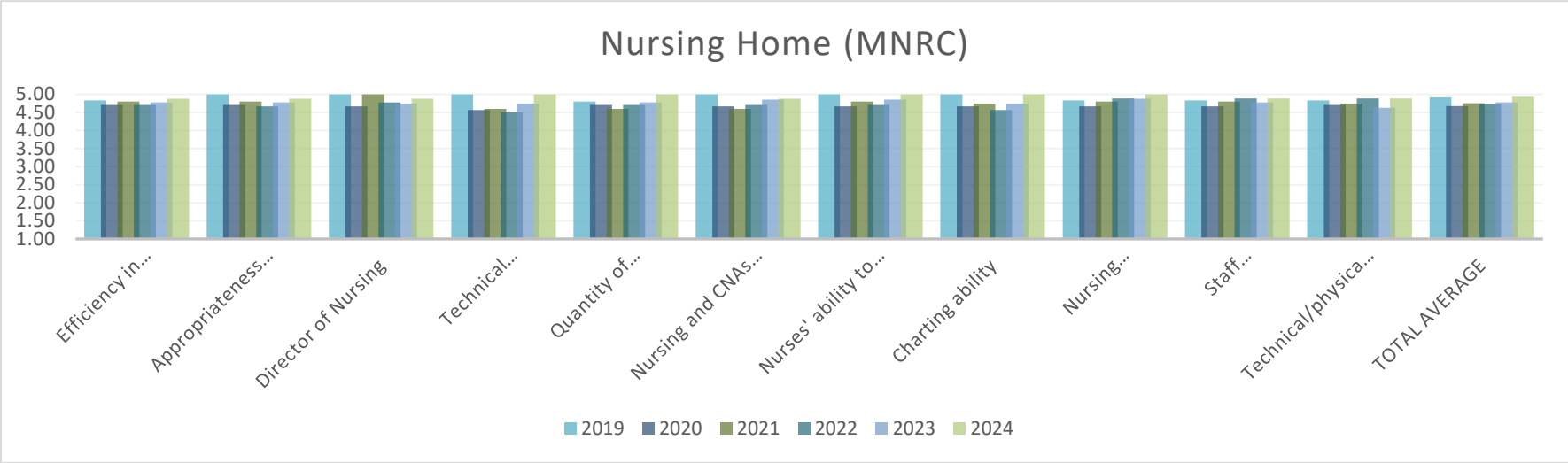
Other Ancillary	2019	2020	2021	2022	2023	2024
Therapy Services (PT/ST/OT)	**4.80**	**4.90**	**4.86**	**4.92**	**4.90**	**4.89**
Home Health	**4.88**	**4.60**	**4.71**	**4.92**	**4.80**	**5.00**
Hospice	**4.89**	**4.67**	**4.86**	**4.77**	**4.80**	**4.78**
Respiratory Therapy	**4.89**	**4.88**	**4.63**	**5.00**	**4.82**	**4.89**
Medical Staff Services (Credentialling)	**4.80**	**4.90**	**4.67**	**4.83**	**4.83**	**4.80**
Risk Management / Quality Assurance	**4.63**	**4.80**	**4.88**	**4.62**	**4.82**	**4.89**



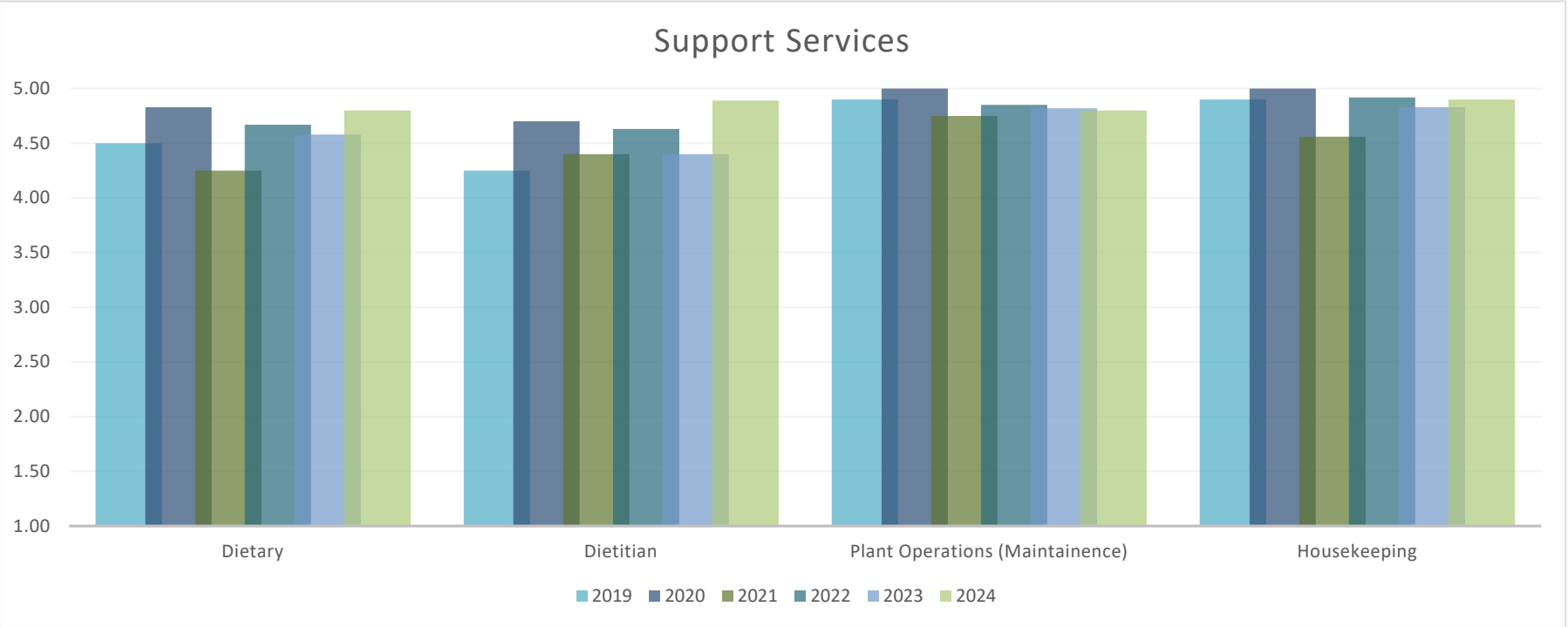
MNRC Administrator						
	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	**5.00**	**4.78**	**4.80**	**4.75**	**4.73**	**4.89**
Efforts to reolve physician related issues	**5.00**	**4.78**	**4.80**	**4.75**	**4.80**	**5.00**
Promotes a Physician Friendly Atmosphere	**5.00**	**4.89**	**5.00**	**4.78**	**4.80**	**4.89**
Commitment to quality patient care	**5.00**	**4.78**	**5.00**	**4.67**	**4.91**	**5.00**
Commitment to making MCHD a great place for physicians to practice	**5.00**	**4.89**	**5.00**	**4.75**	**4.80**	**5.00**
TOTAL AVERAGE	**5.00**	**4.82**	**4.92**	**4.74**	**4.81**	**4.96**



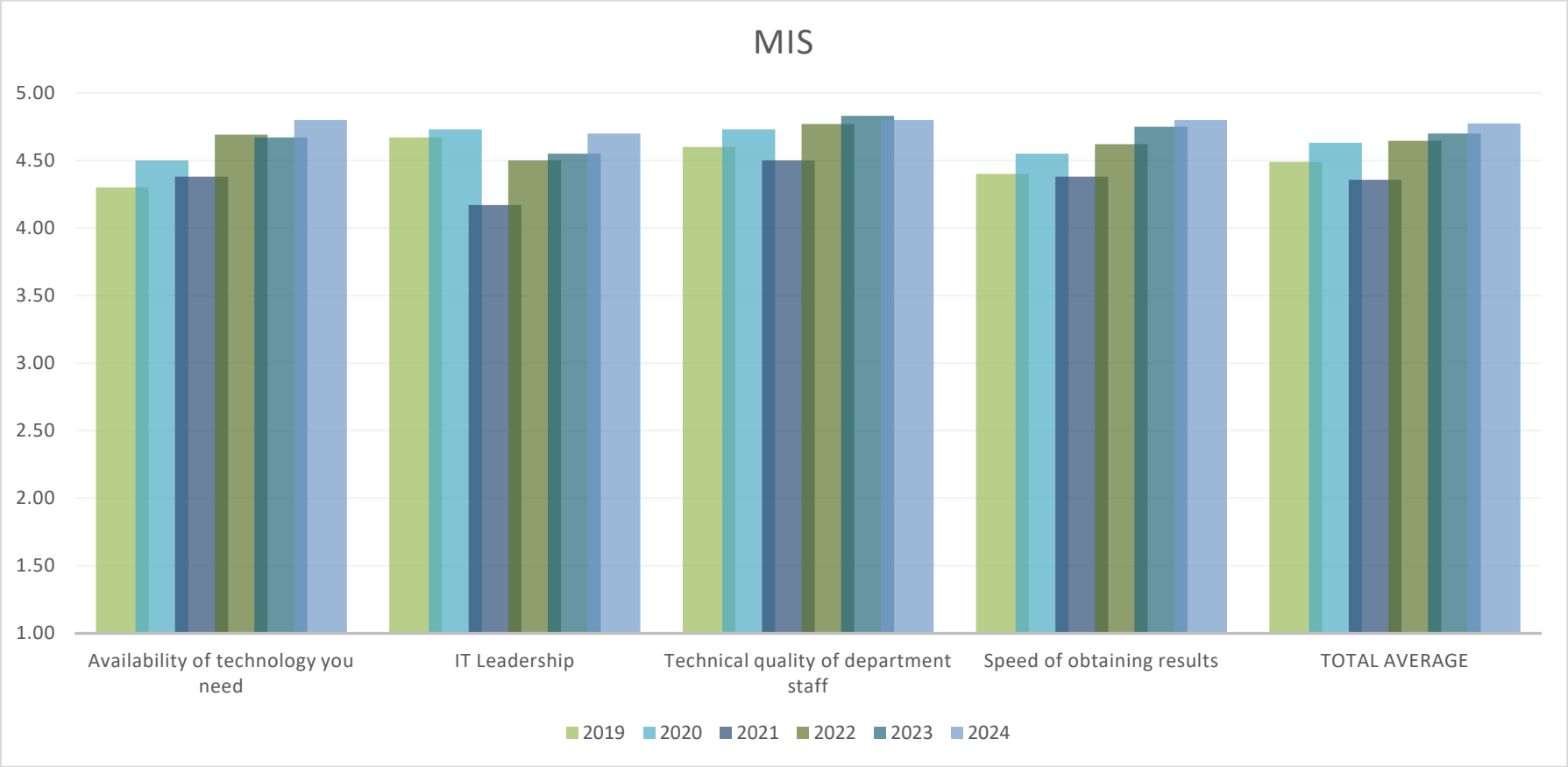
NURSING HOME (MNRC)						
	2019	2020	2021	2022	2023	2024
Efficiency in handling physician's orders	4.83	4.71	4.80	4.71	4.78	4.88
Appropriateness of nurse calls to physician	5.00	4.71	4.80	4.67	4.78	4.88
Director of Nursing	5.00	4.67	5.00	4.78	4.75	4.88
Technical skill/quality of nurses and CNAs	5.00	4.57	4.60	4.50	4.75	5.00
Quantity of nurses and CNAs	4.80	4.71	4.60	4.71	4.78	5.00
Nursing and CNAs staff stability (low turnover)	5.00	4.67	4.60	4.71	4.86	4.88
Nurses' ability to keep patients informed about procedures	5.00	4.67	4.80	4.71	4.86	5.00
Charting ability	5.00	4.67	4.75	4.57	4.75	5.00
Nursing interpersonal skills	4.83	4.67	4.80	4.89	4.88	5.00
Staff interpersonal skills	4.83	4.67	4.80	4.89	4.78	4.89
Technical/physical facilities	4.83	4.71	4.75	4.89	4.63	4.89
TOTAL AVERAGE	4.92	4.68	4.75	4.73	4.78	4.94



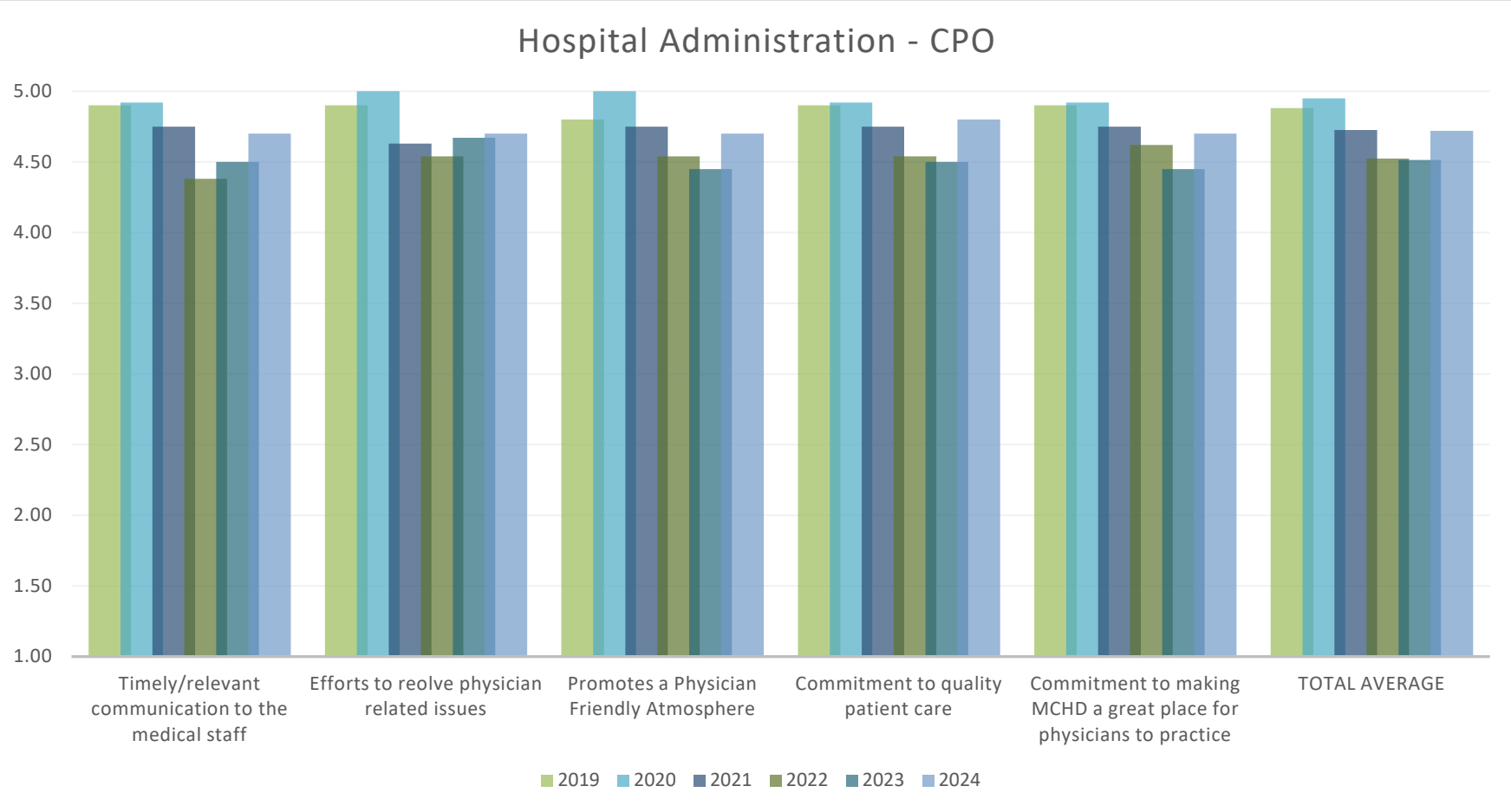
Support Services						
	2019	2020	2021	2022	2023	2024
Dietary	**4.50**	**4.83**	**4.25**	**4.67**	**4.58**	**4.80**
Dietitian	**4.25**	**4.70**	**4.40**	**4.63**	**4.40**	**4.89**
Plant Operations (Maintainence)	**4.90**	**5.00**	**4.75**	**4.85**	**4.82**	**4.80**
Housekeeping	**4.90**	**5.00**	**4.56**	**4.92**	**4.83**	**4.90**



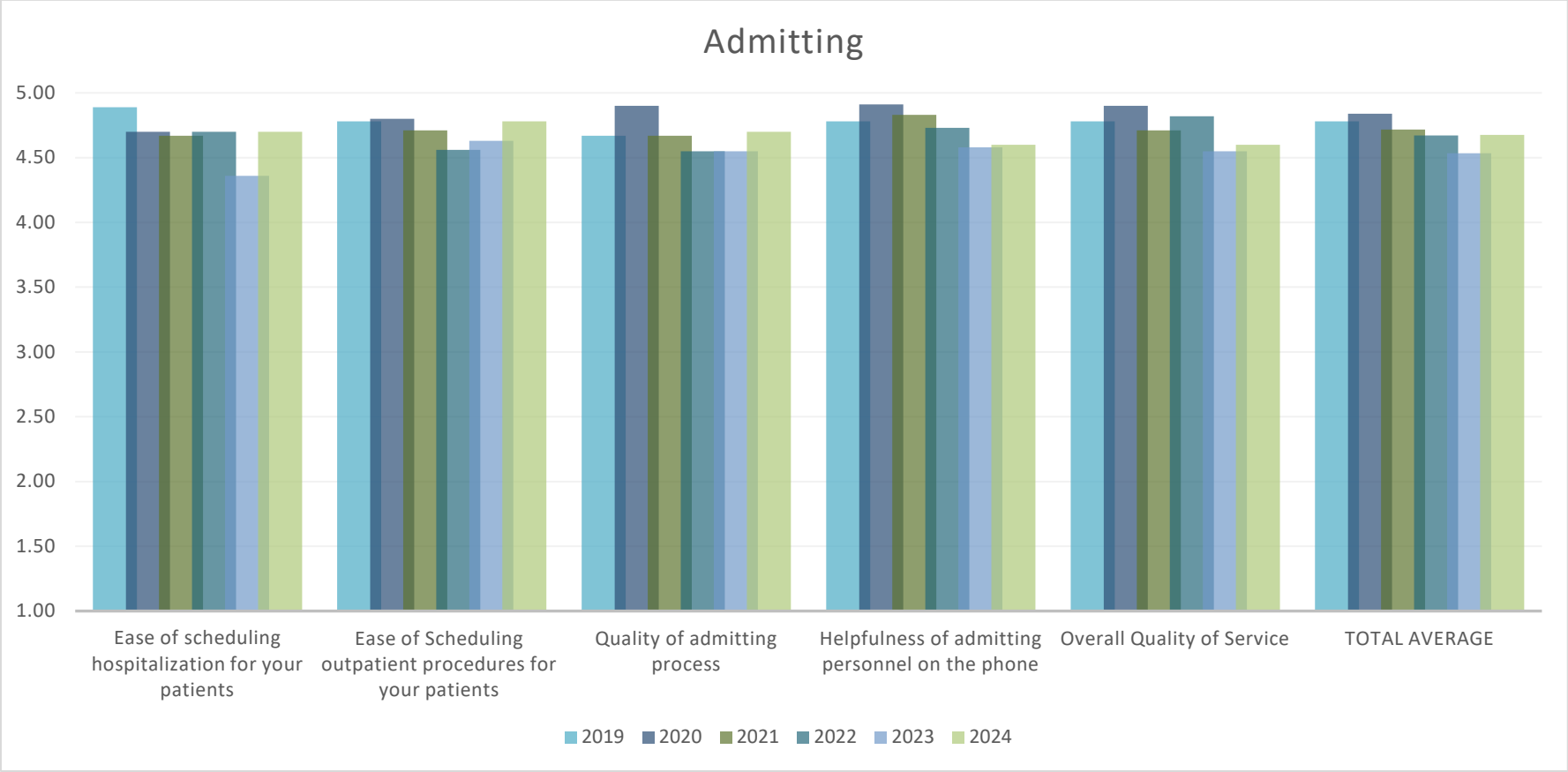
MIS (Information Technology)	2019	2020	2021	2022	2023	2024
Availability of technology you need	**4.30**	**4.50**	**4.38**	**4.69**	**4.67**	**4.80**
IT Leadership	**4.67**	**4.73**	**4.17**	**4.50**	**4.55**	**4.70**
Technical quality of department staff	**4.60**	**4.73**	**4.50**	**4.77**	**4.83**	**4.80**
Speed of obtaining results	**4.40**	**4.55**	**4.38**	**4.62**	**4.75**	**4.80**
TOTAL AVERAGE	**4.49**	**4.63**	**4.36**	**4.65**	**4.70**	**4.78**



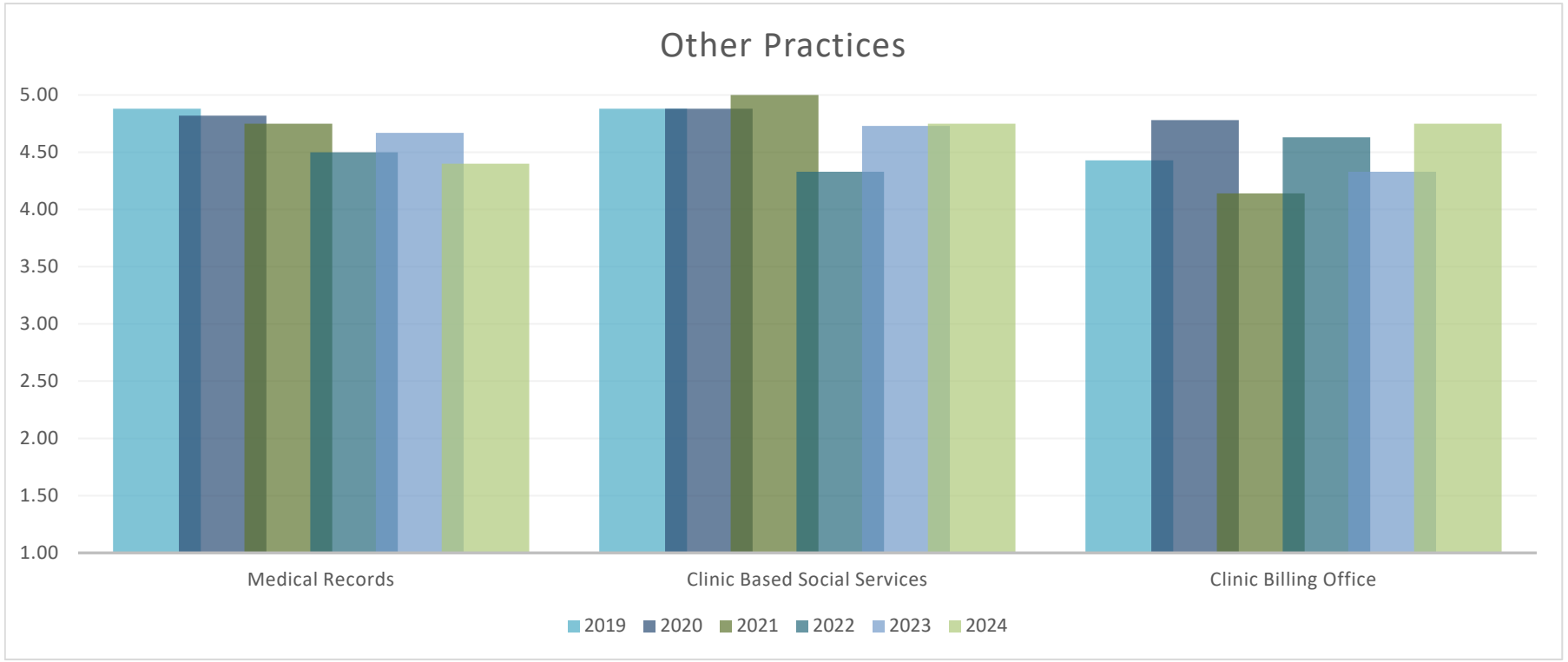
HOSPITAL ADMINISTRATION - CPO	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	**4.90**	**4.92**	**4.75**	**4.38**	**4.50**	**4.70**
Efforts to reolve physician related issues	**4.90**	**5.00**	**4.63**	**4.54**	**4.67**	**4.70**
Promotes a Physician Friendly Atmosphere	**4.80**	**5.00**	**4.75**	**4.54**	**4.45**	**4.70**
Commitment to quality patient care	**4.90**	**4.92**	**4.75**	**4.54**	**4.50**	**4.80**
Commitment to making MCHD a great place for physicians to practice	**4.90**	**4.92**	**4.75**	**4.62**	**4.45**	**4.70**
TOTAL AVERAGE	**4.88**	**4.95**	**4.73**	**4.52**	**4.51**	**4.72**



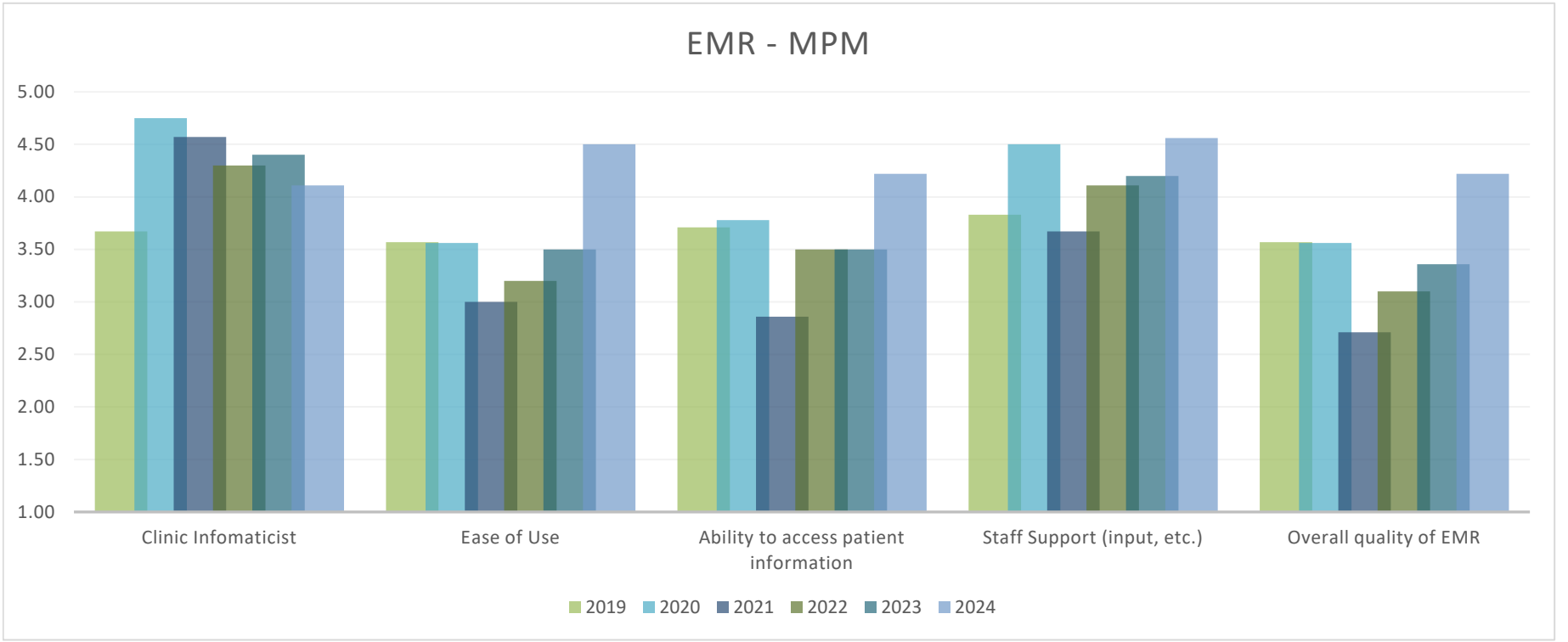
INPATIENT ADMITTING/SCHEDULING	2019	2020	2021	2022	2023	2024
Ease of scheduling hospitalization for your patients	**4.89**	**4.70**	**4.67**	**4.70**	**4.36**	**4.70**
Ease of Scheduling outpatient procedures for your patients	**4.78**	**4.80**	**4.71**	**4.56**	**4.63**	**4.78**
Quality of admitting process	**4.67**	**4.90**	**4.67**	**4.55**	**4.55**	**4.70**
Helpfulness of admitting personnel on the phone	**4.78**	**4.91**	**4.83**	**4.73**	**4.58**	**4.60**
Overall Quality of Service	**4.78**	**4.90**	**4.71**	**4.82**	**4.55**	**4.60**
TOTAL AVERAGE	**4.78**	**4.84**	**4.72**	**4.67**	**4.53**	**4.68**



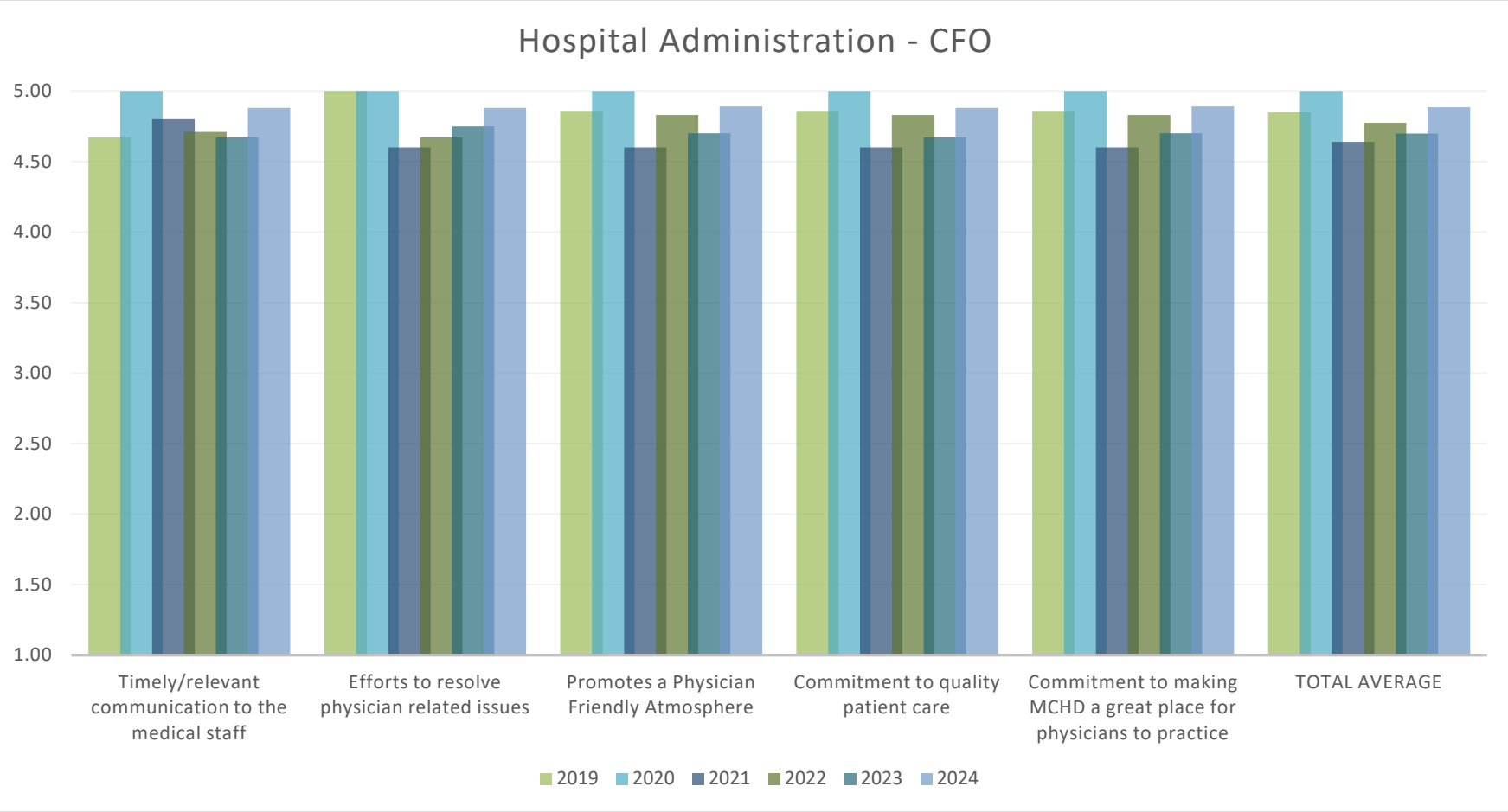
Other Practices	2019	2020	2021	2022	2023	2024
Medical Records	**4.88**	**4.82**	**4.75**	**4.50**	**4.67**	**4.40**
Clinic Based Social Services	**4.88**	**4.88**	**5.00**	**4.33**	**4.73**	**4.75**
Clinic Billing Office	**4.43**	**4.78**	**4.14**	**4.63**	**4.33**	**4.75**



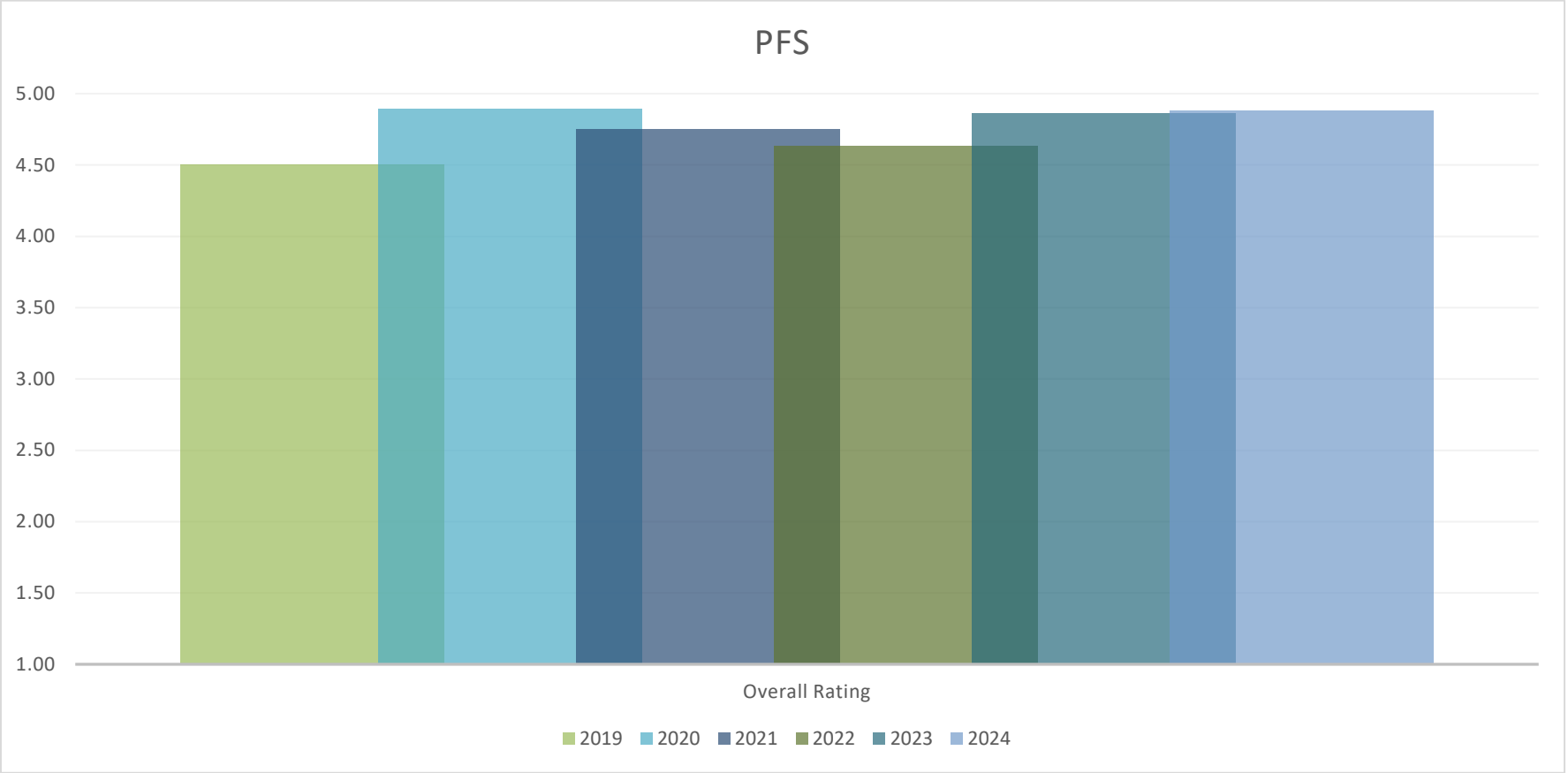
EMR - MPM	2019	2020	2021	2022	2023	2024
Clinic Infomaticist	**3.67**	**4.75**	**4.57**	**4.30**	**4.40**	**4.11**
Ease of Use	**3.57**	**3.56**	**3.00**	**3.20**	**3.50**	**4.50**
Ability to access patient information	**3.71**	**3.78**	**2.86**	**3.50**	**3.50**	**4.22**
Staff Support (input, etc.)	**3.83**	**4.50**	**3.67**	**4.11**	**4.20**	**4.56**
Overall quality of EMR	**3.57**	**3.56**	**2.71**	**3.10**	**3.36**	**4.22**



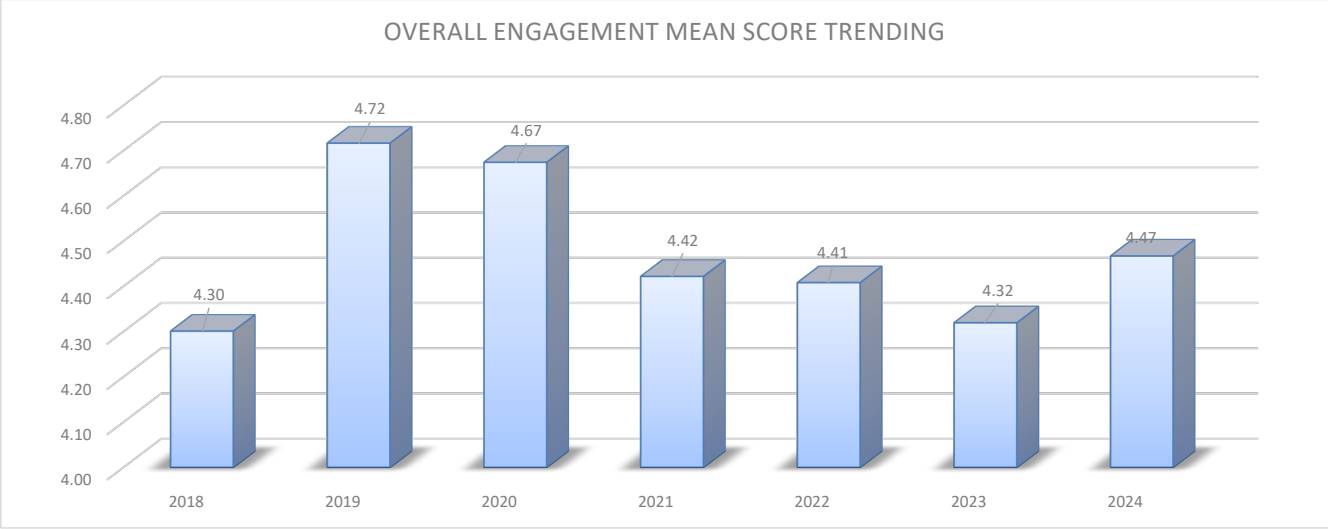
HOSPITAL ADMINISTRATION - CFO	2019	2020	2021	2022	2023	2024
Timely/relevant communication to the medical staff	**4.67**	**5.00**	**4.80**	**4.71**	**4.67**	**4.88**
Efforts to resolve physician related issues	**5.00**	**5.00**	**4.60**	**4.67**	**4.75**	**4.88**
Promotes a Physician Friendly Atmosphere	**4.86**	**5.00**	**4.60**	**4.83**	**4.70**	**4.89**
Commitment to quality patient care	**4.86**	**5.00**	**4.60**	**4.83**	**4.67**	**4.88**
Commitment to making MCHD a great place for physicians to practice	**4.86**	**5.00**	**4.60**	**4.83**	**4.70**	**4.89**
TOTAL AVERAGE	**4.85**	**5.00**	**4.64**	**4.77**	**4.70**	**4.88**



Patient Financial Services	2019	2020	2021	2022	2023	2024
Overall Rating	**4.50**	**4.89**	**4.75**	**4.63**	**4.86**	**4.88**



	2018	2019	2020	2021	2022	2023	2024
OVERALL ENGAGEMENT MEAN SCORE TRENDING	4.30	4.72	4.67	4.42	4.41	4.32	**4.47**
# responses	*8*	*10*	*12*	*7*	*13*	*7*	*9*
ALL PHYSICIANS							
Q1. I have the opportunity to do what I do best every day.	4.75	5.00	4.67	3.86	4.77	4.71	4.78
Q2. I am inspired to go above and beyond what is expected of me.	4.63	5.00	4.83	4.50	4.62	4.43	4.67
Q3. I can easily communicate ideas and concerns to MCHD Leadership.	4.38	4.90	4.83	4.71	4.77	4.71	4.56
Q4. I am involved in decisions that affect my role as a physician.	4.63	4.90	4.83	4.71	4.58	4.86	4.67
Q5. MCHD leadership is open to change.	4.13	4.70	4.58	4.43	4.54	3.29	4.56
Q6. I understand what is expected of me as a physician practicing at MCHD.	4.63	5.00	4.83	4.71	4.77	4.86	4.78
Q7. MCHD provides opportunities for personal and professional growth.	3.88	4.80	4.92	4.83	4.77	4.71	4.67
Q8. My fellow physicians are committed to doing quality work.	4.63	4.90	4.92	4.86	4.69	4.86	4.67
Q9. I am treated with respect.	4.63	4.90	4.92	4.57	4.69	4.57	4.78
Q10. I am satisfied with the recognition I receive.	4.63	4.80	4.92	4.71	4.62	4.57	4.78
Q11. The Electronic Medical Record system is easy to use and efficient.	2.63	3.80	3.50	3.00	3.08	2.43	3.44
Q12. I am making a meaningful difference in my work.	4.75	5.00	4.83	4.43	4.62	4.71	4.67
Q13. I enjoy my personal time without focusing on work matters.	3.75	4.50	4.08	3.86	4.17	4.14	4.11
Q14. I rarely lose sleep over work issues.	3.38	4.30	4.17	3.86	4.34	3.86	3.78
Q15. I am able to disconnect from work communications during my free time.	3.13	4.00	3.75	3.71	4.36	3.86	3.78
Q16. I can easily communicate ideas and concerns to the Hospital Board.	4.00	4.89	4.83	4.33	4.50	3.00	4.22
Q33. Dumas is a great place to live.	4.40	4.44	4.45	4.29	3.77	3.43	4.00
Q34. My family and I are comfortable and well liked in our community.	4.60	4.75	4.82	4.00	4.08	3.57	4.38
Q35. Dumas/Amarillo provide all the important things my family and I need.	4.20	4.63	4.64	4.43	4.50	4.14	4.22
PRIVATE PRACTICE							
Q18. I prefer to admit/refer my patients to MCHD.	5.00	5.00	5.00	4.43	4.73	5.00	4.67
Q19. MCHD is well prepared to meet the challenges of the next decade.	4.33	5.00	5.00	4.43	4.70	4.29	4.56
Q20. I view MCHD as a strategic partner in navigating the changing healthcare landscape.	4.67	5.00	5.00	4.71	4.36	4.71	4.78
Q21. MCHD supports the economic growth and success of my individual practice.	3.33	4.75	4.75	4.71	4.36	4.71	4.56
Q22. The actions of the executive team reflect the goals and priorities of the participating physicians.	4.33	4.75	4.50	4.71	4.18	4.29	4.44
Q23. I am willing to put in a great deal of effort to help MCHD succeed.	5.00	4.75	5.00	4.71	4.73	4.86	4.78
DISTRICT EMPLOYED							
Q24. I am able to spend the time I need with my patients.	5.00	4.86	4.89	4.50	4.77	5.00	4.67
Q25. I have the right amount of input into my clinical schedule.	5.00	4.71	4.67	4.50	4.00	4.71	4.56
Q26. I have adequate input into clinical decisions that affect how I practice medicine.	4.40	5.00	5.00	5.00	4.46	5.00	4.89
Q27. The office is appropriately staffed for the volume and complexity of my patients.	4.20	4.50	4.22	3.83	3.92	3.86	4.33
Q28. The office staff has sufficient clinical expertise to care for our patients.	4.00	4.33	4.78	4.67	4.08	4.57	4.56
Q29. Patient flow is efficient in my office.	4.40	4.50	4.33	4.50	4.17	3.86	4.22
Q30. I believe my patients feel highly satisfied with the care they receive.	4.80	4.71	4.78	4.83	4.62	4.71	4.44
Q31. My compensation and benefits are comparable to what I would make at other locations.	4.20	4.43	4.78	4.33	4.23	4.14	4.33
Q32. MCHD supports my desired work-life balance.	3.80	4.85	4.89	4.67	4.31	4.43	4.56



Goal: To deliver 5-star service to all MCHD customers across all service lines.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Year 2 of CLS 5-Star Service Tools across all MCHD service lines: a. Special Emphasis: MCHD-owned Clinics b. Special Emphasis: Emergency Department c. Hospital, including Swing Bed Services d. Nursing Home	Bethany, Ops Team	→	→	→
2. Service Excellence Council a. Implement Service Excellence Advisors Training	Bethany	→	→	→
3. Implement OASIS Teams a. Key Words at Key Times b. Resignation Recovery c. ER Academy	John/Jamie Jeff/Amy Yessenia/Kelly/Dr. Knight	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)			
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue			

CLINIC PERCEPTIONS OF CARE

Strategic initiatives for a clinic setting that focus on patient perception and organizational culture, using principles from our Values and Standards. Custom Learning Systems (CLS), can significantly enhance the patient experience and employee engagement. Custom Learning Systems is known for its patient-centered approach and culture transformation strategies in healthcare.

1. Implement a “Culture of Ownership” Framework
    a. Initiative: Launch a Culture of Ownership Program
        i. Engage staff with storytelling and workshops about accountability and pride in work.
2. Patient Perception - Focus directly on improving what patients say about their experience.
    a. Initiative: Patient Experience Rounding
        i. Train leaders and staff to conduct regular, purposeful patient rounds.
        ii. Ask specific questions about their care, communication, and responsiveness.
        iii. Track trends and close feedback loops quickly.
3. Mystery Patient Program - Evaluate patient experience from a neutral perspective.
    a. Initiative: CLS Mystery Shopper Model
        i. Use trained individuals to assess courtesy, cleanliness, timeliness, and clarity.
        ii. Debrief teams and use results for continuous improvement.
4. Recognition and Reward Systems - Celebrate staff who embody the desired culture and deliver excellent patient experiences.
    a. Initiative: Caught You Caring Program
        i. Peer and leader nominations for going above and beyond.
        ii. Public recognition boards and monthly awards

Advanced Service Excellence Workshop™

Custom Learning Systems
1.800.667.7325 customlearning.com

Moore County Hospital District
Advanced Service Excellence Workshop™

Mission:
"Continuing Our Journey to Become a 5 Star Hospital of Choice."

SUPERLEARNING SUGGESTIONS:

How many new ideas can you find in this seminar? How soon can you put them to work?

1. Make this workshop personally valuable by searching for your 'Most Useable New Idea.'
2. Constantly ask yourself, "*How can these new ideas and behaviors make me more valuable to my organization --- and to myself?*"
3. This is a safe place to learn. There are no wrong answers!
   - ❒ Participate actively.
   - ❒ Ask questions.
   - ❒ Be open-minded.
   - ❒ Share your experience and insights with your table-group.
   - ❒ Make notes of ideas you find useful.
   - ❒ Put away cell phones.
4. Be personally accountable for putting these new ideas and behaviors to work in your department.
5. Have fun!

Dimension #1 – Take a Look at Us Now

Year I Accomplishments & Recognition

17 SEAs

WORKSHOP SUMMARY

377 STAFF	566 TOTAL EDUCATION HOURS	4 SEA TEACHING TEAMS
AVERAGE SEA WORKSHOP RATING 4	98% ATTENDANCE	20 WORKSHOPS COMPLETED

3 OASIS PERFORMANCE IMPROVEMENT TEAMS

OASIS = Organizationally Advanced Service Improvement System

KEYWORDS

John Sharp (Team Liasion)
Jamie Batenhorst (Team Captain)
Maria Mendoza, Lindsey Hammock, Kelly Galloway, Melissa Venzor, Krystal Beltran, Stacey Robinson, Katelyn Salcido, Steve Fuston, Zandy Perez (OASIS Super Coach)

OASIS Key Words and Phrases Team rolled out the following:
The Six Foot Rule and Telephone Etiquette providing guidance to appropriate and always expectations with patients, visitors, and fellow employees.

ONBOARDING

Ashleigh Wiswell (Team Liasion)
Allison Loya (Team Captain),
Amanda Garcia, Christine Kimbrell, Terrance McKean, Shawn Shafer, Larry Churchill, Amy Davis, Zandy Perez (OASIS Super Coach)

OASIS Onboarding Team was a huge part of identifying needs for NEO regarding Service Excellence and how to engage new members in our culture.

PROVIDER ENGAGEMENT

Jeff Turner, Michele Sharp, Dr. Priyanka Patel, Amanda Jones, Sandra Qualls, Beatriz Beltran, Tina Harding, Elise Heil, Zandy Perez (OASIS Super Coach)

OASIS Physician/Provider Engagement Team organized times and dates our physician teams could volunteer in assisting community nonprofits. They also organized a Progressive Christmas Dinner for the doctors to attend.

28 FUTURE SEA VOLUNTEERS

36 LEADERS TRAINED

954 EDUCATION HOURS

Bethany Scroggins
Implementation Coordinator

SEC rolled out DO IT Meetings and monthly DO IT Awards.

We began collecting submissions the end of January 2025 and have awarded 3 DO IT Winners to a department or clinic. We are still going strong and receive 10-15 submissions of DO ITs monthly.

FEBRUARY: Med/Surg Department;

MARCH: Moore County Family Health Clinic;

APRIL: Respiratory Therapy Dept.

Service Excellence Accomplishments

1 Service Recovery was initiated in September of 2024. With the assistance of KC Mild, Service Recovery Champion, MCHD has been looking for opportunities to identify and "fix" short comings throughout the district. We are using "Fix IT" Forms and gift cards to apologize to patients an average of 8 times per month.

3 We have added Service Excellences updates and reviews to our quarterly Town Hall Meetings and SEAs often present at the meeting.

4 We have utilized SEAs to attend monthly New Employee Orientation (NEO) trainings to assist HR in educating new employees about our Service Excellence Initiative and set high expectations.

12 ACTIVE SEC MEMBERS

10 COURSES PRESENTED BY CLS

4.9 AVERAGE CLS COURSE RATING

CAHPS/PATIENT SATISFACTION SCORE IMPROVEMENT PROGRESS

- ↑3% COMMUNICATION WITH NURSES
- ↑1% COMMUNICATION WITH DOCTORS
- ↑16% RESPONSIVENESS OF STAFF
- ↑5% CLEANLINESS OF HOSPITAL
- ↑1% QUIETNESS OF HOSPITAL
- ↑6% TRANSITION OF CARE
- ↑3% OVERALL RATING
- * COMMUNICATION ABOUT MEDICATION **STAYED AT 99TH PERCENTILE**

IMPROVED IN **7*** AREAS

5 CURRENT HCAHPS STAR RATING

National Rural Rating System

Brief description of 4 star rating

Other Awards

Dimension #2 – The Patient's Power of Choice: Where Are We Now?

Plan Sheet – Annual Patient Experience Score Improvement

	Starting Year July 2023 to March 31, 2024		Year I – Q3 July to September 2024			Year I – Q4 October to December, 2024			Year I – Q1 January to March, 2025		
Star Rating											
HCAHPS Scores	**Top Box**	**%tile**	**Top Box**	**%tile**	**%tile Rank Increase***	**Top Box**	**%tile**	**%tile Rank Increase***	**Top Box**	**%tile**	**%tile Rank Increase***
Communication with Nurses	89.43	96	97.78	99	3	96.97	99	-	92.16	90	-9
Communication with Doctors	85.11	98	93.33	99	1	96.55	99	-	86.27	75	-24
Responsiveness/Hospital Staff	84.41	83	85.95	99	16	90.48	99	-	91.67	99	-
Communication about Medicines	82.98	99	80.91	99	-	94.12	99	-	76.19	90	-9
Cleanliness of Hospital Environment	90.24	98	86.67	94	-4	100	99	5	82.35	50	-49
Quietness of Hospital Environment	73.17	91	80	96	5	77.78	94	-2	76	80	-14
Discharge Information	96.12	98	100	99	1	100	99	-	90	90	-9
Transition of Care	64.36	93	75.56	99	6	80.65	99	-	84.31	75	-24
Overall	87.80	96	100	99	3	100	99	-	76.47	49	-50
Willingness to Recommend	80.49	85	80	83	-2	100	99	16	88.24	75	-24
# of Domains Increased	N/A		7			2					
Avg. %tile Increase	N/A		5			7.5					

Patient Satisfaction	**Mean/ Top Box**	**%tile**	**Mean/ Top Box**	**%tile**	**Mean/ Top Box**	**%tile**	**Mean/ Top Box**	**%tile**
Inpatient	87.80	96	100	99*	96.97	99	76.47	49
ED	73.29	66	76.18	73*	57.14	15	63.30	15
Ambulatory OAS CAHPS	89.61	57	88.24	47	***-	-	85.71	75
Medical Practice CG CAHPS	81.91	28	83.13	33*	83.05	70	84.74	70

**%tile Rank Improvement since starting year*

****Ambulatory OAS CAHPS 2nd Quarter numbers (Oct-Dec) not available due to issue with vendor conversion.*
Data amount is insufficient for percentiles from Survey Solutions. Percentiles based on posted top boxes of state and national database.

Key Drivers Quiz

Communication with Nurses

True False 01 Involving patients in decisions regarding their treatment shows courtesy and respect. It's also good medicine.

True False 02 People feel listened to when you express empathy for their concerns.

True False 03 Since we're all basically alike, there's no need to pay attention to patient's personal preferences.

Communication with Doctors

True False 04 Sitting at bedside --- rather than standing --- demonstrates that you're prepared to listen to the patient's story.

True False 05 Offering treatment options and allowing the patient to participate in treatment decisions shows courtesy and respect.

True False 06 Using complicated medical terms reassures the patient that you are up-to-date on the latest procedures.

Responsiveness of Hospital Staff

True False 07 It's a wise policy to test for patient familiarity with call light and intercom functions.

True False 08 If we don't respond as quickly to the grumpy patients, they'll get the message and shape up.

True False 09 When hospital-wide standards for response to call-lights are set and adhered to, patients feel a greater degree of comfort and security.

Physical Environment

True False 10 If we're short-staffed on a weekend, it's okay that bathrooms aren't cleaned.

True False 11 Reducing the noise level on the nursing floor is everybody's responsibility.

True False 12 A housekeeping staff member that asks the patient what else they'd like tidied up sends a message of care and concern.

Pain Control

True False 13 Nurses should be able to educate patients about the difference between "total absence of pain" and "pain management."

True False 14 Because the level of pain changes, we need to constantly check the patient's level of discomfort, and monitor whether pain meds are indeed working.

True False 15 Nurse staff should be prepared for pain management in children.

Communication about Medicine

True False 16 It's wise to regularly ask patients if they have any questions about the medications they're taking.

True False 17 Asking patients to describe, in their own words, what each medication is for is an excellent way to be sure they do know.

True False 18 If a new medication is prescribed, there's no reason to worry the patient with information about any possible adverse reaction.

Discharge Information

True False 19 Before discharge, staff needs to prepare patients to care for themselves physically and emotionally.

True False 20 It's not important to involve the family or support services in discharge planning.

True False 21 Open-ended questions (that start with "How ...?" and "What …?) are a good way to uncover any lingering concerns and anxieties a patient may have about going home.

Global Rating

True False 22 The last two questions of the survey are not reported because they are on a 10-point scale.

True False 23 Each employee directly or indirectly contributes to the patient's rating and likeliness to recommend.

2024 Leadership Empowerment Survey
All Managers Report

Question	July 2024 Participants Response Rate: 66% Average
1. This Leader helps me understand change and to see the "Big Picture."	3.68
2. This Leader practices what he/she preaches, is a good role model, and treats me with courtesy and respect.	3.81
3. This Leader keeps me informed so that I truly feel like a knowledgeable "insider."	3.62
4. This Leader does a good job of inspiring patient/resident-centered service in my department and is always aware of feedback from our satisfaction surveys.	3.73
5. This Leader promotes teamwork within our department and with other departments/units.	3.73
6. This Leader runs meetings/huddles that inspire me and encourage me to speak up.	3.60
7. This Leader ensures that I have the tools and training to do my job in a timely and effective way.	3.77
8. This Leader encourages open and creative problem-solving in my department.	3.72
9. This Leader gives me clear assignments and empowers me to do my best.	3.74
10. This Leader is effective at coaching me, developing my skills and keeping me on track.	3.68
11. This Leader is timely and appropriate with both positive feedback and corrective action.	3.67
12. This Leader is actively engaged in the Service Excellence Initiative™ process.	3.88
Overall Rating of Leader	
13. Overall, I rate my working relationship with this Leader as:	3.71
Overall Average Rating	**3.711**

Based on 4.0-point scale

Conversation to Hold People Accountable

Balanced Coaching

Giving feedback is intended to be a non-threatening conversation to recognize the talents while challenging an individual (or your team) to perform better, without taking offense to your comments and suggestions.

A Model for Balanced Coaching

- Name – First name (and look at him/her)… _____
- Describe a strength and its benefit – *"Thank you for…"* or *"You are very good/gifted at…"*

  _____

  "This is important because…" _____
- Suggest an improvement and its value – *"May I suggest…"*

  _____

Examples for Holding People Accountable

"Steve, thank you for your support as a Service Excellence Advisor. This is important because it helps me fulfill my responsibilities. May I suggest you let me know of any scheduling conflicts that impact you or our department?"

"Kim, you are very calming with patients and their families. This is important for them to trust you and feel comfortable under your care. May I suggest you show your coworkers the same degree of patience and compassion?"

"Chris, you are so gifted with creativity. This is important when you are problem solving. May I suggest you share and support other coworkers' creative problem solving during our DO IT meetings?"

Practice: (Write out what you would actually say and suggest to someone)

Dimension #3 – Using Our Power of Choice to Be a Good Influence

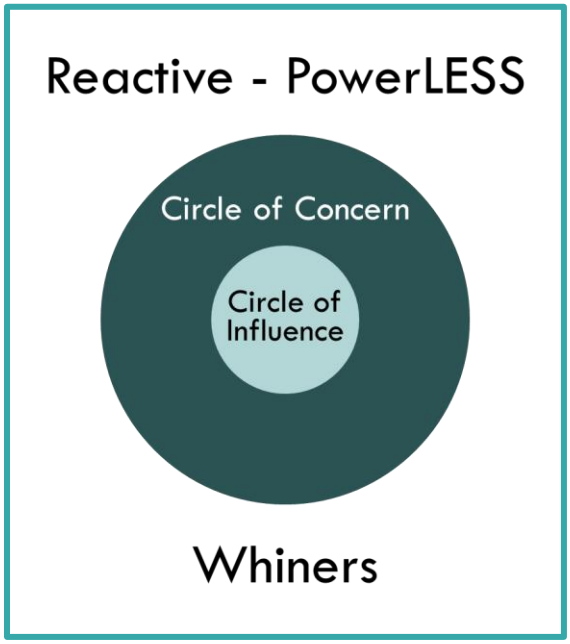
- We have **choices**. *How you feel is up to you.*
- **Who controls how we set** our priorities?
- Conclusion: We're either **WHINERS** or **WINNERS**.

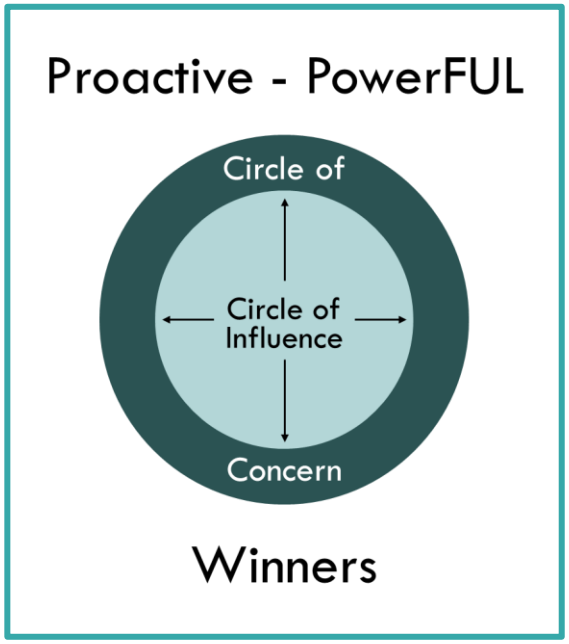
  WHINERS - Blame others for their situation, create lots of excuses = **POWERLESS**
  WINNERS - Take responsibility, are accountable, can change = **POWERFUL**

"There's nothing you can do about that? No, there's always something you can do about that."
- David K. Reynolds, Ph.D.

"No one can make you feel inferior without your consent."
- Eleanor Roosevelt

- What we imagine is what we GET (so beware the power of the self-fulfilling prophecy).
- Yes, there are exceptions.





*Adapted from the 7 Habits of Highly Effective People by Stephen Covey

Four Keys to Personal Power

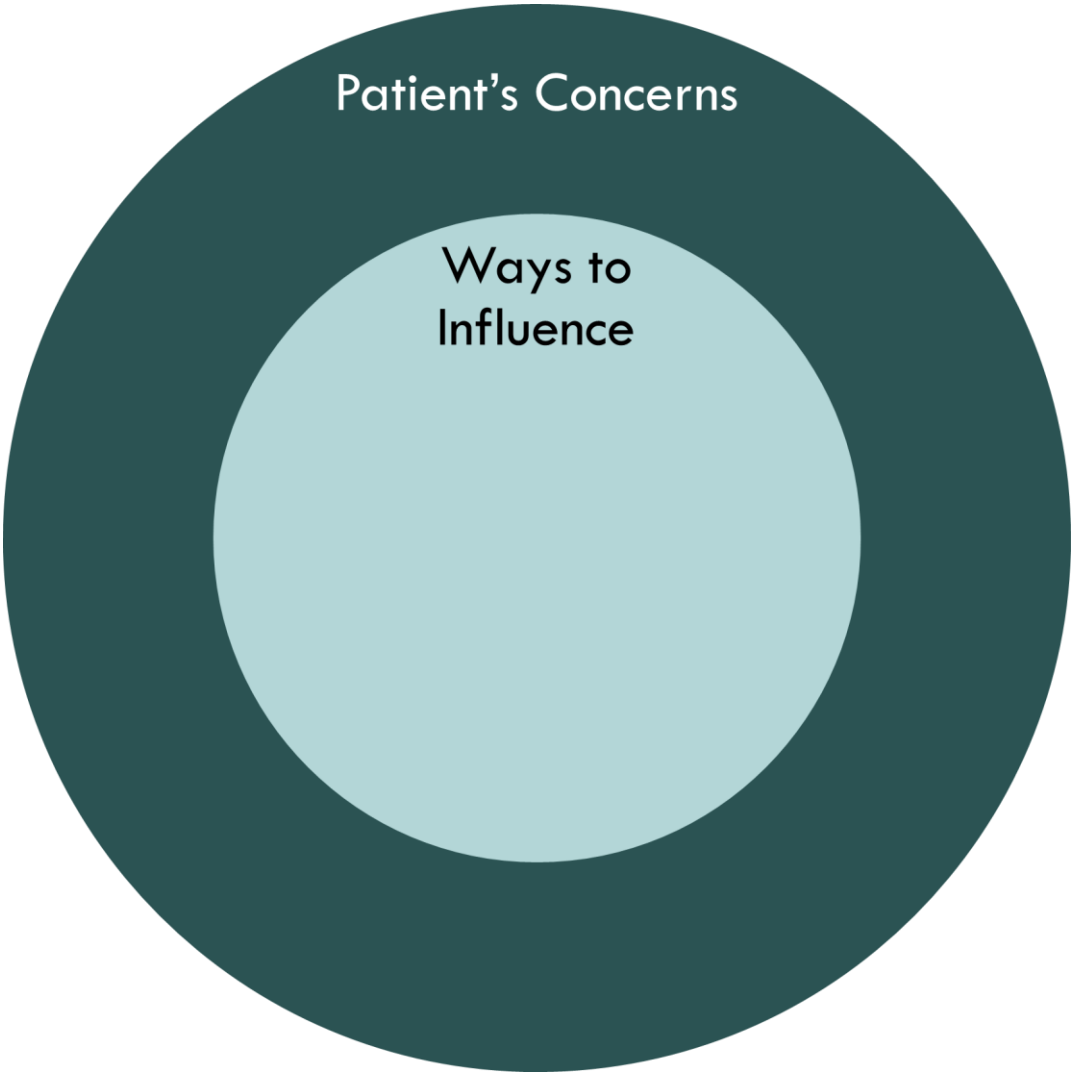
☐ 1. Don't let the things you **can't control** interfere with the things you can.
☐ 2. **Love** what you do.
☐ 3. **Stand** for something.
☐ 4. Expect the **best.** *Support people's best selves!*

Worksheet

Circle of Concern – Circle of Influence

What are our patients concerned about?

How can we be "good influences" in responding to our patient concerns?



How might patients benefit when their emotional needs are attended to, along with their purely medical ones?

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Are you ready to walk a mile in your patient's shoes?

Moore County Hospital District Values and Standards

POSITIVITY

"Be Optimistic"

- Maintain an upbeat attitude and encourage others.
- Don't let personal issues impact work.
- Show appreciation and gratitude.
- Be mindful of your tone and body language.
- Approach situations with an open mind and consider new ideas.

EXCELLENCE

"Be the Best."

- Take pride/ownership in our facilities and all that we do.
- Provide exceptional care always.
- Strive to improve skills, knowledge, and use evidence-based practices.

INTEGRITY

"Have Strong Morals & Ethics"

- Be accountable for actions and outcomes.
- Do what is right when no one is looking.
- Be honest, ethical, dependable, loyal, and trustworthy.

PROFESSIONALISM

"Be the Employee You Want to Work With"

- Be confident in your skills, and manage up co-workers.
- Graciously give and receive constructive feedback.
- Practice transparent and respectful communication.
- Make a positive impression and maintain appropriate appearance & cleanliness.
- Be reliable, punctual, consistent, and accountable.

UNITY

"One Family. One Goal."

- Be proactive. Work as a team. Respect one another.
- Effectively communicate.
- Be dedicated to the success of MCHD and the health of the community.

COMPASSION

"Care & Empathy for All"

- Address mental & physical comfort of patients and families.
- Be selfless. Put yourself before yourself.
- Show kindness.
- Listen and show concern.

I have been provided a copy of these Values and Standards and I commit myself to upholding them.

Print Name: _____ Dept: _____

Signature: _____ Date: _____

Updated 08/31/2023

Values and Standards in Action

***Instructions**: Describe what you can SAY, ASK or DO to demonstrate each of our Values and Standards. List Taboos as things NOT to say, ask or do for each value.*

POSITIVITY	
To Dos:	Taboos:

INTEGRITY	
To Dos:	Taboos:

UNITY	
To Dos:	Taboos:

COMPASSION	
To Dos:	Taboos:

PROFESSIONALISM	
To Dos:	Taboos:

EXCELLENCE	
To Dos:	Taboos:

DO IT Team Accomplishments

Department	Received Date	DO IT Project
Med. Surg. / IMC	January 2025	1. **Plan:** Patients unable to find channels on TV and verbalized during administration rounding. 2. **Do:** TV "guides" were printed and laminated for each room. 3. **Check:** Did it work? YES 4. **Adjust:** Did you make the necessary changes and retest? None needed.
Moore County Family Health Clinic	February 2025	1. **Plan:** Dirty breakroom after monthly birthday celebrations. Supplies out of stock. 2. **Do:** Cleaned up breakroom. Checked for needed supplies and informed manager of what was needed. 3. **Check:** Did it work? Yes. 4. **Adjust:** Did you make the necessary changes and retest? Yes.
Respiratory Therapy	March 2025	1. **Plan:** Patients asking for a *Return to Work/School* note and we did not have anything in our department. 2. **Do:** Typed up a standard form on MCHD letterhead and made copies handy for the RT department. 3. **Check:** Did it work? Yes. Letter typed, printed and RT notified of its location. 4. **Adjust:** Did you make the necessary changes and retest? Yes.
Rehabilitation	April 2025	1. **Plan:** Conflict with nursing home patients not being available for therapy treatments due to being at MNRC activities. 2. **Do:** Requested MNRC send the monthly activity calendar to the rehabilitation department. 3. **Check:** Did it work? Yes. We are now able to schedule patients around activities so residents may participate in activities and not miss therapy treatments. 4. **Adjust:** Did you make the necessary changes and retest? None needed.

GOAL: 1 DO IT Project each month from every department, minimum

DO ITs Defined

Departmentally **O**rganized **I**mprovement **T**actics

We view the monthly DO IT improvement process as our ongoing best shot at engaging caregivers to improve the culture for becoming the Provider and Employer of Choice.

DO IT speaks to the very heart of our Service Excellence Initiative™. This is how we can empower all caregivers to improve our service at the department level.

We need every single department to consistently:

- Listen to all caregivers/patients.
- Prioritize the problems that are most urgently in need of fixing.
- Take responsibility for the problem.
- Create a plan to solve the problem.
- Make sure the plan works.

Goals for Monthly DO IT Projects

1. To eliminate the current patient/resident problems in our department.

2. To involve everyone in constantly reviewing how well we are doing.

3. To ensure what was taught in the Service Excellence Workshop™ is used.

4. To improve employee communication, empowerment, and job satisfaction.

5. To track DO IT Wins and make sure they are being done.

6. Projects will be addressed with DO IT Wins Forms.

7. To build greater teamwork --- and have fun along the way!

Service Recovery Policy

Moore County Hospital District
Policy #: 9500-RI-1015
Responsible Dept: Administration
Title: Patient Complaints/Grievances with Service Recovery
Effective Date: 12/08

Policy Statement:

Definitions:

Complaints:

1. A concern raised by someone other than the involved patient or their representative
2. A request for things that can be quickly resolved such as changes in bedding, room cleaning, or food choices
3. Verbal patient care concerns that are resolved or corrected by the staff who are immediately present
4. Verbal patient care concerns that are received after the patient's discharge but that would have routinely been resolved by staff who would have been immediately present
5. Minor complaints about the cost of services

Grievances are concerns raised by the patient or their representative and include:

1. A verbal complaint about the patient's care that cannot be immediately resolved
2. A written complaint about patient care (including an e-mail or fax) regardless of how quickly it may have been resolved
3. Any report (verbal or written) alleging abuse or neglect
4. Any report (verbal or written) alleging a failure to comply with CMS regulations;
5. A concern requested to be handled as a Grievance (e.g. if the patient [representative] requests a formal written response from the hospital)
6. Medicare billing concerns when they deal with patient rights guaranteed by federal regulations (e.g. the Medicare Conditions of Participation or EMTALA).

Rules:

A. MCHD, through its customer service activities, will resolve routine operational issues on behalf of customers without initiating a formal Grievance resolution process.

B. When a significant Grievance is brought to MCHD's attention, MCHD will initiate a formal patient grievance mechanism to provide a means of both resolving problems at early stages and collecting data to use as a means of improving processes.

C. Good customer service demands that all issues be taken seriously and handled promptly. An appropriate and timely reply will be made to the individual expressing a complaint or grievance. Expression of such will not compromise a patient's care.

D. All employees at MCHD are responsible for recognizing opportunities for improvement and taking responsibility to resolve the issue as soon as it is identified. Immediate resolution to all issues should be attempted using the "RELATE" approach.

E. Utilizing Service Recovery:

   1. A Service Recovery Toolkit Reporting Sheet must be completed and kept in the binder upon receipt of any complaint or grievance as defined above.
   2. Information must include names, times, dates, specific content of conversations, and/or correspondence received from the patient or patient's representative.
   3. See attached Decision Making Service Recovery Flow Chart

When utilizing the service recovery process, it may be appropriate to make a proactive gesture to compensate for the failure to meet the expectation of the patient or family member. The Service Recovery Toolkit is a resource for employees when offering a small token to demonstrate our regret when appropriate. Generally, patients and patient representatives simply want someone to listen to their concerns, empathize and apologize. While the Service Recovery Toolkit should not be the first choice to resolve service issues, it is available to use at the employee's discretion. Use of the Service Recovery Toolkit must include filling out a Service Recovery Toolkit Reporting Sheet.

RELATE model to address service recovery.

Recognize—Empathize—Listen—Apologize—Thank—Explain

R – Recognize

- Recognize that you have a "service recovery" opportunity, or a chance to turn a perceived wrong into a right.

E – Empathize

- Put yourself in the customer's shoes. How would you feel? Acknowledge the difficulty whether you agree or not.

L – Listen

- Focus on the customer, making eye contact and listening patiently. Listen to the whole story, do not interrupt. Acknowledge what has been said questions for clarity and repeat information provided to ensure accuracy. Don't be defensive or take it personally.

A – Apologize

- A simple "I'm sorry" can at times save a negative situation. Don't feel you have to have a justification for the situation, sometimes a broken process is just that until we are aware and figure out why. Do not blame anyone else for what happened. Don't try to excuse the incident with statements like, "we're short-staffed." Or, "He's a new employee."

T – Thank

- Thank them for giving us the opportunity to address their immediate concern and to improve the process and/or service for future patients. This step allows you to regain their trust by showing we appreciate their opinion and it does matter to us.

E – Explain

- Explain how you are going to address their concern. What immediate action are you taking – this may be when you provide them with an item from our service recovery toolkit. However, remember that giving them an item doesn't solve this issue or prevent it from happening again.
- Write down the patient's information and specifics regarding the concern on the Service Recovery Toolkit Reporting Sheet– this not only shows the patient you are serious but it is the documentation used for reporting and tracking.
- If you cannot resolve the issue immediately, or at all, tell the customer what you will do and what they can expect (phone call, letter, someone else contacting them) and report the complaint to the Department Manager, Risk Manager or the Officer of that area.

F. Patients/residents are advised of their ability to file a complaint at any time during their stay. Written notice of complaint procedures will be given to patient/residents upon admission. (Nursing Home residents and/or family that are unable to resolve problems or differences with the facility staff should contact a local Ombudsman.)

G. Any complaint by a patient/resident will be reported to the department manager in the affected area immediately. Complaints will be reviewed and addressed as soon as they are received.

If the department manager cannot resolve the complaint to the satisfaction of the patient/resident/family, the complaint will be immediately referred to Risk Management.

1. Any complaint or grievance brought to Risk Management will result in a QA being completed to document the incident and determine trends in complaints. The QA record shall include any supporting information, research or attempted corrective actions.

2. Trends and summaries of complaints reaching Administration will be kept and submitted to appropriate review committees (Administrative or Medical Staff) for quality assurance purposes.

3. Any patient with a grievance resulting in review with PEC will receive a letter from PEC indicating that there will be a review of said incident.

H. All staff members must be aware that when a complaint is directed at their service, it is expected that in no way will this complaint interfere with proper treatment of the patient/resident. There will be no retaliation, coercion, discrimination, or reprisal directed at those that register complaints or grievances.

I. Any offer of financial restitution or waiving of patient/ resident charges to a complaining party must be discussed with the Director of Patient Financial Services and approved by the appropriate MCHD Administrative Officer. This clearance will be obtained prior to any commitment being made to the patient/resident or family.

J. A grievance committee, comprised of MCHD personnel appropriate to the situation, may be formed, if necessary, to obtain resolution.

1. The author of the grievance will be notified in writing within 7 days.

2. Should a Grievance Committee need to be formed it should be formed within 7 days of MCHD receiving a grievance. The notice shall include:
    a. The name of the contact person
    b. The anticipated steps taken on behalf of the individual to investigate the complaint
    c. The anticipated date of completion

3. Upon completion of the Grievance Process, MCHD will send the author of the grievance a final letter explaining the resolution of the concern.

4. If the results of the Grievance Committee actions fail to bring the issue to a satisfactory resolution, additional input may be obtained first from the Chief Executive Officer and then the Board, if necessary, at the next available scheduled meeting.

K. Anyone wishing to file a complaint may contact the agencies below at any time.

Complaint Agencies:

Texas Department of State Health Services
HHSC Office of the Ombudsman
Mail Code: H-700
P. O. Box 13247
Austin, Texas 78711-3247

Phone Toll-free: 1-877-787-8999
People who are deaf, hard of hearing, or speech impaired can call by using the toll-free Texas Relay service: 7-1-1 or 1-800-735-2989.
Fax Toll-free: 1-888-780-8099

KEPRO, Area 3
Rock Run Center, Suite 100
5700 Lombardo Center Dr.
Seven Hills, OH 44131
Attention: Beneficiary Complaints
Beneficiary Helpline – 844-430-9504
Fax 844-878-7921

Health and Human Services Commission
Consumer Rights and Services Section, E-249
ATTN: Intake Coordinator
P.O. Box 149030
Austin, TX 78714-9030
Phone: 1-800-458-9858 (To Report)
Fax: 1-877-438-5827

CIHQ
Online:
On-line https://cihq.org/complaint

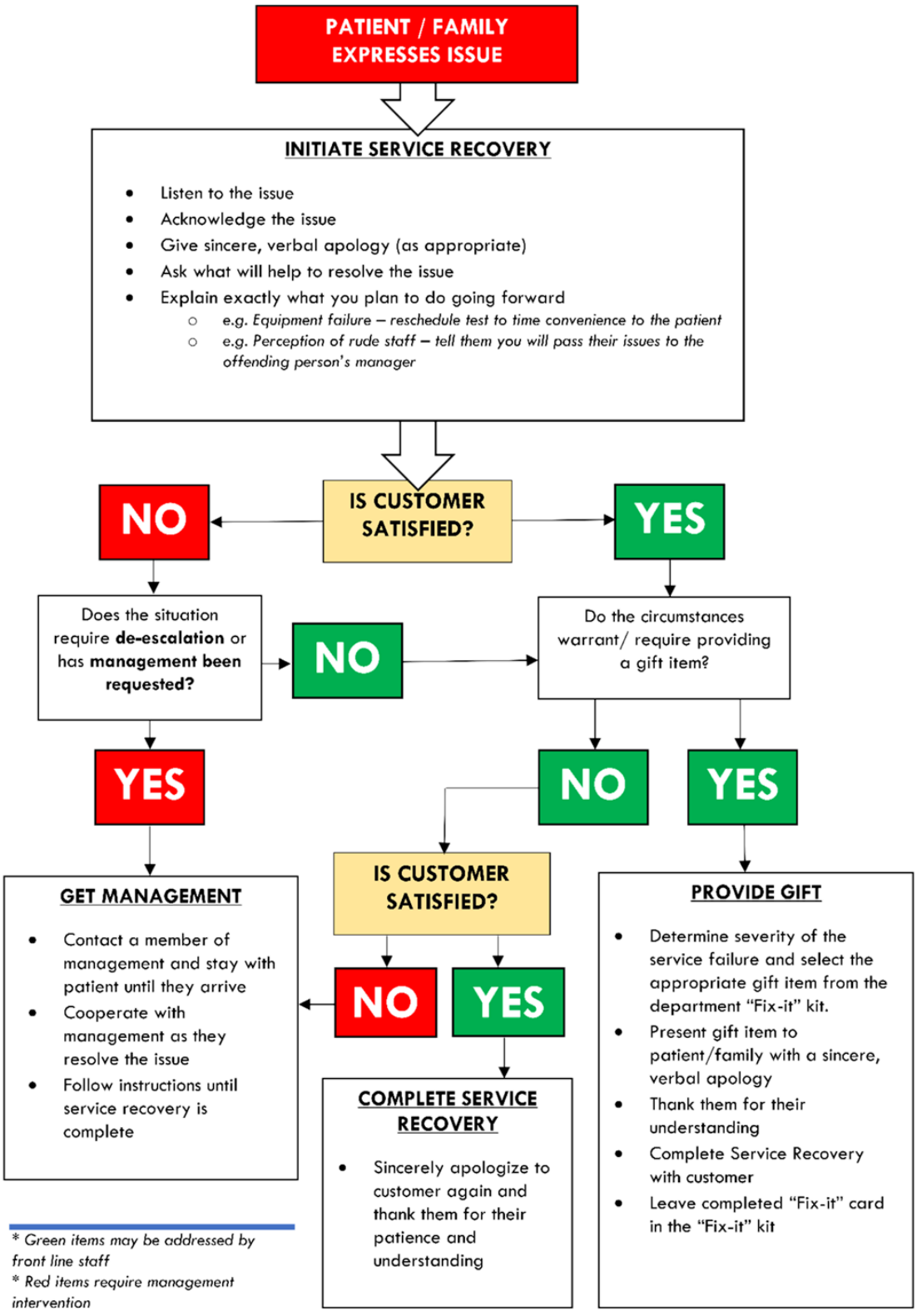
Mail: Center for Improvement in Healthcare Quality
P.O. Box 1540
Mexia, TX 76667-1540
Attn: Chief Executive Officer

Phone: 512-661-2813

Most Common Reasons Service Recovery Was Used in 2024

1. Wait times to see Provider and/or services
2. Misunderstanding/miscommunication of information between patient and staff and between departments
3. Incorrect scheduling/overbooking

Moore County Hospital District
Service Recovery ("Fix-it") Flow Chart



"Fix-It" Card

Patient: Recipient:

Department: Date:

Reason for Service Recovery

	Communication with (circle)		Family	Patient	Physician		Staff
	Attention to needs		Staff Attitude		Cleanliness		Dietary Complaint
	Privacy		Noise Level		Delay		Equipment Complaint
	Parking		Ethics		Property		Discharge Complaint
	Safety / Security		Confidentiality		Other:		

"Fix-It" Kit Item Used

	No Gift Needed		Gift Card (note amt below)		Meal Voucher		Drink Coupon
	$10		$20		$30		Other:

Completed By:

Comments:

"Fix-It" Card

Patient: Recipient:

Department: Date:

Reason for Service Recovery

	Communication with (circle)		Family	Patient	Physician		Staff
	Attention to needs		Staff Attitude		Cleanliness		Dietary Complaint
	Privacy		Noise Level		Delay		Equipment Complaint
	Parking		Ethics		Property		Discharge Complaint
	Safety / Security		Confidentiality		Other:		

"Fix-It" Kit Item Used

	No Gift Needed		Gift Card (note amt below)		Meal Voucher		Drink Coupon
	$10		$20		$30		Other:

Completed By:

Comments:

The Cycle of Service

1. **Definitions:**

Moment of Truth	*"Any interaction in which a customer comes into contact with an organization and gets an impression of its service."*
Cycle of Service	*"Any combination of Moments of Truth experienced by a customer using your service(s)."*
Reward Strategy	*"At each Moment of Truth, deliver the very best experience/service to the customer."*

2. **Grocery Store "Cycle of Service" Example:**

Moments of Truth	**Reward Strategy**
Enter parking lot	*Convenient and safe*
Enter store	*Clean and smells good*
Rate appearance	*Well-stocked and items faced*
Ask clerk for help	*Friendly and helpful*
Check store directory	*Accurate and easy to understand*
Enter checkout lane	*Efficient and focused*
Exit store	*Appreciated and helpful*

Cycle of Service Practice

Imagine you are taking someone to our Emergency Room or one of our Clinic locations. Complete the "Cycle of Service" by identifying each "Moment of Truth" during your experience. Brainstorm a "Reward Strategy" for each "Moment of Truth."

3. Recommendation:

Back in your department, participate in conducting the Cycle of Service exercise to document your patient's Moments of Truth.

What would be the value of conducting this "Cycle of Service" for each dissatisfier at a monthly DO IT Meeting?

DO IT Assignment:

- ❑ 1. Prepare to help your manager lead this exercise with **everyone** in your work group.
- ❑ 2. Look for ways to **improve each Moment of Truth.**
- ❑ 3. Brainstorm on "reward strategies" for customers.
- ❑ 4. Create systems for **consistent service.**
- ❑ 5. **Document your progress** --- ***and keep improving.***

> ***"At the moment of truth, there are either reasons or results."***
> - Chuck Yeager

Advanced Service Excellence Workshop™
Graduate Review

INSTRUCTIONS:

*The following questions reflect the critical concepts that have been taught in this course. Circle your **TRUE** or **FALSE** answer, and then we will review the answers with you.*

Mastering Customer Expectations

True False 1. A "Moment of Truth" is any time a customer gets an impression of your service.

True False 2. It would be valuable to develop a reward strategy for each Moment of Truth.

True False 3. Consumers don't like to be asked how they feel about the service provided.

True False 4. Compassion is as much a way of being as it is a way of skillful communication.

True False 5. Each department needs to hold either weekly DO IT Meetings or Service Huddles.

True False 6. A "whiner" is powerless since they blame others for their situation.

True False 7. By growing our "Circle of Influence" we increase our capacity to help people heal.

True False 8. It is always better to "Expect the Worst" in order to prepare ourselves for the future.

True False 9. It is not unusual for our consumers to perceive our service differently than we do.

True False 10. In order to become a Hospital of Choice, we need to make our Values and Standards a part of our everyday work life.

Ask the Admin Team

Questions and suggestions to be answered by the Admin Team.

1.

2.

3.

4.

5.

Please note: Answers to appropriate questions will be answered via communication from the CEO to all staff.

❒ I would like a personal response to my question. Please email me at:

Service Excellence Workshop™
Evaluation Form

Please print clearly:
You've just heard from us, now we'd like to hear from you. Evaluation is a critical part of our goal of continuously improving customer satisfaction. Thank you for your help.

- Your SEAs

Date:_____ Our SEAs Names:_____

Name:_____ Department:_____ Position:_____

1. For me, the most valuable idea I gained and will use immediately is:

2. What I would tell others about the quality of the trainers and value of the content:

   OK to quote me: YES NO

3. On a scale of 1-5 stars, I rate this training as: (Poor) 1 2 3 4 5 (Great)

4. If you do not feel you can award five stars, please honor us by telling us what we can do to improve our score:

5. On a scale of 1-5, I'd rate my understanding of Service Excellence as: (Low) 1 2 3 4 5 (High)

6. Yes No I may be interested in becoming a Service Excellence Advisor next year.

7. P.S.

ED Blueprint for Success™

Custom Learning Systems
1.800.667.7325 customlearning.com

Jeff Turner
Chief Executive Officer
Moore County Hospital District
224 East Second Street
Dumas, TX, 79029

Subject: **Emergency Department Blueprint for Success Report – May 12-13, 2025**

Dear Jeff,

Please find enclosed your ED Blueprint for Success Report that was completed based on my visit, my conversations with staff, and the information your staff provided. I want to thank everyone for their cooperation and thorough response to the information I requested. Your staff, especially Kelly, Yesenia, and Dr. Knight, went above and beyond to work with me and make the most out of the assessment.

My assessment showed that there are many positive practices currently in place in your Emergency Department. These should continue to be supported. However, there is clearly a disconnect between the level of care being provided and the perception of that care by the community. There are opportunities for improvement in some areas to address this disconnection. I want to emphasize that the recommendations made here are not deficiencies, but truly recommendations to assist you in becoming a 5 Star Emergency Department.

This report should be shared with all appropriate members of your team for their review. If you wish to discuss this report after review, please reach out to schedule a one-hour videoconference with your team. My goal is to assist you in facilitating the implementation of your process improvement plan.

Thanks again, and please call me at (314) 974-9743 with any questions or concerns.

Sincerely,

Mark Brodeur

Mark Brodeur, MHA, CPXP
Vice President of Process Improvement
Custom Learning Systems Group Ltd.

Moore County Hospital District
ED Blueprint for Success™

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APPENDIX

ED Blueprint for Success™
Final Report

Moore County Hospital District

On Site Assessment Conducted by: Mark Brodeur, MHA, CPXP

Dates of Assessment: May 12-13, 2025

A. Purpose and Scope

The purpose of this report is to provide detailed and actionable recommendations for improving the operation of the Emergency Department of Moore County Hospital District. The scope of the assessment conducted focused on the following areas:

1. ED Throughput
2. Satisfaction of ED Patients
3. Engagement of ED Staff
4. Operational Efficiency of the ED
5. ED Patient Volume Growth
6. Admissions from the ED

B. Assessment Protocol

The review of Emergency Department operations included the following:

1. Review of data provided by Hospital:
    a. ED Throughput and Operational Metrics
    b. Best Practice Gap Analysis
    c. Recent Patient Satisfaction Scores
2. Tour of the ED and Inpatient areas
3. Focus groups of:
    a. ED Providers
    b. Frontline Staff
4. Interviews with key department directors that interface with the ED including Inpatient areas.
5. Observations of ED operations
6. Review of financial information with the CFO
7. Debrief with Leadership Team

C. Situation Summary

1. **ED Volume:**
   8,275 visits over the last 12 months (22.7 patients/day). It was reported that volume increased over last year.

2. **Patient Acuity Mix:**
   The acuity mix of patients is somewhat higher than a typical ED patient mix at similar hospitals. There is a higher than the typical number of Billing Level 4 and 5 patients.
   - 79% of patients are seen as Billing Level 3 or higher.
   - 14.2% of ED patients are hospitalized following treatment (8.4% are admitted, 5.8% are transferred to other facilities).

3. **ED Satisfaction Scores:**
   The ED has recently switched from Press Ganey to Survey Solutions for ED Patient Satisfaction surveys. The "Overall" rating scores for Top Box score for the last 3 months is 65.19%, up from 57.33% the previous quarter. This represents a Percentile Ranking well below the 50th percentile. The actual percentile rankings were not yet available since the quarter had not yet closed during my visit. When they become available, they should be used as the focus of scores improvement. There is a strong desire to improve these metrics. The chart below shows the breakdown of the Top Box Scores for the last 6 months.

ED Survey Domains	Top Box Q4 2024	Top Box Q1 2025	State Top Box
During Your ED Visit	81.12%	85.28%	85.66%
People Who Took Care of You	66.46%	75.09%	79.72%
Leaving the ED	72.5%	89.71%	91.28%
Overall Experience	57.33%	65.19%	70.13%

4. **Patient Throughput:**
   Throughput times for all patients, regardless of their final disposition, is very good. Your overall throughput is among the best I have seen. This should have a very positive impact on patients' satisfaction.
   a. Throughput time for discharged patients is 99 minutes, almost at a best practice of 90 minutes.
   b. Throughput time for admitted patients is 88 minutes, which is phenomenal and much shorter than a best practice time of 180 minutes. Clearly best practices are solidly in place and waiting on inpatient bed availability is seldom an issue.
   c. Throughput time for transferred patients (not counting behavioral health) is 164 minutes, still below a best practice of 180 minutes.

5. **Quality Metrics:**
   I usually only look at a few quality metrics since my focus is on patient satisfaction and throughput.
   a. Patients who left without being seen is 0.3% which is better than a best practice of 0.5%.
   b. Patients who returned within 72 hours is 3% which is slightly above to a best practice of <2%. Call backs are currently in place for some patients but should be expanded to include all eligible patients.
   c. The percentage of patients receiving a CT is roughly 50%. This is much higher than would be expected even considering the acuity mix of the patients seen. This reflects a trend I have seen in many EDs, but these should be reviewed by an objective medical panel to ensure medical necessity in all cases. I also recommend doing a comparative profile of all Providers' ordering habits.

6. **ED Operations Indicators for the Previous 12 Months**
Patient throughput is very good, particularly for patients being admitted, which is the lowest I have ever seen. There is also very good throughput for Lab and Radiology, including getting Radiologist interpretations. Overall, these numbers represent a model for other EDs:

Key Metrics	Actual	Best Practice
Average Time for Pts Discharged Home	99	90
Average Time for Pts Admitted	88	180
Door to Triage	7	7
Door to Room Time	12	10
Door to Doctor Time	11	15
Admit Decision to ED Departure	12	50
Lab Test Order to Lab Arrival Time	45	Test Specific
CT Test Order to Results Time	60	Test Specific
Percent Patients Getting a CT	50%	<25%
% ED Patients that are Admitted	8.35%	>10%
% ED Patients that are Transferred	5.8%	<5%
% Left Before Evaluation (LBE)	0.3%	0.50%
% Pts Who Return within 72 Hours	3%	<2%
Overall ED Patient Satisfaction Score	<50th%tile	90th %tile
Paid Hours Per Visit	2.8	2.5

7. **Patient Volume by Acuity**

Total Number of ED Patients (12 Months)	Actual	Percent
Billing Level 1	578	6.98%
Billing Level 2	1,124	13.58%
Billing Level 3	3,614	43.67%
Billing Level 4	1,852	22.38%
Billing Level 5	981	11.85%
Critical Care	126	1.52%
Total	**8,275**	

8. **Payer Mix**
Financially, the ED is making money despite a significant percentage of Self Pay (no pay) patients. With its strong mix of billing Level 4 and 5 patients, along with its low Paid Hours/ Visit, this makes a solid contribution to the bottom line.

Medicaid	1,440	17%
Self-Pay	1,905	23%
Medicare	1,026	12%
Other Insurance	3,904	53%

D. Observations from Focus Groups

1. ED Provider Focus Group

Participants: Jim, Gene, Nicole, Meghan

What does this ED do best? What are you proud of working here?

"We move patients. They leave promptly."
"The goal is to get patients in and out expeditiously. All staff work for this."
"All staff, including the ancillary staff are helpful to each other."
"Lab and Radiology have very quick turnarounds."
"We work well together. We get patient needs addressed. We sit with our patients."

What do you struggle with working here? What are the barriers to you providing even better service?

"We have a low survey return rate."
"The many different languages we deal with is a barrier. This affects our survey return rate."
"There is a mismatch between care delivered and care perceived."
"Patients look up their issue on Google and then get upset when the treatment doesn't match what they read on Google."
"We have a high % of non-emergency clinic patients. Patients don't understand that they have a clinic option."
"Peak times are too much for one Provider."
"Survey Solutions only has surveys in 2 languages. We deal with 129 different languages."
"We can't give as much facetime to patients because of our fast throughput."
"Patients don't all recognize that the NPs, particularly the female ones, are their Providers."

Other comments

"We have bi-weekly meeting with Jeff, Yesenia and Dr. Knight."
"Drug seeking patients are not a major issue here."

2. Frontline Staff Focus Group

Staff Interviewed: 7 Frontline Staff Members from ED and supporting departments

When asked what this ED does best, they said:

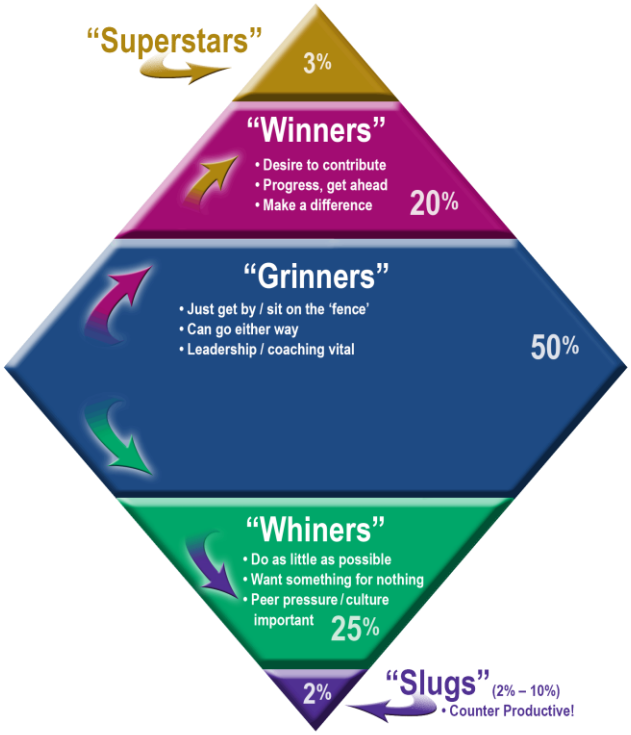
"We are like family."
"We have a strong nursing staff, both days and nights."
"Teamwork. We work well together."
"We feel like a family even when it is stressful."
"Teamwork. We do quick registration followed by full registration at the bedside."
"We roll many patients through with ease. Nurses are competent and qualified."
"Everyone is polite, quick, and efficient."
"Quality of our staff and the way they get along."

When asked what they would change, they said:

1. **The ED layout**
   a. Rooms are too small
   b. Nurses station doesn't face any rooms
   c. Patients feel abandoned because the nurses are out of sight
2. **Remove memories of previous bad visits from patients**
3. **Be less busy-** Don't have time to chart in patient rooms
4. **Put room numbers on Radiology orders** – Radiology gets orders before a patient room is assigned
5. **Make charting with Meditech Expanse more user friendly**

6. **Have a separate entrance for ED walk in patients** – Mixing patients that need ED care with the main hospital entrance is not good.
7. **Remove some of the other tasks from Registration** – In addition to registering patients for ED, we also:
   a. Verify insurance
   b. Handle lab drop-offs
   c. Do overflow for general admissions
8. **Get Providers to be more informative to patients and staff**
   a. Explain treatments to patients
   b. Explain results to patients
   c. Update the Nurses on what they have ordered
9. **Standardize what Providers order**
10. **Make care provided to inpatients more consistent and continuous when Hospitalists change.**

The "5 Attitudes" of Engagement of Staff



Does this reflect the breakdown of employees here that you come in contact with?
Yes

Can you think of someone in the organization who is a slug? (actively disengaged employee)
Yes, but many of the ones in the ED are gone.

Does leadership address the negative behaviors?
They have in the ED

Attitude

Yes	No	Question
6	1	A. How many would rather work "short" than do a shift with an actively disengaged co-worker?

PRIORITY PERCEPTIONS

Leave for a better job/more money

Yes	No	Question
3	4	A. How many of you would leave if offered a better position or more compensation at a nearby facility?

Comments:

For those who would leave, what is really driving you to leave?

- Too much work is required for what we get paid
- I could use the money

For those who would not leave, why do you stay?

- I don't want 24/7 on call
- My schedule
- I feel comfortable here
- I feel valued as an RT
- The family culture

Recommend Family

Yes	No	Question
3	**4**	A. How many would encourage your **family and friends** to be treated here?

Comments:

It depends on who's on. Would not see the following Physicians:

- Dr. Morsch – He is rude to patients
- Dr. Bella
- Dr. Riley (Ortho)

Our NPs are solid, but the Doctors don't help them.

FOCUS GROUP – CULTURE EXERCISE

CURRENT CULTURE	FUTURE PREFERRED CULTURE
Driver: Finance vs Patient	
We are more finance than patient driven	**Should be more patient driven**
Tasks: How much do they interfere with your "real" job?	
Registration is the only area were tasks really interfere	**Take away some of the other jobs Registration is asked to do.**
Leadership Style: Top Down vs Bottom Up	
More Top Down	**More input that is listened to**
Teamwork vs Silos:	
Mostly Teamwork	**All Teamwork**
Under-Staffing: Manageable or Unmanageable	
Mostly manageable	**All positions filled**
Communication:(On a scale of 1 to 10)	
5 out of 10	**10 out of 10**
Valued by my manager:	
6 out of 7 feel valued by their manager	**All feel valued by their manager**
Trust:(On a scale of 1 to 10)	
6 out of 10-Depends on the person	**10 out of 10**
Stress: Manageable or Unmanageable	
Manageable	**Keep this**
Overall rating of culture:(+ or -)	
Positive – 7 or 8 out of 10	**10 out of 10**

E. What Is Working Well

There are many aspects of the Emergency Department that are functioning very well and should be acknowledged. These include:

1. Active, engaged Leadership in the department that is visible and well supported by the staff.
2. An engaged Medical Director who is genuinely focused on improving patient experience and throughput.
3. Great throughput times, especially for patients being admitted.
4. High quality care supported by measured metrics.
5. Registration will do quick registration in the front of the department and will do the full registration in the patient room after the patient is triaged and treatment begins.
6. Provider in Triage (PIT) is in place for many patients. This is a strong Best Practice that is currently in place in very few facilities. I strongly encourage this program continue.
7. Comprehensive Treatment Protocols are in place.
8. An empowering Service Recovery program is hardwired.
9. Auto result reporting to Primary care providers identified by patients alerting them of the nature of their patient's ED visit.
10. Competent Nursing staff who advocate for their patients.
11. Strong sense of teamwork within the ED including ancillary departments.
12. Great communication and throughput from Lab and Radiology.
13. Quick Radiologist interpretations provided.
14. Diagnostic results flagging.
15. Timely blood draws.
16. Interdepartmental surveys in place.
17. Smooth process for accepting inpatient and observation admissions from the ED.
18. Face to face handoff for ED patients being admitted.
19. Med/Surg is very cooperative receiving new patients from the ED.
20. Bi-weekly meetings between the ED Providers and Jeff, Yesenia and Dr. Knight.
21. Good management of drug seeking patients.
22. Staff stability:
    a. Low turnover rate
    b. Negative staff are gone
    c. Everyone on the team is patient centered

F. Recommendations for Improvement

The following recommendations should be considered by a newly established ED OASIS Team to assist in improving throughput, efficiency, and/or patient experience in the Emergency Department. Recommendations are presented in the following categories:

I. ED Process Improvement – Oversight
II. ED Process Improvement – Key Metrics
III. Registration and Triage
IV. ED Provider Engagement
V. Transition to Inpatient Improvement
VI. ED Nursing Engagement
VII. Ancillary Department Integration
VIII. ED Integration with Service Excellence Initiative
IX. ED Patient Experience Scores Improvement - Key Metrics

I. ED Process Improvement –Oversight

A. **Establish a Multidisciplinary ED OASIS Team**
Leadership will establish an ED OASIS Team as part of the Service Excellence Initiative™ with Custom Learning Systems (CLS). Membership of this team should include: ED Director; ED Medical Director; ED Clinical and Non-clinical staff; Lab, Radiology, Registration, and Inpatient Nursing representation. This team will review the recommendations from this assessment and any other recommendations, determine which of these is practical for implementation, set priorities and timeframes for implementation, and monitor progress. This team will report to the Service Excellence Council.

Best Practice Tool – See CLS Team Charter

II. ED Process Improvement – Key Metrics

A. **Key Metrics Goal Setting**
Ultimately your objective is to ensure that all Key Metrics get to and remain at a Best Practice level. Below is a Metric Tracking Form with columns for setting goals. All the metrics listed should be tracked and documented accurately. Each metric should be assigned to someone to track it and monitor progress. I have included recommended goals for the first year for your review.

The ED OASIS Team will review the Year 1 goals and may choose to adjust them. Then they will set goals for Year 2 and 3. The ED Manager will provide updated metrics to the OASIS Team on a quarterly basis for the team to review progress and intervene as necessary with the individual who has responsibility for the lagging metric.

Key Metric	Who Owns It	Actual	Best Practice	12 month Goal	24 month Goal	36 month Goal
Avg Time for Pts Discharged Home		99	90	90		
Avg Time for Pts Admitted		88	180	88		
Door to Triage		7	7	7		
Door to Room Time		12	10	10		
Door to Doctor Time		11	15	11		
Admit Decision to ED Departure		12	50	12		
Lab Test Order to Results Time		NA	Test Specific	Set Test Specific		
CT Test Order to Results Time		NA	Test Specific	Set Test Specific		
Percent Patients Getting a CT		50%	<25%	35%		
% Left Without Being Seen (LWBS)		0.3%	0.50%	0.3%		
% Pts Who Return within 72 Hrs		3%	<2%	2.0%		
Overall ED Pt Satisfaction Score		<50%ile	90th %ile	65th %ile		
Paid Hours Per Visit		2.8	2.5	2.5		

III. Triage and Registration

No Recommendations

IV. ED Provider Engagement

A. Provider Empowerment Survey

Utilizing the CLS Empowerment Survey form available through CareSay™, the ED Director will have all appropriate staff provide feedback on the working relationship with each of the Providers. This information will be collated and shared only with the individual Providers. Surveys should also be distributed to Providers to rate the staff.

B. Comparative Ranking of ED Providers

The ED Medical Director will track and report the following metrics individually for each Provider and rank them from high to low. A blinded chart showing all Providers will be shared to show each one where they rank in comparison to others. Separate charts will be done for:

- Patient Satisfaction Scores
- Patient Throughput Times
- CT Utilization Rates

C. **Provide additional training on the positive impact of Communication and Managing Patient Expectations, particularly in the following areas:**
   - Thoroughly explain why tests are ordered and what the results mean
   - Reasonable expectations for pain control
   - Sit for all interactions with patients

D. **Use the term "ED Provider" on name badges rather than "NP"**

E. **Standardized orders by Providers for common diagnoses**

F. **Consistency with all Providers providing timely pain relief**

G. **Conduct a medical review of all CTs ordered to ensure medical necessity**

H. **Ensure that all Providers attend a Year 2 SEI Workshop**

I. **Ensure that all Providers have received at least basic onboarding to Moore County**

J. **Have all Providers attend a live 5 Star ED videoconference webinar presented by CLS**

K. **Ensure that all Concord Physicians providing oversight to the NPs fully endorse the Moore County staffing model of NPs serving as primary Providers in the ED**

L. **Address issues with several ED Physician Providers perceived as negative and rude to patients: Drs. Morsch and Bella**

M. **Address perceptions that some Providers are unwilling to assist NPs in the ED when called**

N. **Address perceptions that some NPs are reluctant to request assistance from the Physician when appropriate to do so.**

V. Transition to Inpatient Process Improvement

A. Ensure consistency and continuity of treatment plan for Inpatients when Hospitalists hand off care to each other

VI. ED Nursing Engagement

A. **Ensure 100% utilization of Teach Back for Discharge Instructions**
For all patients being discharged home, the Nurse providing the instructions will say the following, "*I want to make sure that I have explained the discharge instructions correctly so I would like you to repeat back to me what you understood.*"

B. **Continue to work with Meditech to simplify Nurse charting and remove unnecessary steps**

C. **Implement Callbacks on all eligible patients**

D. **Implement repeating back discharge instructions for all patients (or family members) including those requiring translation services.**

VII. Ancillary Department Integration

A. **Review the current translation services and consider utilizing Boostlingo as your translation provider.**

Boostlingo is a leading provider of interpretation technology, designed to expand language access and improve manual processes. Their platform offers a unified suite of services, including on-demand Video Remote Interpretation (VRI), Over-the-Phone Interpretation (OPI), interpreter management, remote simultaneous interpretation, as well as AI-powered captioning and translations.

www.boostlingo.com
Kristy Seiber
Vice President, Sales
C: 865-243-1198
P: 512-387-5543 Ext. 141
E: SeiberL@boostlingo.com

B. **Consider using a handheld translation device such as "Pocketalk" to supplement the translation services by providing quick access for brief conversations**

VIII. ED Integration with Service Excellence Initiative™

A. **Caregiver's Promise**

The ED Director give priority to facilitating a buy-in from all ED providers and caregivers for a Patient and Family "Caregiver's Promise", to be posted in the ED "arrival room" (please discontinue the use of "waiting room")

The approval process would include:

- Appoint a "design team" to coordinate the facilitation/adoption steps, either a Provider, a Nurse (ideally an SEA), or the ED Nursing Director.
- Meet with everyone in small groups of 6-12.
- Note – there would be value in including a group representing registration, lab, imaging, pharmacy and med/surg.
- Present the "draft" Caregivers Promise.
- Ask: "What would be the benefit of adopting and committing to a document like this?"
- Then proceed question by question and facilitate a discussion, with the goal of reaching a consensus on each subject.
- When all questions are completed ask for someone to move and second a motion to adopt the amended draft.
- Repeat with all groups.
- The Design team would then wordsmith a combined final draft.
- The C-suite then signs off on the final Care Promise.
- Produce a clean crisp poster(s) for the arrival room.
- Schedule an adoption ceremony where everyone signs the poster and it's placed in a key location for all to see. (See Best Practice Tool –A sample ED Caregiver's Promise is found in Appendix B, Page 18).

IX. ED Patient Experience Scores Improvement

A. **Patient Satisfaction Survey Awareness**
The ED Director will have all ED staff and Providers take the ED Patient Satisfaction survey. Tabulate the results and compare them to your actual patient scores. Then have a discussion with staff about why staff perception of care they give is different than the patient's perception.

B. **Provide access to Survey Solutions results to all key leaders including the CNO and ED Manager.**
This can be easily accomplished by reaching out to Survey Solutions and providing contact information for all those whom you wish to have access.

C. **Ensure that you are regularly tracking both Top Box scores and Percentile Rankings**

D. **Implement the 7 Ways to Improve Your Patient Survey Response Rate**

- **Inform Patients at Registration when feasible:**
"*We are a learning organization striving to improve and will be sending you a short survey after discharge asking you how we did and how to improve. Would you be kind enough to complete it?"*

- **Anticipate Patients Objections:**
"*I understand there have been times when I've been reluctant to answer these surveys myself, because nothing ever seems to get done, so why waste your time! However, we at Moore County do take patient feedback very seriously?"*

- **At discharge the nurse asks:**
"We're all committed to providing an excellent patient experience"
"May I ask a small favor of you?" (wait for a response)
"When you receive an envelope (like this) from our patient survey provider, "Would you please complete and send it in?" (wait for a response)

- **Hand them a brightly colored paper as a reminder of what you just asked**

- **At the conclusion of your post discharge call, repeat questions:**
"We're all committed to providing an excellent patient experience"
"May I ask a small favor of you?" (wait for a response)
"When you receive an envelope from our patient survey provider, "Would you please complete and send it in?" (wait for a response)

- **Send a reminder letter or email from your CEO:**
Dear Betty,
We're all committed to providing an excellent patient experience. May I ask a small favor of you?
When you receive a text or email from our patient survey provider, would you please complete and send it in?
Thank you for the opportunity to serve you.
Sincerely, Jeff Turner
CEO, Moore County Hospital District

- **Put up Poster Reminders:** These will be provided by Survey Solutions

E. **Publicize your ED throughput times promoting your Best Practice performance that puts you above other area hospitals**

F. **Establish an ED Patient Liaison position to cover peak volume hours either through a volunteer network or hiring community college students seeking healthcare experience**

G. **Set Annual Goals**
As a critical component of its Charter, the ED OASIS Team is accountable to track and improve its patient experience scores to the 90th percentile, in other words 5-Stars.
Your goal should be to have a Percentile Rank in the top 10% in 36 months. Interim goals should be set from there for 12- and 24-month intervals.

ED Percentile Rank Scores	Baseline	Year 1	Year 2	Year 3
During Your ED Visit	<50th	65th	80th	90th
People Who Took Care of You	<50th	65th	80th	90th
Leaving the ED	<50th	65th	80th	90th
Overall Experience	<50th	65th	80th	90th

G. Follow Up Implementation Coaching

Although this report is designed to provide all the necessary information for implementation on your own, Mark Brodeur would be available for consultation to assist in the implementation of the plan outlined above to be utilized at your discretion. He can attend (via videoconference) the meetings of the OASIS Team and serve in a consulting capacity throughout the process.

Appendix

A. Percent of Patients Getting a CT Test Overview

B. Emergency Department Caregiver's Promise

Appendix A

Percent of Patients Getting a CT Test Overview

The number of ED patients receiving a CT exam grows every year, from about **6% 20 years ago** to **20% or more today**.

Some interesting facts on this growth of CT scans in EDs

- There has been no increase in the overall acuity of ED patients during this period.
- The majority of these exams are head CTs.

It is hard to put a number on the proper % of patients needing CT exams because it is highly dependent on patient mix.

All CTs should be based on solid medical justification and not legal concerns or weak diagnostic skills.

Impact of CT Utilization

Appropriate CTs are an essential diagnostic tool and should be utilized whenever indicated, but unnecessary CTs:

1. Waste valuable and scarce resources
2. Significantly lengthen ED stays
3. Add major costs to the patient and the system.

Also keep in mind that even though Xray exposure from CT has been reduced greatly, one head CT is equivalent to the natural radiation exposure you would get over 8 months.

Our role is to be both patient advocate and good steward of healthcare resources.

Every patient that needs a CT should get one, but **only** those patients that **need** one.

DO IT Recommendations:

1. Have an ongoing peer review process in place for all ED CT tests ordered.
2. Profile these by physician and report the results back to them.

Appendix B

Emergency Department Caregiver's Promise

Welcome to Moore County Hospital District's Emergency Department.

We promise you can expect:

1. To be acknowledged within 2 – 5 minutes.

2. In case of a serious or life-threatening condition, to be triaged immediately.

3. To be greeted in a kind and empathetic manner always.

4. To be in the Reception Area no longer than 30 minutes.
   Should there be a surge with critical care patients, we promise to keep you informed.

5. In the event there may be a need to see higher severity patients ahead of you, Caregiver will keep you informed of wait times every 15 – 20 minutes.

6. The ED Reception Area will be clean and always maintained as a friendly place for you, your family, and friends.

7. Whatever your condition, we care about you, and will use our best judgement to minimize your pain.

We are all committed to ensuring you receive timely responsive healing kindness.

EMPLOYEES

"Be a great place for employees to work"

1. Workforce Development and Volunteer Opportunities
    a. Culinary
    b. Clinical
    c. DISD & SISD CTE Programs
2. Employ a CNA Instructor (Partnership with DISD)

Goal: Build tomorrow's workforce by working with community partners.

ACTION STEP	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Target DISD, SISD, and Amarillo College Programs for Development Opportunities: a. Explore potential of a Culinary Mentorship Program with DISD b. DISD & SISD Healthcare Professions CTE	Jeff, Terrance Jeff, Amy, Ashleigh			
2. Employ CNA Instructor (Partnership with DISD)	Yessenia			

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

INTERLOCAL AGREEMENT AND MEMORANDUM OF UNDERSTANDING
FOR
A CERTIFIED NURSING ASSISTANT INSTRUCTOR

This Interlocal Agreement (the "Agreement") is entered into under authority of Texas Government Code Chapter 791 by and between Dumas Independent School District ("DISD") and Moore County Hospital District ("MCHD") (collectively the "Parties"), which shall take effect on the date set forth in section 2.1 herein.

WITNESSETH:

WHEREAS, the Parties are authorized by Texas Government Code Chapter 791 to enter into interlocal agreements with each other to provide governmental functions; and

WHEREAS, the Parties are local governmental entities created and governed under the laws of State of Texas to provide educational programs and health services; and

WHEREAS, DISD has a Certified Nursing Assistant Program (the "CNA Program") as part of its curriculum, and is in need of a properly licensed registered nurse to instruct students enrolled in the CNA Program; and

WHEREAS, MCHD employs, or will employ, an individual on a fulltime basis who is a lawfully licensed registered nurse and qualified to instruct DISD students in DISD's CNA Program curriculum; and

WHEREAS, MCHD and DISD mutually desire for MCHD to provide a registered nurse to instruct DISD students enrolled in DISD's CNA program.

NOW, THEREFORE, in consideration and subject to the terms, conditions and general provisions of this Agreement, the above named governmental entities agree as follows:

ARTICLE I
PURPOSE

1.1 Engagement. DISD hereby engages MCHD, and MCHD hereby accepts such engagement, to provide CNA Program instruction to DISD students ("Services"). MCHD shall perform the Services and DISD shall accept such Services upon the terms and conditions contained in this Agreement.

ARTICLE II
EFFECTIVE DATE; TERM

2.1 Term. The Agreement shall be effective as of July 1, 2025 ("Effective Date") and end on the last day of DISD's 2025-2026 school year ("Initial Term"), unless earlier terminated under Article V of this Agreement. Following the Initial Term, this Agreement may be renewed for successive terms (each, a "Renewal Term") which will run concurrently with the DISD school calendar.

ARTICLE III
SERVICES, EMPLOYMENT, AND COMPENSATION

3.1 Scope of Services. MCHD will employ a full-time licensed registered nurse whose Primary Duties will be to instruct DISD students in an approved CNA curriculum for the Fall and Spring

semesters of each DISD school year (the "Instructor"). Instructor will report to DISD for the performance of Primary Duties according the schedule adopted by DISD and perform the Services in accordance with State and local course requirements. The Instructor shall comply with DISD policies, procedures, regulations, in addition to all applicable federal and state laws. In this capacity, Instructor will serve DISD's Program Manager for the CNA Program curriculum. At times other than the DISD instructional days, including weekends and holidays and student holidays throughout the year, Instructor will be available for Secondary Duties at MCHD, which will include covering PRN nursing shifts. In the performance of Secondary Duties, Instructor will report to MCHD and comply with MCHD policies, procedures, and regulatory requirements. MCHD acknowledges and agrees that Instructor's Secondary duties for MCHD will not interfere with Instructor's Primary Duties for DISD. Any Paid Time Off (PTO) which is provided to MCHD employees will be used and coordinated by Instructor with DISD Primary Duties, with the exception of unplanned sick or bereavement leave. If Instructor requires absence from Primary Duties for illness, any substitute teaching duties will be arranged for by DISD.

3.2 Employment. Instructor will be an employee of MCHD and entitled to MCHD employee benefits, according to MCHD's defined benefit plan. MCHD retains full and final authority for terminating or renewing Instructor's employment relationship with MCHD. DISD will notify and include MCHD in all discussions related to Instructor's performance. DISD will participate in MCHD's annual evaluation process for the Instructor. Should DISD object to Instructor's performance of Services after providing to MCHD no less than 10 calendar days advanced written notice and an opportunity to cure, MCHD shall remove Instructor. In the event that Instructor has to be removed, DISD and MCHD will work in good faith to find a suitable replacement solution, which may necessitate the termination of this Agreement. Notwithstanding any other provision in this Agreement, DISD shall have the right to suspend Instructor, and MCHD shall immediately remove Instructor, upon written notice from DISD that there is reasonable evidence that Instructor engaged in any conduct that would require DISD to report a certified educator to CPS pursuant to Texas Family Code Chapter 261, subchapter B or to the Texas Education Agency/State Board of Educator Certification as set forth in Texas Education Code section 21.006(b)(2).

3.3 Compensation. MCHD will invoice DISD monthly, September through May during this Agreement, for the Total Compensation costs of Instructor. MCHD will pay Instructor's Total Compensation costs for the months of June, July, and August. Total Compensation includes salary plus eighteen percent (18%) benefit costs associated with the employment of Instructor, and does not include any other cost or expense. As an employee of MCHD, Instructor is eligible for annual merit increases, which go into effect in November of each year and will affect the amount invoiced to DISD. Instructor's initial starting Total Compensatioll be $90,223.74, which equates to a starting wage of $76,460.80 and a benefit cost of $13,762.94. DISD's monthly initial share of Instructor's Total Compensation will be $7,518.65 beginning in August 2025. DISD shall not be responsible and will not be invoiced for any other cost, expense, or benefit either directly or indirectly. In the event that DISD or MCHD require Instructor to attend conferences, continuing education, or other work-related training, DISD and MCHD agree to cover the cost of such educational events, including any travel related expenses, independent of this Agreement and as necessary for the Instructor's performance of services to each organization: DISD for Primary Duties, and MCHD for Secondary Duties.

3.4 Taxes. MCHD, and not DISD, shall be solely responsible for paying all required federal, state and local taxes related to Instructor's employment by MCHD under this Agreement. DISD shall not be responsible for (a) withholding any amounts for any federal, state or local income or other tax; (b) making unemployment insurance contributions; or (c) obtaining workers' compensation insurance on behalf of MCHD.

3.5 Payments. DISD will make payments to MCHD in accordance with Texas Government Code §2251.001, *et seq.* DISD will endeavor to pay invoices within fifteen (15) days of receiving an invoice from MCHD. Such payments by DISD fairly compensate MCHD for the Services provided.

3.6 Funding. The Parties hereby warrant that all payments, contributions, fees and costs required hereunder shall be made from the Parties' current available revenues. The Parties specifically acknowledge that funding for each Party's costs for fulfilling their respective obligations under this Agreement shall be processed and appropriated through the budgeting process of each Party's governing body. The Parties agree that if either Party fails to appropriate such amounts when adopting its annual budget, such Party may terminate this Agreement immediately, as set forth in section 5.1 herein.

ARTICLE IV
RELATIONSHIP OF PARTIES, INDEMNIFICATION AND RELEASE

4.1 Relationship of Parties. Each Party at all times shall be an independent contractor with respect to the other Party. Nothing in this Agreement shall be construed to create the relationship of employer and employee, principal and agent, partnership, or joint venture as between MCHD and DISD. Neither Party shall have any authority to incur any obligation or bind or commit the other Party to any agreement, contract, or commitment, or to waive, modify, or amend any rights of the other Party under any agreement, contract, or commitment, except as expressly authorized in writing by the other Party. Neither Party shall in any manner be answerable or accountable for: (a) any violation by the other Party of any federal, state or local laws, regulations, ordinances, rules or orders; or (b) for any injury, loss or damage arising from or out of any act or omission of the other Party. To the extent allowed by Texas law, MCHD assumes full responsibility for the actions of its personnel while performing any services incident to this Agreement, and shall remain responsible for their supervision, daily direction and control, payment of salary (including withholding of income taxes and social security), workers' compensation, disability benefits and like requirements and obligations. Nothing in this Agreement shall be deemed or construed to create any third party beneficiaries or otherwise give any third party any claim or right of action against any Party to this Agreement.

4.2 Indemnification and Release. To the extent permitted by law, each Party agrees to indemnify and hold the other harmless from and against any and all claims, demands, losses, causes of action, damages, lawsuits, judgments, including attorney's fees and costs, to the extent caused by or arising out of or relating to the work, errors, omissions and/or operations of the other Party. Further, the Parties hereby release, waive, acquit and forever discharge the other Party and its respective providers, officers, agents, and employees from every claim, suit action, demand or right to compensation for damages claimed or that it may have arisen out of their own acts or omissions or acts and omissions of its officers, providers, agents, and employees as a result of any Services provided under this Agreement. The Parties acknowledge and agree that neither party shall be liable or responsible to the other Party for damages arising from the acts or omissions of any DISD student.

ARTICLE V
TERMINATION

5.1 No Cause Termination. Either Party may terminate this Agreement by providing written notice to the other Party at least thirty (30) days prior to its projected termination date. The terminating Party shall remain obligated to provide all services and/or pay all costs which were lawfully incurred by such Party prior to the date of termination.

5.2 Termination upon Mutual Agreement. This Agreement shall terminate on such date as DISD and MCHD may mutually agree in writing.

5.3 Termination for Breach. Either Party may terminate this Agreement upon the default of the other Party of any term, covenant, or condition of this Agreement, where such default continues for a period of ten (10) days after the defaulting Party receives written notice thereof from the other Party specifying the existence of such default. If such default is not cured within the time specified, this Agreement shall terminate at the end of the ten (10) day period without further notice or demand.

5.4 Effects of Termination. Upon any termination of this Agreement, neither Party shall have any further rights against, or obligation to, the other Party, except with respect to any rights or obligations accruing prior to the date and time of termination, and any obligations, promises, or agreements which expressly extend beyond the termination, including, but not limited to the continuing obligations provided for in this Agreement regarding insurance, responsibility, confidentiality and conflicts of interest.

ARTICLE VI
MISCELLANEOUS PROVISIONS

6.1 Authorization of Agreement. Each Party represents and warrants to the other that (1) the services contemplated under this Agreement are necessary and authorized activities that are properly within its statutory functions and programs; (2) it has the authority to contract for the services under Chapter 791, Texas Government Code; (3) the execution of this Agreement has been duly authorized, and that this Agreement constitutes a valid and enforceable obligation of such Party according to its terms; and (4) payments for services under this Agreement will come from revenues currently available.

6.2 Severability. If any provision of this Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof, but rather this entire Agreement will be construed as if it did not contain the particular invalid or unenforceable provision or provisions, and the rights and obligations of all Parties shall be construed and enforced in accordance therewith. The Parties acknowledge that if any provision of this Agreement is determined to be invalid or unenforceable, it is the desire and intention of each that such provision be reformed and construed in such a manner that will, to the maximum extent practicable, give effect to the intent of this Agreement and be deemed to be valid and enforceable.

6.3 Construction. Each Party acknowledges that it and its counsel have reviewed this Agreement, and that there will be no presumption that any ambiguities will be resolved against the drafting Party in the interpretation of this Agreement.

6.4 No Waiver of Immunities. Nothing in this Agreement shall be deemed to waive, modify or amend any legal defense available at law or in equity to either Party, or their past or present officers, employees, or agents, nor to create any legal rights or claim on behalf of any third party. Neither Party waives, modifies, or alters whatsoever the availability of the defense of governmental immunity under the laws of the State of Texas and of the United States.

6.5 Choice of Law; Jurisdiction and Venue. This Agreement shall be performable in the State of Texas. This Agreement and all of the rights and obligations of the Parties and all of the terms and conditions shall be construed, interpreted and applied in accordance with, and governed by the laws of the State of Texas, without reference to its conflicts of law provisions. Moore County, Texas shall be the exclusive place of jurisdiction and venue for any legal action arising from or related to this Agreement.

6.6 Assignment. The rights and duties of DISD and MCHD may not be assigned or delegated without the prior written consent of the other Party. Any authorized assignment or delegation of such rights or duties shall be consistent with the terms of any contracts, resolutions, indemnities, and other

obligations of this Agreement. This Agreement shall inure to the benefit of, and be binding upon, the authorized successors and assigns of the Parties.

6.7 Multiple Counterparts and Electronic Signature. This Agreement may be executed in multiple counterparts, each of which shall be considered an original, and all of which shall be considered as one original, fully-executed agreement as of the last date when both Parties have executed an identical counterpart, notwithstanding the fact that all signatures may not appear on the same counterpart. This Agreement may be duly executed and delivered in person, by mail, or by facsimile or other electronic format (including portable document format (pdf) transmitted by email). The executing Party agrees to promptly deliver a complete, executed original or counterpart of this Agreement to the other executing Party. This Agreement shall be binding on and enforceable against the executing Party whether or not it delivers such original or counterpart.

6.8 Entire Agreement. This Agreement constitutes the entire agreement between the Parties, and supersedes all other oral and/or written negotiations, agreements, and understandings of any kind. The Parties understand, agree, and declare that no promise, warranty, statement, or representation of any kind whatsoever which is not expressly stated in this Agreement has been made by any Party, or its respective officers, employees, or other agents to induce execution of this Agreement.

6.9 Permits and Licenses. The Parties shall be responsible for obtaining and maintaining any and all required federal, state, and local licenses and certifications required to perform their respective duties under this Agreement.

6.10 Insurance. During the Term of this Agreement, each Party agrees to continue to carry and maintain insurance in the types and amounts currently carried.

6.11 Notice. All notices given under this Agreement shall be in writing and shall be deemed effective (a) three (3) days after deposited as first class, postage prepaid, certified U.S. Mail, return receipt requested, (b) upon hand delivery to the intended address, or (c) one (1) day after deposited with a nationally recognized overnight courier, to the following:

To MCHD: Moore County Hospital District
224 E. 2nd St.
Dumas, TX 79029
Attn: CEO

To DISD: Dumas Independent School District
421 W. 4th St.
Dumas, Texas 79029
Attn: Superintendent

6.12 HIPAA Obligations. To the extent a Party comes into contact with information considered Individually Identifiable Health Information as defined by 42 U.S.C. §1320(d), Protected Health Information or Electronic Protected Health Information (collectively known as "Protected Information") as regulated by the Department of Health and Human Services ("DHHS") through the adoption of standards, 45 CFR Parts 160 and 164 ("Privacy Rule") and 45 CFR Parts 160, 162 and 164 ("Security Rule"), collectively referred to as "the HIPAA Rules," such Party agrees to keep private and to secure any information considered Protected Information in accordance with federal law.

6.13 FERPA Obligations. For purposes of this Agreement, pursuant to the Family Educational Rights and Privacy Act of 1974 ("FERPA"), DISD hereby designates the Instructor as a school official

with a legitimate educational interest in the educational records of the students who receive Services to the extent that access to the records is required by MCHD to provide the Service as set forth in this Agreement. MCHD and Instructor agree to maintain the confidentiality of the education records in accordance with the provisions of FERPA.

6.14 No Waiver. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision shall be construed to be a waiver of such breach.

6.15 Public Records. Notwithstanding any provisions of this Agreement to the contrary, the Parties understand this Agreement and all data and other information generated or otherwise obtained in its performance may be subject to the Texas Public Information Act, Texas Government Code, Chapter 552 ("TPIA"). As such, each Party will comply with the TPIA, as interpreted by judicial opinions and opinions of the Attorney General of the State of Texas. It shall be the independent responsibility of the Parties to comply with the provisions of the TPIA, as those provisions apply to the Parties' respective information. No Party is authorized to receive public information requests or take any action under the Public Information Act on behalf of another Party.

6.16 Criminal History. To the extent MCHD is authorized by the National Child Protection Act (NCPA), MCHD shall obtain all criminal history information required by Texas Education Code Chapter 22 regarding its "covered employees," as defined below. If MCHD is required by Chapter 22 to obtain the national criminal history record information from the DPS Fingerprint Application Clearinghouse of Texas (for covered employees whose date of employment is on or after January 1, 2008), then MCHD will also subscribe to such service. Before an employee of MCHD provides any Services to DISD, MCHD will provide, in writing, updated certification (on the form provided by DISD attached hereto as Exhibit "A") that MCHD has complied with the statutory requirements as of that date. Upon request by DISD, MCHD will provide, in writing, updated certifications and the names and any other requested information regarding covered employees. MCHD shall assume all expenses associated with obtaining criminal history record information.

6.16.1 If MCHD is not authorized by the NCPA to access national criminal history record information and so that DISD can obtain the national criminal history record information required by Texas Education Code § 22.0834 on all "covered employees" of MCHD (as defined below), or any subcontracting entities who will perform the Services, MCHD shall submit to DISD the name and all identifying information necessary to enable DISD to obtain the national criminal history information on those covered employees before they begin providing Services. MCHD's submission will include the employee's written authorization for DISD to obtain such criminal history information. DISD may, in its sole discretion, prohibit the use of any employee to perform the Services after its review of the criminal history information, but cannot disclose the criminal history information to MCHD.

6.16.2 If MCHD receives information that a "covered employee" has a reported "disqualifying criminal history", as those terms are defined below, then MCHD will immediately remove the covered employee from DISD property and notify DISD in writing. If DISD objects to the assignment of any covered employee on the basis of the covered employee's criminal history record information, then MCHD agrees to discontinue using that covered employee to provide Services.

6.16.3 For the purposes of this Agreement, "covered employees" means employees, agents, or applicants of MCHD who have or will have continuing duties related to the Services to be performed and has or will have direct contact with DISD's students. DISD will decide what

constitutes direct contact with DISD's students. "Disqualifying criminal history" means: any conviction or other criminal history information designated by DISD; any felony or misdemeanor conviction that would disqualify a person from obtaining educator certification under Texas Education Code Section 21.060, and 19 Texas Administrative Code Section 249.16; or one of the following offenses, if at the time of the offense, the victim was under 18 years of age or enrolled in a public school; a felony offense under Texas Penal Code Title 5 Offense Against Persons; an offense for which a defendant is required to register as a sex offender under Texas Code of Criminal Procedure Chapter 62; or an equivalent offense under federal law or the laws of another state.

6.16.4 In addition to the above requirements, MCHD will provide information to DISD at least annually so that DISD may obtain criminal history record information that relates to any employee, agent, or applicant of MCHD, if the person has or will have duties related to the Services, and the duties are or will be performed on DISD property, or at another location, where students are likely to be present. MCHD shall provide a list of all covered employees, with all necessary identifying information, to allow DISD to obtain criminal history record information for covered employees of the MCHD. MCHD shall update this list on DISD's request. MCHD shall immediately remove any employee, agent, or subcontractor who was convicted of a felony or a misdemeanor involving moral turpitude from providing Services to DISD students and not permit them on DISD's property, or other location where students are likely to be present. DISD shall determine what constitutes "moral turpitude" or a "location where students are likely to be present."

6.16.5 Failure to comply with the requirements of Texas Education Code §22.0834 to the extent MCHD is capable shall constitute an immediate event of default by MCHD.

6.17 Mutual Cooperation. The Parties will cooperate with each other, reasonably and in good faith, for the purposes of facilitating the performance of their respective obligations hereunder.

DUMAS INDEPENDENT SCHOOL DISTRICT

Monty Hysinger, Superintendent

6/10/2025
Date

MOORE COUNTY HOSPITAL DISTRICT

Jeff Turner, Chief Executive Officer

6/10/2025
Date

EXHIBIT A
Criminal History Certificate

Introduction: Texas Education Code Chapter 22 and Texas Education Agency Rule 153.1101 require that service contractors obtain criminal history record information regarding covered employees and the covered contract employees of its subcontractors and certify to the Customer ("District") that they have done so. Covered employees and subcontractors with disqualifying convictions are prohibited from serving at a school district.

Definitions:

Covered employees: All employees of a contractor who have or will have continuing duties related to the service to be performed at the District and have or will have direct contact with students. The District will be the final arbiter of what constitutes direct contact with students.

Disqualifying conviction: One of the following offenses, if at the time of the offense, the victim was under 18 or enrolled in a public school: (a) a felony offense under Title 5, Texas Penal Code; (b) an offense for which a defendant is required to register as a sex offender under Chapter 62, Texas Code of Criminal Procedure; or (c) an equivalent offense under federal law or the laws of another state.

On behalf of Moore County Hospital District ("Contractor"), I certify that [check one]:

[ ] None of Contractor's employees are *covered employees,* as defined above. Or

[X] Some or all of Contractor's employee are *covered employees.* If this box is selected, I further certify that:

(1) Contractor has obtained all required criminal history record information, through the Texas Department of Public Safety, regarding its covered employees; or Contractor has provided District with sufficient personnel information for District to obtain all required criminal history record information. None of the covered employees for which Contractor has obtained criminal history record information has a disqualifying conviction. Contractor has taken reasonable steps to ensure that its employees who are not covered employees do not have continuing duties related to the contract services or direct contact with students.
(2) If Contractor receives information that a covered employee has a disqualifying conviction, Contractor will immediately remove the covered employee from contract duties and notify the District in writing.
(3) Upon request. Contractor will make available for the District's inspection the criminal history record information of any covered employee. If the District objects to the assignment of a covered employee on the basis of the covered employee's criminal history record information, Contractor agrees to discontinue using that covered employee to provide services at the District.

Noncompliance with this certification may be grounds for contract termination.

Signature

6/16/2025
Date

SUMMARY OF OPPORTUNITIES

QUALITY

"Endure that MCHD's clinical outcomes meet or exceed national Benchmarks for each service line"

1. Build an MCHD Hospitalist Group
    a. Employ Dr. Khushbu Patel
    b. Look for additional hiring opportunities to include PAs/NPs
2. Quality Data Collection/Submission:
    a. American Heart Association Quality Data
    b. ACO
    c. JBS
    d. Clinics
    e. Hospital eCQR and abstractions on various measures
    f. Flex-MBQIP
    g. CMS Abstracted and Electronic Core Measures
    h. Internal PI Dashboard
3. Board Quality Initiatives
    a. Sepsis
    b. CLS ER and Clinic Data
        i. Patient Perception
        ii. Clinical Data
    c. NRHA/ CHARTIS Top 100

QUALITY STRATEGY 1 | BUILD A MCHD HOSPITALIST GROUP

Goal: To more closely align MCHD's Hospitalist program with the goals of District.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Build an MCHD Hospitalist Group a. Employ Dr. Khushbu Patel? b. Look for additional hiring opportunities to include PAs/NPs	Jeff, MEC	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

Goal: Benchmark Quality Data to assure MCHD's performance.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Quality Data Collection/Submission: a. American Heart Association Quality Measures (for rural hospitals) b. ACO Key Performance Metrics c. JBS Quality Incentive Criteria d. Clinic Metrics e. Hospital eCQR and abstractions 2. Maintain "Top 100" Chartis/NRHA Quality Award status.	Yessenia Jeff, Yessenia Jeff, PHO, Yessenia Jeff, Connie, MEC Yessenia Exec Team	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

GPRO Performance - 2024

Market : All Contract

POD : All POD

Speciality : All Speciality

Practice : Moore County Hospital District (751302152)

Provider : All Provider

Performance Year : 2024

GPRO PERFORMANCE

Domain	Measure	Sampled	Eligible	Measure Met	Rate	Corridor	Next Corridor %	% Gap	ACO Score	Total Score	%
CMS WI Measures	DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	22.00	13.00	2.00	84.62%	80.00	90.00%	5.38%	9.46	10.00	94.60%
CMS WI Measures	CARE-2: Falls: Screening for Future Fall Risk	24.00	9.00	9.00	100.00%	90.00			10.00	10.00	100.00%
CMS WI Measures	HTN-2 Controlling High Blood Pressure	27.00	27.00	23.00	85.19%	80.00	90.00%	4.81%	9.51	10.00	95.10%
CMS WI Measures	MH-1: Depression Remission at Twelve Months	14.00	0.00	0.00					0.00	0.00	0.00%
CMS WI Measures	PREV-05 Breast Cancer Screening	20.00	10.00	9.00	90.00%	90.00			10.00	10.00	100.00%
CMS WI Measures	PREV-06 Colorectal Cancer Screening	26.00	26.00	21.00	80.77%	80.00	90.00%	9.23%	9.07	10.00	90.70%
CMS WI Measures	PREV-07 Influenza Immunization	23.00	10.00	8.00	80.00%	80.00	90.00%	10.00%	9.00	10.00	90.00%
CMS WI Measures	PREV-10: Tobacco Use: Screening and Cessation Intervention	24.00	3.00	3.00	100.00%	90.00			10.00	10.00	100.00%
CMS WI Measures	PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	23.00	10.00	7.00	70.00%				0.00	0.00	0.00%
CMS WI Measures	PREV-12: Screening for Clinical Depression and Follow-Up Plan	24.00	15.00	15.00	100.00%	90.00			10.00	10.00	100.00%
	CMS WI Measures Subtotal	227.00	123.00	97.00					77.04	80.00	96.30%
	2024 GPRO Preliminary Audit Score								77.04	80.00	96.30%

Quality Reporting

Flex Program-MBQIP

1. Global Measures-CAH Quality Infrastructure
2. Patient Safety-NHSN/CDC reporting
    a. Influenza Vaccination Coverage Among Healthcare Personnel
    b. Antibiotic Stewardship
    c. Antimicrobial Use and Resistance (AUR)
    d. Healthcare-Associated Infections (HAI)
3. Patient Experience-CAHPS
4. Care Coordination
    a. Hybrid Hospital Wide Readmission (HWR)
    b. Social Determinants of Health Screening (SDOH)
    c. Claims Based Measures-
        i. Complications
        ii. Hospital Return Days
5. Emergency Department
    a. Emergency Department Transfer Communication (EDTC)
    b. Medium Time from ED Arrival to ED Departure for Discharged ED patients (OP-18)
    c. Patient Left without Being Seen (OP-22)

CMS-Abstracted and Electronic Measures

1. Abstracted
    a. Appropriate follow-up interval for Normal Colonoscopies in average-risk patients (OP-29)

b. Hospital Outpatient Stroke (OP-23)-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients with goal of Interpretation of Scan within 45 minutes of arrival.
c. Sepsis-Severe Sepsis and Septic Shock Management Bundle

2. Electronic Measures
   a. Severe Obstetric Complications (PC-07)-Patients with severe obstetric complications that occur during the inpatient delivery hospitalization
   b. Severe Obstetric Complications Excluding Blood Transfusions (PC-07)
   c. Cesarean Birth (PC-02)-Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth
   d. Discharged on Antithrombic Therapy (STK-2)
   e. Venous Thromboembolism Prophylaxis (CMS 108)
   f. Safe Use of Opioids-Concurrent Prescribing (CMS 506)-Proportion of inpatient hospitalizations for patients 18 and older prescribed, or continued on, 2 or more opioids or an opioid + benzodiazepine concurrently at discharge.
   g. Anticoagulation Therapy of Atrial Fibrillation/Flutter (STK-3)
   h. Antithrombic Therapy by End of Hospital Day 2 (STK-5)

AHA-Getting with the Guidelines

1. Stroke
2. Coronary Artery Disease
3. Heart Failure

Internal Quality Indicators-Department Specific

CHARTIS

Moore County Hospital

Chartis Rural Hospital Performance INDEX

Fall Data Release - 2024

What Makes INDEX Unique?

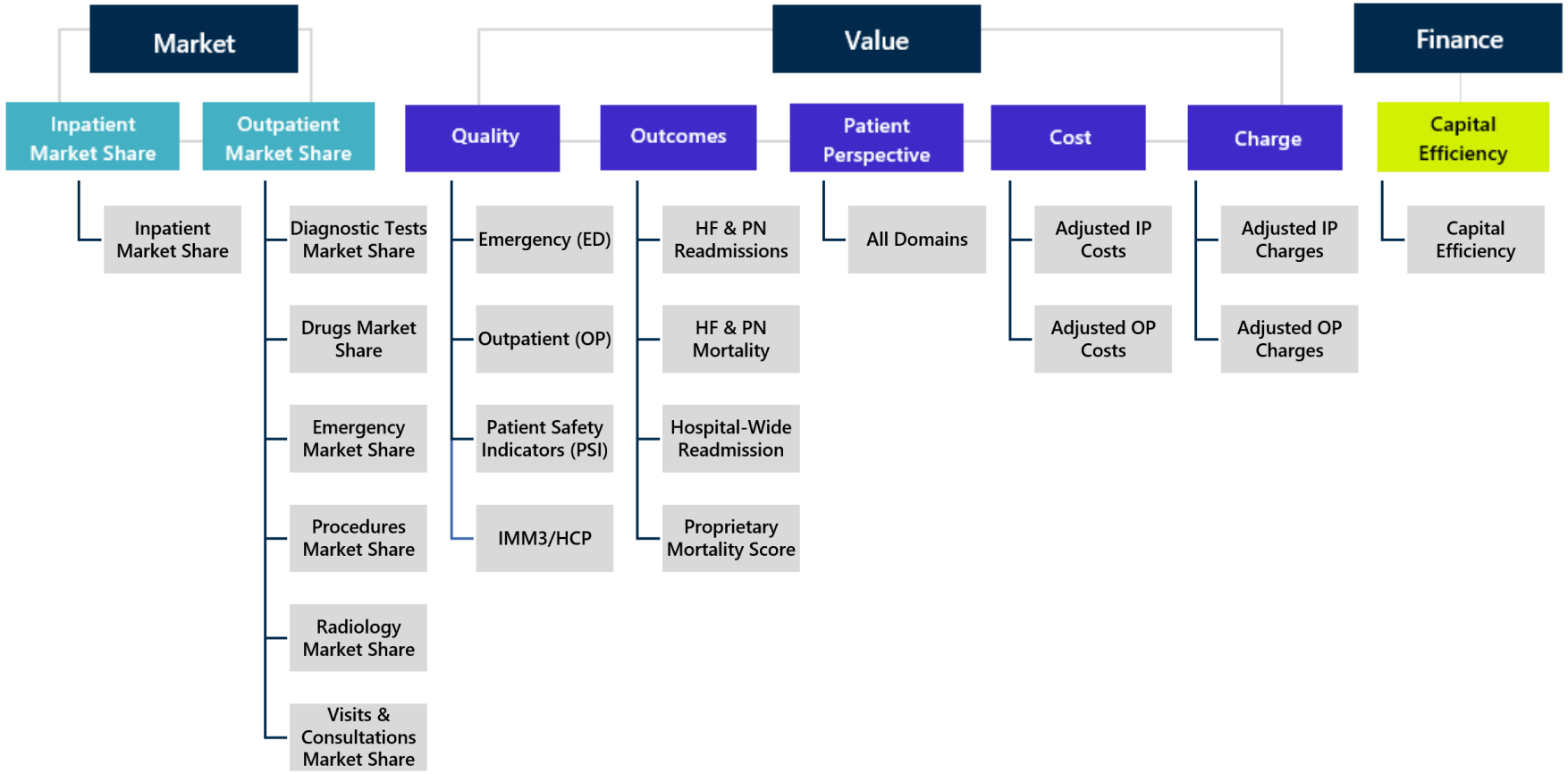
The INDEX was **built** for rural hospitals.

- OBJECTIVE
- RURAL-RELEVANT
- ACTIONABLE

Today, more than **200** rural hospitals rely on INDEX benchmarks to help improve the delivery of care.

Chartis Rural Hospital Performance INDEX

Methodology Structure



Rural Hospital Performance INDEX Data

Data Source Table

Source	Data Set Name	Time Period
CMS	Service Area File 2023	January 2023-December 2023
CMS	Standard Analytical File - OP 2023	January 2023-December 2023
CMS	MedPAR 2022 Final Rule	October 2020-September 2023
CMS	Hospital Compare - IMM3	October 2022-March 2023
CMS	Hospital Compare - OP 18b	October 2022-September 2023
CMS	Hospital Compare - OP 22	January 2022-December 2022
CMS	MedPAR 2021 Final Rule	October 2020-September 2023
CMS	Hospital Compare - (Overall, HF & PN) Mortality / Readmissions	July 2020-June 2023
CMS	Hospital Compare - HCAHPS	October 2022-September 2023
CMS	Standard Analytical File - OP 2022	January 2023-December 2023
CMS	MedPAR 2021 Final Rule	October 2022-September 2023
CMS	Healthcare Cost Report Information Systems (HCRIS) Q1 2024	Most recent Cost Report provided as of 10/1/2024
CMS	MedPAR 2022 Final Rule	October 2022-September 2023
CMS	Standard Analytical File - OP 2022	January 2023-December 2023
CMS	Healthcare Cost Report Information Systems (HCRIS) Q1 2024	Most recent Cost Report provided as of 10/1/2024

Each data file used is the most currently available file for the Source.

Chartis Rural Hospital Performance INDEX

INDEX Summary Report

CHARTIS

CHARTIS RURAL HOSPITAL PERFORMANCE INDEX™ SUMMARY REPORT

PERFORMANCE SUMMARY

Provider Name: MOORE COUNTY HOSPITAL
Medical Provider: 451386
Location: DUMAS, TX 79029
Release Date: Fall 2024

INDEX RANK

94.2

QUARTILE RATING SCALE

1=100-75 2=74.9-50 3=49.9-25 4=24.9-0

MARKET		VALUE					FINANCE
INPATIENT MARKET SHARE	OUTPATIENT MARKET SHARE	QUALITY	OUTCOMES	PATIENT PERSPECTIVE	COST	CHARGE	FINANCE
48	77	99	61	84	50	69	36

Chartis Rural Hospital Performance INDEX

QUARTILE RATING SCALE

1=100-75 2=74.9-50 3=49.9-25 4=24.9-0

Performance Benchmarks

	Overall INDEX Score	IP Market Share	OP Market Share	Quality	Outcomes	Patient Sat.	Cost	Charges	Capital Efficiency
Moore County Hospital	94.2	48	77	99	61	84	50	69	36
TX CAH Median	51.9	20	59	58	54	80	43	69	64
All U.S. CAH Median	59.6	42	50	65	47	66	37	61	55
Top 100 CAH Median	96.0	64	75	84	67	79	55	70	83

Top 100 medians are taken from the winter 2024 INDEX release

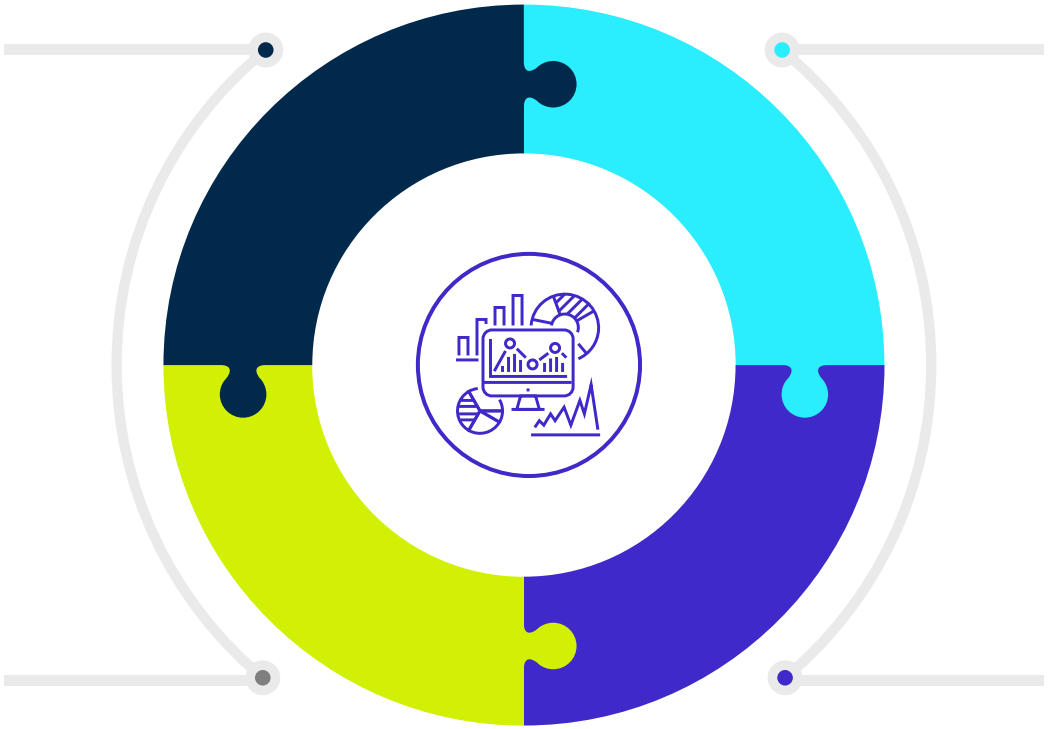
CHARTIS

Expertise, Analytics and Insights to Support Strategic Goals

Working with The Chartis Center for Rural Health

INDEX Programming: Comparative Analytics

Full Access to INDEX Metrics
Gain access to your hospital's individual INDEX metrics – 36 indicators across 8 pillars.



Custom Peer Group
Measure your hospital's INDEX performance against a custom peer group of 10 'like' hospitals.

In-depth Data Review
Review metrics with a Chartis Center for Rural Health analyst and identify immediate opportunities for improvement,.

Expanded Analytics
DRG level Cost & Charge comparisons and Flex Financials data offer additional views for understanding performance.

INDEX Programming: Strategic Advisory

Full Access to INDEX Metrics
Gain access to your hospital's individual INDEX metrics – 36 indicators across 8 pillars.

Quarterly Leadership Updates
In-depth data reviews and analysis provide opportunities to assessments plan progress and create sustainable improvement.

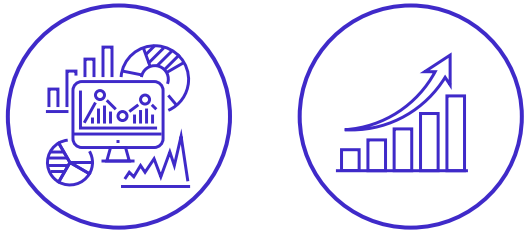
Model Performance
Work with our team to measure and monitor Performance Improvement Plan progress.

Custom Peer Group
Measure your hospital's INDEX performance against a custom peer group of 10 'like' hospitals.

Expanded Analytics
Market Share, Medicare Outmigration, DRG level Cost & Charge comparisons and Flex Financials data provide a comprehensive view of performance.

Advisor Access
Work with our team to evaluate data, ID specific opportunities and goals, and develop Performance Improvement Plans.

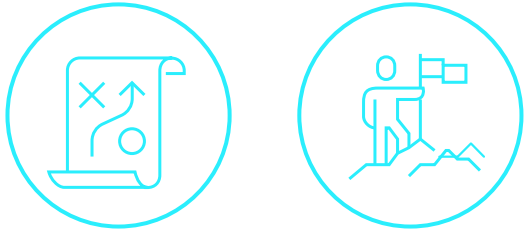
INDEX and Customized Assessments



INDEX Comparative Analytics

$9,500 (1-year engagement)
3 INDEX data releases

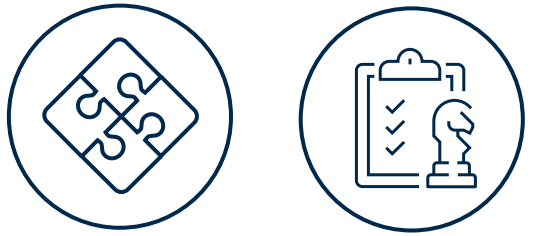
$25,500 (3-year engagement)
9 INDEX data releases



INDEX Strategic Advisory

$19,500 (1-year engagement)

$32,000 (2-year engagement)



Custom Data Assessments

Hospital Community Impact
Help stakeholders understand hospital's impact

Medicare Patient Outmigration
Who's leaving service area and for which services

Population Health
Understand disparities and unmet needs

$9,500 each

Connect with Our Team

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Thank *you*

CHARTIS

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CHARTIS RURAL HOSPITAL PERFORMANCE INDEX™ SUMMARY REPORT

PERFORMANCE SUMMARY

Provider Name: MOORE COUNTY HOSPITAL
Medical Provider: 451386
Location: DUMAS, TX 79029
Release Date: Summer 2024

INDEX RANK

91.1

QUARTILE RATING SCALE

1=100-75 2=74.9-50 3=49.9-25 4=24.9-0

MARKET		VALUE					FINANCE
INPATIENT MARKET SHARE	OUTPATIENT MARKET SHARE	QUALITY	OUTCOMES	PATIENT PERSPECTIVE	COST	CHARGE	FINANCE
56	79	99	57	83	48	58	38

METHODOLOGY - The Chartis Rural Hospital Performance INDEX is the industry standard for assessing - and benchmarking - rural and Critical Access Hospital performance. To learn more about the INDEX or request a 2024 methodology, reach out to us at CCRH@chartis.com.

Honoring Outstanding Performance Among Rural Hospitals

- **February** — 100 — Critical Access Rural & Community Top 100 Hospital
- **May** — NRHA — Rural & Community Top 20 Hospital
- **September** — NRHA — Critical Access Top 20 Hospital
- **November** — Performance Leadership Top Quartile Performance

Working with The Chartis Center for Rural Health

How our expertise, analytics and insights can support your strategic goals

INDEX Strategic Advisory Program – *A customized 12-month engagement designed for rural providers seeking to drive improvement utilizing benchmarks from Top 100 hospitals. We work directly with hospital leadership and frontline decision makers to identify areas of opportunity using INDEX, develop action plans, and monitor progress.*

INDEX Comparative Analytics – *Access to the raw INDEX data across 36 metrics for your facility as well as those of your custom 10-hospital peer group. This program can be configured as a single year engagement or a 3-year engagement.*

Strategic & Operational Assessment – *Detailed analysis focusing on specific areas such as patient outmigration, cost and charge, population health, finance, and market share. Presented in a visual and engaging format, this assessment helps to inform and empower the decision-making process. Project time from start to assessment delivery is typically 3 to 4 weeks.*

Leadership and Board Education – *Our leadership team and Board education sessions are designed to help improve understanding of hospital performance and bring greater clarity around the challenges rural hospitals face within the context of vulnerability, health inequity and staffing shortages. This engagement can be done in-person or virtually.*

To learn more about these programs, reach out to us at CCRH@chartis.com.

To learn more about these programs, reach out to us at CCRH@chartis.com.

CHARTIS

INDEX

2024 Methodology

CHARTIS

Table of Contents

The Chartis Rural Hospital Performance INDEX™ Overview

The Chartis Rural Hospital Performance INDEX is the industry's most comprehensive and objective assessment of rural hospital performance. By assessing performance across eight Pillars of performance, INDEX brings a rural-relevant perspective to healthcare leaders making strategic and operational decisions. For more than a decade, the INDEX has helped more than 750 rural and Critical Access Hospitals integrate sophisticated analytics for benchmarking performance and has been used by more than 25 state agencies, state hospital associations, and federal grant programs. The INDEX is the foundation for many of rural healthcare's most prominent awards (e.g. Top 100 Critical Access Hospitals and Top 100 Rural & Community Hospitals) and is used by organizations such as the National Rural Health Association (NRHA) in support of its advocacy and legislative initiatives.

Methodology Summary

The INDEX is a holistic performance assessment of all Critical Access Hospitals (CAHs) and Rural & Community Hospitals nationally (see *Hospitals in the Study Group* for details). Each hospital's INDEX score is a percentile rank of aggregate performance across eight Pillars spanning Market, Value, and Finance. Each Pillar score reflects a percentile rank of aggregate performance across each underlying Indicator. In total, 36 Indicators serve as the basis for these Pillars (**Figure 1**).[1]

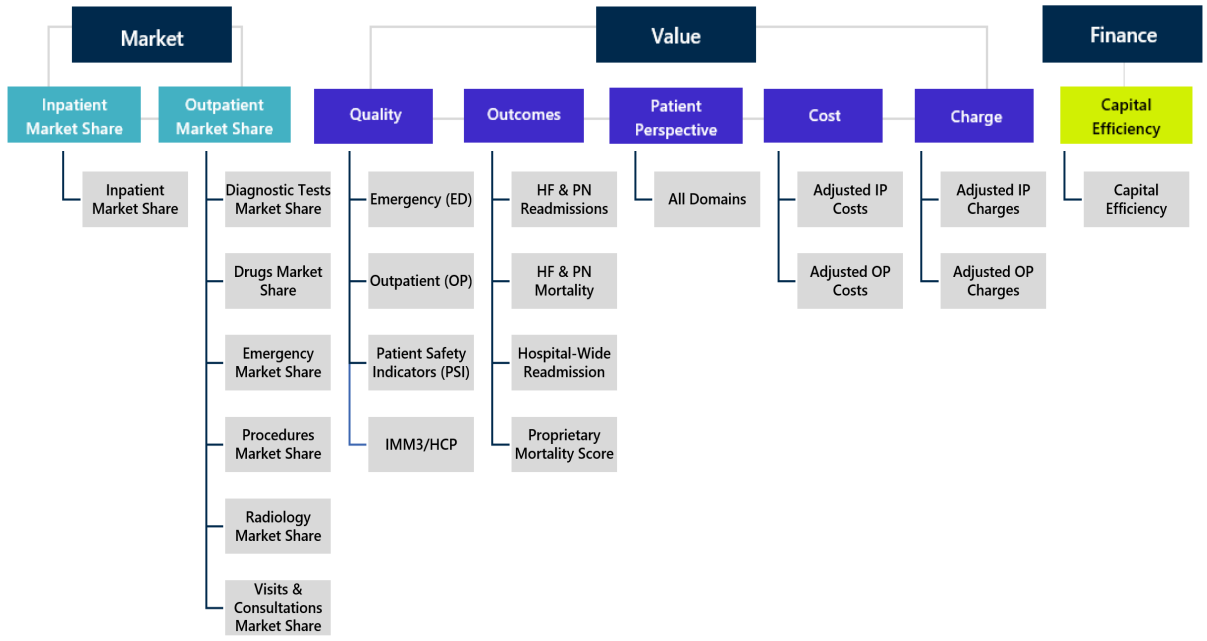


Figure 1. The INDEX is comprised of eight Pillars of performance spanning Market, Value and Finance. Thirty-six Indicators serve as the basis of these Pillars.

[1] Additional Indicators are included in detailed INDEX analytic reports for further benchmarking, although these measures are not included in the INDEX rankings.

All data leveraged in the INDEX are the most recent publicly available from CMS. All information in this release represents the most recently available data as of November 15, 2024 (Table 1).

Table 1. Data Summary

Source	Data Set Name	Time Period
CMS	Service Area File 2023	January 2023-December 2023
CMS	Standard Analytical File - OP 2023	January 2023-December 2023
CMS	MedPAR 2022 Final Rule	October 2020-September 2023
CMS	Hospital Compare - IMM3	October 2022-March 2023
CMS	Hospital Compare - OP 18b	October 2022-September 2023
CMS	Hospital Compare - OP 22	January 2022-December 2022
CMS	MedPAR 2021 Final Rule	October 2020-September 2023
CMS	Hospital Compare - (Overall, HF & PN) Mortality / Readmissions	July 2020-June 2023
CMS	Hospital Compare - HCAHPS	October 2022-September 2023
CMS	Standard Analytical File - OP 2022	January 2023-December 2023
CMS	MedPAR 2021 Final Rule	October 2022-September 2023
CMS	Healthcare Cost Report Information Systems (HCRIS) Q1 2024	Most recent Cost Report provided as of 10/1/2024
CMS	MedPAR 2022 Final Rule	October 2022-September 2023
CMS	Standard Analytical File - OP 2022	January 2023-December 2023
CMS	Healthcare Cost Report Information Systems (HCRIS) Q1 2024	Most recent Cost Report provided as of 10/1/2024

All available data are included in the INDEX. Statistical sampling and data projection methodologies are employed only when necessary. Missing data are imputed using the medians method. Indicators unable to be ranked after imputation due to missing or excluded data are removed from Pillar and composite INDEX rankings.

Each Pillar score reflects a percentile rank of the hospital's aggregate performance across underlying metrics relative to all hospitals in the analysis. In some instances, weighting and/or standardization across Indicators within each Pillar are performed. See Appendix A: Detailed Methodology for additional information specific to each Pillar.

The composite INDEX score reflects each hospital's aggregate performance across all Pillars relative to the study group. For each hospital, a composite score is computed as the percentile rank of the sum of all eight Pillar scores. All Pillars are equally-weighted. Providers missing three or more Pillars are excluded from the overall INDEX ranking and no INDEX score is denoted.

Hospitals in the Study Group

The INDEX strives to include all active Critical Access Hospitals (CAHs) and Rural & Community Hospitals. CCRH defines Rural & Community Hospitals as all active U.S. short-term acute care, non-specialty and non-federal hospitals located in zip codes designated as "rural" by the Federal Office of Rural Health Policy (FORHP) with no more than 200 beds. A total of 762 Rural PPS and 1,328 CAHs were included in the final study.

The most recently available CMS Provider of Services (POS) file is used to determine the initial population of eligible hospitals. This file contains individual records for each Medicare-approved provider and is updated quarterly. This dataset is cross-checked against other sources including the AHA Hospital Directory and the American Hospital Directory to confirm hospital identity, status, and appropriateness for inclusion. Exclusions are based on the following criteria:

- Specialty Hospital Designation:
    - Providers designated as specialty hospitals in the CMS Hospital Provider of Services file are excluded. These include psychiatric, rehab, long-term care, surgical specialty and other specialty facilities.
    - Hospitals designated as cancer centers and children's or pediatric hospitals are excluded.
    - Governmental facilities including Veterans Administration, Indian Health Service hospitals and related federal facilities are excluded.
    - Hospitals with 80 percent of their MS-DRG inpatient case mix concentrated in three or fewer Major Diagnostic Categories (MDCs) are excluded.
- Geography:
    - Hospitals in outlying U.S. Territories (i.e. Samoa, Virgin Islands, Puerto Rico, etc.) are excluded.
- Data Availability:
    - Hospitals with missing or implausible critical financial indicators, including revenue and balance sheet data, in their Medicare Hospital Cost Report Information System (HCRIS) filings are excluded.
    - Hospitals that do not participate in Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs are excluded from the affected Pillar and overall INDEX rankings. Hospitals whose data are suppressed by CMS due to low volumes are included in the study; missing data are imputed for these facilities.
    - Hospitals missing more than 40 percent of the Indicators in each Pillar are excluded from that Pillar analysis.
    - Hospitals missing three or more Pillar scores due to lack of supporting data are excluded from the composite INDEX analysis.

Appendix A: Detailed Methodology

Table 2. Inpatient Market Share Pillar Methodology

Component	Inpatient Market Share
Data Source	CMS Service Area File
Indicator	Medicare Inpatient Market Share
Methodology	Each hospital's inpatient service area is defined as the fewest number of zip codes comprising 65 percent of the hospital's total inpatient Medicare case count over the most recent three years of available data. Zip codes with fewer than an average of one (1) case per year are removed. Zip codes with a center point more than 35 miles from the hospital are removed. The home zip code is included. Total cases are suppressed for provider/zip combinations with cases of less than 11. Inpatient market share is computed as the total inpatient Medicare hospital cases from the defined service area divided by the total inpatient Medicare market cases from the defined service area for the most recent year of available data.
Scoring	Inpatient market share values are percentile ranked across all hospitals in the analysis. To reward facilities with strong market positions, higher market shares receive higher percentile rankings.

Table 3. Outpatient Market Share Pillar Methodology

Component	Outpatient Market Share
Data Source	Outpatient Standard Analytical File (OPSAF)
Indicators	Medicare Outpatient Market Share – Diagnostic Tests Medicare Outpatient Market Share – Drugs Medicare Outpatient Market Share – Emergency Medicare Outpatient Market Share – Procedures Medicare Outpatient Market Share – Radiology Medicare Outpatient Market Share – Visits and Consultations
Methodology	For each service line, each hospital's outpatient service area is defined as the fewest number of Federal Information Processing Standard (FIPS) codes comprising 65 percent of the hospital's outpatient Medicare procedures over the most recent three years. FIPS codes with fewer than an average of one (1) procedure per year are removed. FIPS codes with a center point more than 35 miles from the hospital are removed. The home FIPS code is included. For each service line, market share is computed as the total outpatient hospital Medicare payments from the defined service area divided by the total outpatient market Medicare payments from the defined service area for the most recent year of available data. Principal Components Factor Analysis is employed to determine the appropriate weighting for each service line.
Scoring	Percentile rankings are calculated based on the market share scores for each service line. Service lines are weighted according to Factor Analysis. To reward facilities with strong outpatient market positions, greater market shares receive higher percentile rankings.
Notes	Outpatient procedures are categorized under the highest-ranking category by case based on CPT and revenue codes. Procedures that do not fall into those categories are excluded. Dialysis, Urgent Care, and Anesthesia procedures were excluded due to low volumes across the study group.

Table 4. Quality Pillar Methodology

Component	Quality
Data Source	Hospital Compare – Process of Care
Indicators	OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients OP-22 Percent of Patients Leaving without Being Seen PSI 6 Iatrogenic Pneumothorax Rate PSI 9 Perioperative Hemorrhage or Hematoma Rate PSI 11 Postoperative Respiratory Failure Rate PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis PSI 13 Postoperative Sepsis Rate HCP/IMM-3 Influenza Vaccination Coverage Among Healthcare Personnel (HCP)
Methodology	Process of Care data are compiled as reported on Hospital Compare. No further data manipulation is performed. Patient Safety Indicator (PSI) risk adjusted rates are produced by AHRQ WinQI software based on the most recent three years of available MedPAR data (excluding the first 2 quarters of discharges from 2020). Data suppressed by CMS due to insufficient volume are imputed to estimate missing values. Hospitals not reporting these measures citing the footnote of, "Data are shown only for hospitals that participate in the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs" are excluded from the Pillar analysis. Hospitals missing data for six or more Indicators are excluded from the Pillar analysis. Pillar score is denoted as a blank. Principal Components Factor Analysis is employed to determine the appropriate weighting for each Indicator.
Scoring	Lower values receive higher scores. Across all Indicators, the weighted average (as determined by Factor Analysis) is percentile ranked against all analyzed providers to derive the Pillar score.
Notes	The analyzed Indicators represent the most widely-accepted, rural-relevant measures with data for at least 50 percent of hospitals in the study. New metrics and measures that are not representative of rural hospital performance are purposefully omitted. The incorporation of additional measures in the future will be considered based on industry acceptance and data availability.

Table 5. Outcomes Pillar Methodology

Component	Outcomes
Data Sources	Hospital Compare – Mortality and Readmission Medicare Provider and Analysis Review (MedPAR)
Indicators	30-Day Pneumonia (PN) Readmission Rate 30-Day Heart Failure (HF) Readmission Rate 30-day Mortality Rates for PN 30-day Mortality Rates for HF 30-Day Hospital-Wide Readmission Rate Proprietary Risk-Adjusted In-Hospital All-Condition Mortality Score
Methodology	Readmission rates are compiled as reported on Hospital Compare. No further data manipulation is performed. To compute the Proprietary Risk-Adjusted In-Hospital All-Condition Mortality Score, data are first stratified by DRG cluster. In clusters with lower mortality rates, contingency tables are used to stratify according to age, history of covid-19 infection, and number of comorbidities. National per-stratum mortality rates are used to calculate expected mortality rates for each hospital. In clusters with higher mortality rates, logistic regression models are fit, adjusting for age, gender, history of covid-19 infection, cluster-specific comorbidities, and admission source. Expected rates from the contingency table and logistic models are risk-adjusted for each hospital based upon patient mix. For each hospital, the number of standard deviations between the observed and expected mortality rates is computed. Note inpatients age 65 or older are excluded if the patient stayed less than two days (unless died), left against medical advice, was transferred, or was assigned DRGs 981-999. Discharges from the first two quarters of 2020 were excluded. Inpatients with a primary diagnosis of covid-19 or a secondary diagnosis of covid-19 present on admission were excluded. Missing data that are suppressed by CMS due to insufficient volume imputed to estimate missing values. Hospitals not reporting these measures citing the footnote of, "Data are shown only for hospitals that participate in the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs" are excluded from the Pillar analysis. Hospitals missing data for four or more Indicators are excluded from the Pillar analysis. Pillar score is denoted as a blank. Principal Components Factor Analysis is employed to determine the appropriate weighting for each Indicator.
Scoring	To reward facilities with strong outcomes, lower readmission and mortality rates receive higher scores. Higher Mortality Scores receive higher scores. Across all evaluated Indicators, the weighted average (as determined by factor analysis) is percentile ranked against all analyzed providers to derive the Pillar score.
Notes	The analyzed Indicators represent the most widely-accepted, rural-relevant measures with data for at least 50 percent of hospitals in the study. New metrics and measures that are not representative of rural hospital performance are purposefully omitted. The incorporation of additional measures in the future will be considered based on industry acceptance and data availability.

Table 6. Patient Perspective Pillar Methodology

Component	Patient Perspective
Data Source	Hospital Compare – HCAHPS
Indicators	Patients Reporting they would "Definitely Recommend" the Hospital Patients Rating the Hospital a 9 or 10 on a Scale from 0 (Lowest) to 10 (Highest) Patients Reporting their Room and Bathroom were "Always" Clean Patients Reporting Nurses "Always" Communicated Well Patients Reporting Doctors "Always" Communicated Well Patients Reporting they "Always" Received Help as Soon as they Wanted Patients Reporting Staff "Always" Explained Medications Before Administering Patients Reporting "Yes" they were Given Information About what to Do during their Recovery at Home Patients Reporting the Area Around their Room was "Always" Quiet at Night Did patients understand their care when they left the hospital?
Methodology	HCAHPS scores are compiled as reported on Hospital Compare. No further data manipulation is performed. Data that are suppressed by CMS due to insufficient volume are imputed to estimate missing values. Hospitals not reporting these measures citing the footnote of, "Data are shown only for hospitals that participate in the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs" are excluded from the Pillar analysis. Hospitals missing data for seven or more Indicators are excluded from the Pillar analysis. Pillar score is denoted as a blank. Principal Components Factor Analysis is employed to determine the appropriate weighting for each Indicator.
Scoring	Across all evaluated Indicators, the weighted average (as determined by factor analysis) is percentile ranked against all analyzed providers to derive the Pillar score. To reward facilities with strong patient satisfaction, hospitals with higher scores receive higher percentile ranks.

Table 7. Cost Pillar Methodology

Component	Cost
Data Sources	Medicare Provider and Analysis Review (MedPAR) Outpatient Standard Analytical File (OPSAF) Healthcare Cost Report Information Systems (HCRIS)
Indicators	Medicare Adjusted Average Costs – Inpatient Medicare Adjusted Average Costs – Outpatient
Methodology	An overall average cost-to-charge ratio is computed for each hospital based on total charges and costs as reported in the Medicare Hospital Cost Report Information System. See Charge Pillar Methodology (Table 8) for detail regarding charge calculations. To calculate inpatient average costs, each hospital's cost-to-charge ratio is applied to MedPAR inpatient charge data at the claim/patient level and adjusted based on the CMS-assigned case weight for that claim's MS-DRG. Each hospital's costs are aggregated for all inpatients to derive an overall average adjusted inpatient cost. To calculate outpatient average costs, a hospital's cost-to-charge ratio is applied to Medicare Outpatient Standard Analytical File charge data at the claim/HCPCS level and adjusted based on the CMS-assigned case weight for that claim's Ambulatory Payment Classification (APC) code. Each hospital's costs are aggregated for all outpatient procedures to derive an overall average adjusted outpatient cost.
Scoring	For each hospital, scores for both Indicators are aggregated and percentile ranked against all analyzed providers to derive the Pillar score. Both Indicators are equally-weighted. To reward facilities with strong cost efficiency, lower average costs receive higher percentile rankings.

Table 8. Charge Pillar Methodology

Component	Charge
Data Sources	Medicare Provider and Analysis Review (MedPAR) Outpatient Standard Analytical File (OPSAF)
Indicators	Medicare Adjusted Average Charges – Inpatient Medicare Adjusted Average Charges – Outpatient
Methodology	For each hospital in the analysis, inpatient charges are case-mix adjusted based on the CMS-assigned case weight for each claim's MS-DRG. Ungroupable cases not assigned a DRG are excluded from the analysis. Each hospital's case-mix adjusted inpatient charges are aggregated to derive an average adjusted inpatient charge per case. Average inpatient charges are wage-rate adjusted according to CMS-defined provider wage indices. For each hospital in the analysis, outpatient charges are case-mix adjusted based on the CMS-assigned case weight for each claim's Ambulatory Payment Classification (APC) code. Procedures not assigned an APC code are excluded from the analysis. Each hospital's case-mix adjusted outpatient charges are aggregated to derive an average adjusted charge per unit. Average outpatient charges are wage-rate adjusted according to CMS-defined provider wage indices.
Scoring	For each hospital, scores for both Indicators are aggregated and percentile ranked against all analyzed providers to derive the Pillar score. Both Indicators are equally-weighted. To reward facilities with competitive charges, lower average charges receive higher percentile rankings.

Table 9. Financial Efficiency Pillar Methodology

Component	Financial Efficiency
Data Source	Healthcare Cost Report Information Systems (HCRIS)
Indicator	Net Income/Total Revenue
Methodology	The above ratio is calculated for each hospital based on the most recently available HCRIS data.
Scoring	For each hospital, Net Income/Total Revenue is percentile ranked against all analyzed providers to derive the Pillar score. To reward facilities with greater financial stability, higher ratios receive higher percentile rankings.
Notes	The Financial Stability Index is adapted from academic research identifying the financial ratios most highly correlated to long-term fiscal viability (Lynn, M. & Wetheim, P. Key Financial Ratios Can Foretell Hospital Closures. HFMA Journal, 47(11), 66-70. 1993). Additional metrics were not evaluated in the INDEX due to poor data integrity. The incorporation of additional measures in the future will be considered based on industry acceptance and data availability.

Goal: Improve performance on specific projects

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Sepsis	Yessenia/Dr. Knight	→		
2. CLS ER and Clinic Data a. Patient Perceptions of Care (See Service #2) b. Clinical Data for MCHD Clinics	Bethany, Exec Team	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

Level	Criteria
SIRS (at least 2 symptoms) Any 2 of 4	• Pulse- > 90 • Temp- >100.9 or < 96.8 F • Respirations- >20 min • WBC- >12,000 or <4,000 >10% bands
Sepsis	SIRS **+** Infection
Severe Sepsis (any one of the following) Any 1 of 7	Sepsis **+** Hypotension or Organ Dysfunction • Lactate > 2 mmol/L • SBP< 90 or MAP < 65 or SBP drop of more than 40 points. • Cr > 2.0 or urine output < 0.5 mL/kg/hr for 2hr • Total Bilirubin >2 mg/dL • Platelets < 100,000 • INR > 1.5 or a PTT > 60 sec • Acute respiratory failure requiring invasive or non-invasive mechanical ventilation
Septic Shock	Severe Sepsis **+** Hypotension or Hypoperfusion (after IV fluid bolus) or lactate ≥ 4

Early Management Requirements
Severe Sepsis within **3 HOURS**

1) Measure **lactate** level
   - **> 2** repeat in **2 hrs**
   - **> 4** repeat in **2 hrs** AND give 30ml/kg NS or LR Bolus (+ Septic Shock requirements)
2) Obtain blood cultures **prior to** antibiotics
3) Administer broad spectrum **antibiotics (Unknown source give Vancomycin & Zosyn)**
4) Administer **30 mL/kg IV Normal Saline or Lactated Ringers** (for hypotension or lactate level ≥ 4)

Septic Shock within **6 HOURS**

1) **Vasopressor** initiation to maintain MAP ≥ 65
(for hypotension that does not respond to the initial fluid bolus)
2) If the patient remains hypotensive after the fluid bolus **OR** initial lactate ≥ 4:
   - **Physician/PA/NP Reassessment** ← Within 3hr of bolus
     OR (2) of the following:
   - Measure central venous pressure **(CVP)**
   - Measure central venous oxygen saturation **(ScvO2)**
   - **Echocardiogram**
   - Dynamic assessment of fluid responsiveness with **passive leg raise** or **fluid challenge**
3) **Re-measure lactate** (if initial lactate was > 2)

Domains & Questions

Top Box Scores for 2024 Q4 to 2025 Q2

ED - Digital

		2025 Q2*	2025 Q1	2024 Q4	2024 Q4 - 2025 Q2 Your Top Box	2024 Q4 - 2025 Q2 SS DB State Top Box	2024 Q4 - 2025 Q2 SS DB Natl Top Box
–	**During your Emergency Room Visit**	87.12% ↑ (115/132)	85.32% ↑ (250/293)	81.12% (159/196)	84.38%	85.34%	87.74%
^	During this visit were you seen by a medical professional within 30 minutes of getting to the emergency room? (#1)	92.86% ↑ (26/28)	92.75% ↓ (64/69)	97.73% (43/44)	94.33%	92.13%	94.81%
^	During this visit, did the doctors or nurses ask about all of the medicines you were taking? (#2)	96.43% ↑ (27/28)	92.65% ↑ (63/68)	83.72% (36/43)	90.65%	91.39%	93.49%
^	Before giving you any new medicine, did the medical providers or nurses describe possible side effects to you in a way you could understand? (#3)	80.00% ↓ (20/25)	82.22% ↑ (37/45)	78.79% (26/33)	80.58%	82.81%	82.85%
^	During this visit, did the medical providers do everything they could to help you with your pain? (#4)	82.61% ↑ (19/23)	75.47% ↑ (40/53)	74.29% (26/35)	76.58%	74.90%	75.25%
^	During this visit, did the medical providers give you as much information as you wanted about the results of any tests / procedures performed? (#5)	82.14% ↑ (23/28)	79.31% ↑ (46/58)	68.29% (28/41)	76.38%	82.72%	88.92%
–	**People Who Took Care of You**	81.98% ↑ (91/111)	73.00% ↑ (173/237)	66.46% (109/164)	72.85%	78.91%	82.25%
^	During this emergency room visit, how often did nurses listen carefully to you? (#6)	85.71% ↑ (24/28)	71.19% ↑ (42/59)	68.29% (28/41)	73.44%	78.82%	83.23%
^	During this visit, how often did nurses explain things in a way you could understand? (#7)	81.48% ↑ (22/27)	75.00% ↑ (45/60)	65.85% (27/41)	73.44%	80.90%	84.17%

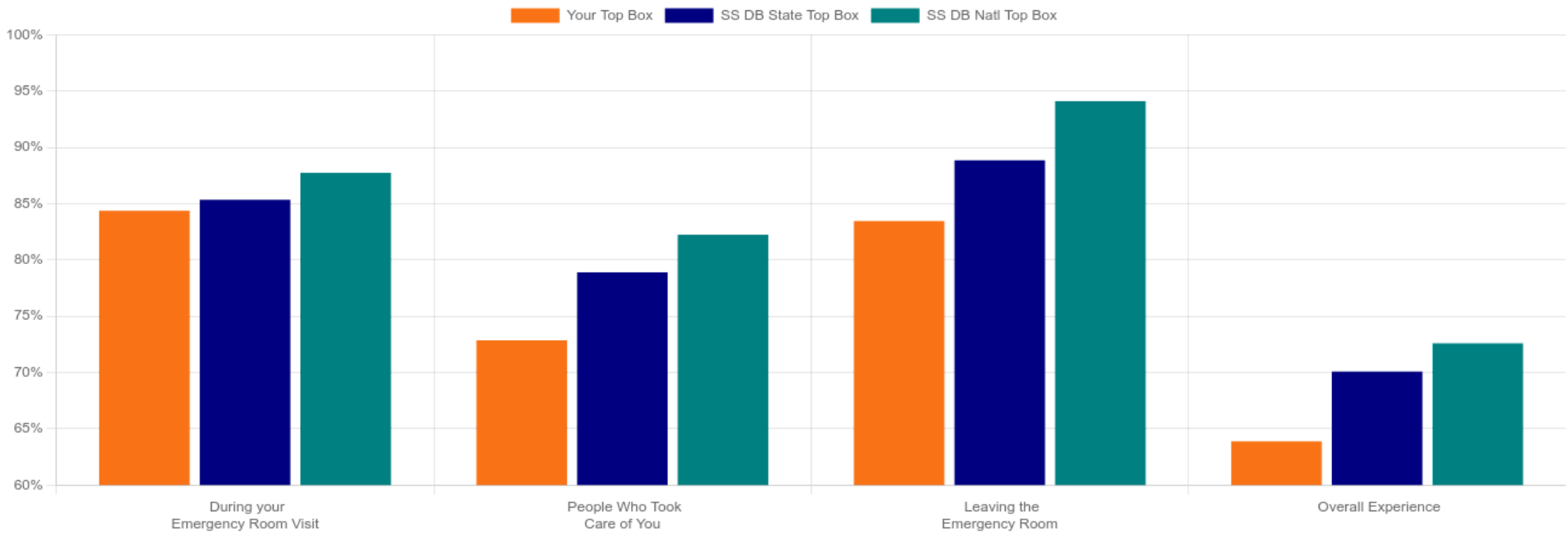
** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

^	During this visit, how often did medical providers listen carefully to you? (#8)	82.14% ↑ (23/28)	72.88% ↑ (43/59)	65.85% (27/41)	72.66%	78.82%	80.14%
^	During this visit, how often did medical providers explain things in a way you could understand? (#9)	78.57% ↑ (22/28)	72.88% ↑ (43/59)	65.85% (27/41)	71.88%	77.08%	81.47%
–	**Leaving the Emergency Room** ▼	84.62% ↓ (22/26)	90.91% ↑ (50/55)	72.50% (29/40)	83.47%	88.85%	94.10%
^	Before you left, did you understand your discharge care instructions regarding the main health reason you came to the emergency room for? (#10)	84.62% ↓ (22/26)	90.91% ↑ (50/55)	72.50% (29/40)	83.47%	88.85%	94.10%
–	**Overall Experience** ▼	74.07% ↑ (40/54)	63.30% ↑ (69/109)	57.33% (43/75)	63.87%	70.09%	72.60%
^	Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency room visit? (#11)	77.78% ↑ (21/27)	61.54% ↑ (32/52)	57.14% (20/35)	64.04%	69.81%	72.58%
^	Would you recommend this emergency room to your friends and family? (#12)	70.37% ↑ (19/27)	64.91% ↑ (37/57)	57.50% (23/40)	63.71%	70.36%	72.62%
	Survey Count	28	70	44			

** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

Your Top Box Scores for 2024 Q4 to 2025 Q2

ED - Digital



** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

4 Quarter Rolling Percentiles for 2024 Q2 to 2025 Q1

ED - Digital

	%ile	Your Top Box	SS DB State Top Box	SS DB Natl Top Box
During your Emergency Room Visit	20th	83.64%	87.50%	88.47%
People Who Took Care of You	10th	70.32%	81.23%	82.70%
Leaving the Emergency Room	--	83.16%	91.98%	93.56%
Overall Experience	15th	60.87%	70.96%	71.85%
		n=114		

Date last updated: 06/01/2025 Next Update: September 2025

1. Percentile comparison data is displayed for survey lines with a minimum of 30 respondents for a given time period (n>=30).

2. Percentile tables are calculated for survey lines with sufficient volume using all available results in the Survey Solutions database. A minimum of 30 data points is required for this calculation. A data point is defined as a quarter's data for a single entity which meets a minimum threshold of completed surveys (n>=50). For quarters which do not meet this threshold, subsequent quarters are combined until it is reached.

** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

Domains & Questions

Top Box Scores for 2024 Q4 to 2025 Q2

CGCAHPS - Adult - Digital

		2025 Q2*	2025 Q1	2024 Q4	2024 Q4 - 2025 Q2 Your Top Box	2024 Q4 - 2025 Q2 SS DB State Top Box	2024 Q4 - 2025 Q2 SS DB Natl Top Box
–	**Getting Timely Appointments, Care and Information**	68.64% ↑ (267/389)	67.75% ↑ (544/803)	67.69% (308/455)	67.94%	67.52%	71.72%
^	My waiting time was acceptable for this visit (#1)	70.26% ↑ (137/195)	67.90% ↑ (275/405)	66.81% (153/229)	68.15%	66.37%	71.56%
^	I was able to receive my appointment when I needed it (#2)	67.01% ↓ (130/194)	67.59% ↓ (269/398)	68.58% (155/226)	67.73%	68.67%	71.88%
–	**How Well Providers Communicate With Patients**	75.07% ↓ (569/758)	75.91% ↑ (1185/1561)	72.92% (649/890)	74.88%	76.35%	77.88%
^	This provider knew the important information about my medical history (#3)	66.84% ↓ (127/190)	69.90% ↑ (274/392)	64.00% (144/225)	67.53%	70.83%	71.81%
^	This provider listened and showed respect for my concerns (#4)	78.01% ↓ (149/191)	80.61% ↑ (316/392)	77.48% (172/222)	79.13%	80.28%	81.40%
^	This provider spent enough time with me (#5)	76.72% ↓ (145/189)	77.24% ↑ (302/391)	72.97% (162/222)	75.94%	78.41%	79.81%
^	The nursing staff listened and showed respect for my concerns (#6)	78.72% ↑ (148/188)	75.91% ↓ (293/386)	77.38% (171/221)	76.98%	75.89%	78.51%
–	**Helpful, Courteous, and Respectful Office Staff**	75.94% ↑ (142/187)	75.00% ↑ (291/388)	74.77% (166/222)	75.16%	71.33%	77.52%
^	The clerks and receptionists showed courtesy and respect to me (#7)	75.94% ↑ (142/187)	75.00% ↑ (291/388)	74.77% (166/222)	75.16%	71.33%	77.52%

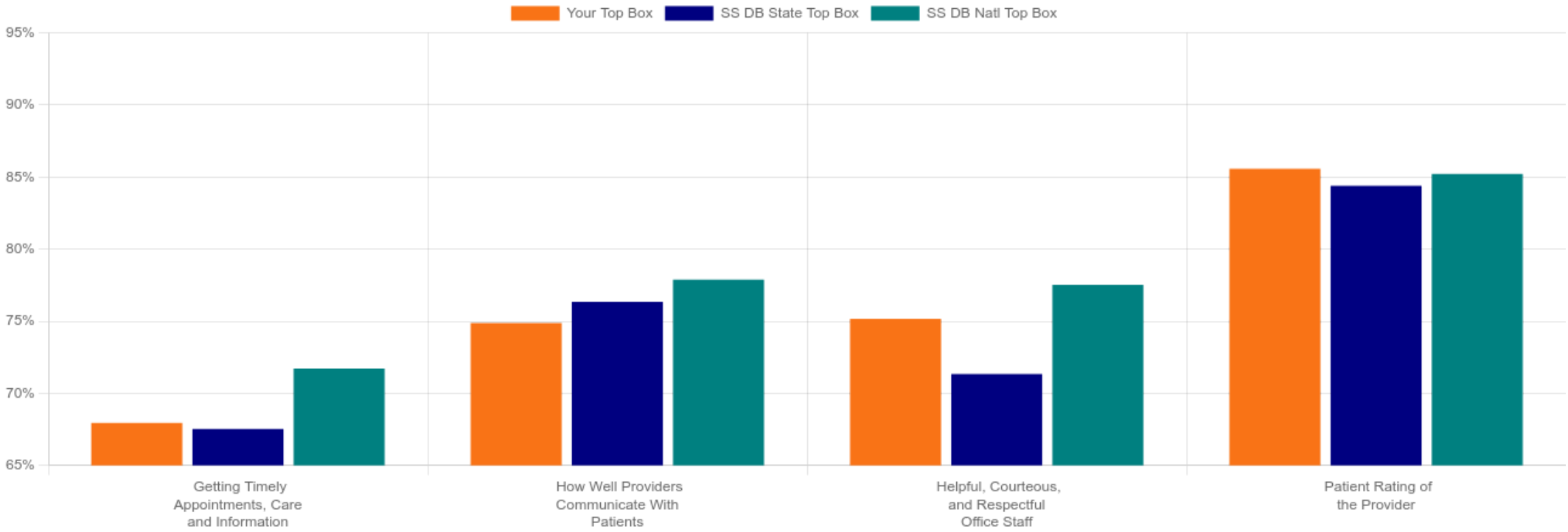
** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

–	**Patient Rating of the Provider**	88.18% ↑ (485/550)	85.74% ↑ (950/1108)	83.05% (534/643)	85.57%	84.38%	85.21%
^	Please rate your experience where 0 is the worst provider/practice possible and 10 is the best provider/practice possible. (#8)	89.94% ↑ (161/179)	81.92% ↓ (281/343)	83.08% (167/201)	84.23%	82.84%	85.37%
^	Would you recommend this provider to your friends and family? (#9)	88.17% ↓ (164/186)	89.82% ↑ (344/383)	86.43% (191/221)	88.48%	87.86%	86.70%
^	How satisfied are you with the overall experience during this visit? (#10)	86.49% ↑ (160/185)	85.08% ↑ (325/382)	79.64% (176/221)	83.88%	82.31%	83.57%
	Survey Count	197	411	231			

** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

Your Top Box Scores for 2024 Q4 to 2025 Q2

CGCAHPS - Adult - Digital



** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

4 Quarter Rolling Percentiles for 2024 Q2 to 2025 Q1

CGCAHPS - Adult - Digital

	%ile	Your Top Box	SS DB State Top Box	SS DB Natl Top Box
Getting Timely Appointments, Care and Information	35th	67.73%	68.69%	71.19%
How Well Providers Communicate With Patients	45th	74.83%	77.43%	77.87%
Helpful, Courteous, and Respectful Office Staff	50th	74.92%	71.53%	77.00%
Patient Rating of the Provider	70th	84.75%	84.69%	84.21%
		n=642		

Date last updated: 06/01/2025 Next Update: September 2025

1. Percentile comparison data is displayed for survey lines with a minimum of 30 respondents for a given time period (n>=30).

2. Percentile tables are calculated for survey lines with sufficient volume using all available results in the Survey Solutions database. A minimum of 30 data points is required for this calculation. A data point is defined as a quarter's data for a single entity which meets a minimum threshold of completed surveys (n>=50). For quarters which do not meet this threshold, subsequent quarters are combined until it is reached.

** Survey results from May 2025 forward are still being received. This data may be incomplete at this time.*

FINANCE

"Manage resources to ensure the long-term viability of MCHD"

1. Governmental Programs (CHIRP, RAPPS, QIPP, etc.)
2. Continue Grant Writing Capacity

Goal: To build community support and financial strength based on demonstrated excellent performance.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Continue Emphasis on Grant Writing	Kathie,	→	→	→
2. Key Governmental Programs: a. QIPP b. ATLIS c. Rural Health Clinic Vaccine Confidence Grant d. 340(b)	Audra John/Connie Connie Ashleigh	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

MNRC Strategic Plan for QIPP:

FY 2025/2026

Component One

HHSC designates five metrics for Component One. Component One is open only to NSGO NFs. Funds in Component One are distributed **quarterly**.

Facility achievement will be based on performance across a pool of five MDS Long-Stay quality measures. NFs are required to meet performance targets (defined below) in **at least two of the five metrics** to earn all Component One funds. The quality metrics are:

- **Metric 1:** (CMS N013.02) Percent of residents experiencing one or more falls with major injury
- **Metric 2:** (CMS N024.02) Percent of residents with a urinary tract infection
- **Metric 3:** (CMS N029.03) Percent of residents who lose too much weight
- **Metric 4:** (CMS N031.04) Percent of residents who received an antipsychotic medication
- **Metric 5:** (CMS N035.04) Percent of residents whose ability to walk independently worsened

Achievement in one of the available measures will earn 90 percent of eligible component funds; achievement in two or more of the available measures will earn 100 percent of eligible component funds.

MNRC Plan:

- Therapy – specific focus on nursing home residents. All disciplines have the potential to positively impact each of the Metrics. Therapy goals added to District Plan. Weekly Therapy meetings with MNRC Team.
- MDS – continued training and development of new MDS Coordinator will improve accuracy in capturing services provided in these areas. MDS Consultant as needed for additional support through new PDPM changes in September.
- Dietary - use of the new steam table will help to improve quality of food, positively impacting each of the metrics. New menu to begin in July. New snack options with more fresh fruits and vegetables beginning.
- Physician Services - GDR's assist with each of the metrics.
- Activities – working to make improvements to the Beauty Shop for a more relaxing area for residents. Using outdoor spaces (Whisper-glide) for improved resident mood.

Component Two – Workforce Development

HHSC designates three quality metrics for Component Two. Component Two is open to all NF types. Funds are distributed **quarterly**. The weight of each quality measure will vary over the course of three upcoming program years:

• For program periods beginning on September 1, 2024, achievement in one metric earns 70 percent, and achievement in two metrics earns 100 percent of total dollars included in the component;

• For program periods beginning on September 1, 2025, achievement in one metric earns 60 percent, achievement in two metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and

• For program periods beginning on or after September 1, 2026, each quality metric will be allocated an equal portion of the total dollars included in the component (equally weighted).

All three measures relate to staff-to-patient ratios and are measured in Hours Per Resident Day (HPRD) based on data NFs provide quarterly to CMS through the Payroll Based Journal (PBJ).[d] The three metrics are:

• **Metric 1:** Reported Certified Nursing Assistant (CNA) HPRD

• **Metric 2:** Reported Licensed Nursing HPRD

• **Metric 3:** Reported Total Nursing Staff HPRD

MNRC Plan:

- DISD CNA Program – working closely with Anna to build relationships with high school students during clinical rotations at MNRC.
- RNEC – continue to remain stable with staffing through use of the RNEC program.

***This measure will pose a challenge as census continues to grow and staffing remains constant, HPRD's will decrease. MNRC has traditionally run higher than State and National averages/requirements.

Component Three – Texas Priority MDS Quality Measures

HHSC designates three equally weighted quality metrics for Component Three. Component Three is open to all NF types. Funds are distributed **quarterly**.

All three metrics relate to MDS Long-Stay quality metrics and are measured against program-wide as well as facility-specific targets. The three metrics are:

- **Metric 1:** (CMS N030.03) Percent of residents who have depressive symptoms
- **Metric 2:** (CMS N036.03) Percent of residents who used antianxiety or hypnotic medication
- **Metric 3:** (CMS N046.01) Percent of residents with new or worsened bowel or bladder incontinence

MNRC Plan:

- Therapy – specific focus on nursing home residents. All disciplines have the potential to positively impact each of the Metrics. Therapy goals added to District Plan. Weekly Therapy meetings with MNRC Team.
- MDS – continued training and development of new MDS Coordinator will improve accuracy in capturing services provided in these areas. MDS Consultant as needed for additional support through new PDPM changes in September.
- Dietary - use of the new steam table will help to improve quality of food, positively impacting each of the metrics. New menu to begin in July. New snack options with more fresh fruits and vegetables beginning.
- Physician Services - GDR's assist with each of the metrics.
- Activities – working to make improvements to the Beauty Shop for a more relaxing area for residents. Using outdoor spaces (Whisper-glide) for improved resident mood.

All metrics are weighted equally.

Component Four – Resident Focus

HHSC designates two equally weighted quality metrics for Component Four. Component Four is open only to NSGO NFs. Funds are distributed **quarterly**.

Both metrics relate to MDS Long-Stay quality metrics and are measured against program-wide as well as facility-specific targets. The two metrics are:

- **Metric 1:** (CMS N045.01) Percent of residents with pressure ulcers
- **Metric 2:** (CMS N026.03) Percent of residents who have/had a catheter inserted and left in their bladder

MNRC Plan:

- Therapy – increased focus for NH residents.
- Physician/Nursing Communication to ensure catheters are necessary and coded accordingly. Restorative Nursing to continue to work with toileting programs.
- Other previously stated actions.

All metrics are weighted equally.

GOVERNMENTAL PROGAMS - CHIRP

The Comprehensive Hospital Increase Reimbursement Program (CHIRP) is a directed payment program (DPP) that provides for increased Medicaid payments to hospitals for inpatient and outpatient services provided to Medicaid enrollees. The target beneficiaries are adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

Quality Goals CHIRP aims to advance the goals of the Texas Managed Care Quality Strategy. Participating hospitals will report quality measures that tie to the following quality strategy goals.

● Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.

● Keep patients free from harm by building a safer health care system.

● Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.

● Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans.

GOVERNMENTAL PROGRAMS - RAPPS

The Rural Access to Primary and Preventive Services (RAPPS) program to provide increased Medicaid payments to rural health clinics (RHCs) for primary and preventive services provided to adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs. Quality Goals RAPPS aims to advance the goals of the Texas Managed Care Quality Strategy. Participating in RHCs will report quality measures that tie to the following quality strategy goals:

- Promote optimal health through prevention and by engaging people, communities, and the health care system to optimize health outcomes.
- Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates.
- Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans.

GOVERNMENTAL PROGRAMS – ATLIS

The Medicaid Managed Care Aligning Technology by Linking Interoperable Systems for Client Health Outcomes Program (ATLIS Program) for achieving certain milestones on a semi-annual basis with the intention that the milestones will build on prior accomplishments over a 5-year period. The milestones will center around MCO achievement of necessary actions required to implement the structures, processes, and use of client data transmitted electronically between MCOs and providers in their networks to improve client outcome measures and to implement, evaluate, improve, and mature alternative payment models (APMs) for Medicaid beneficiaries.

1. Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.

2. Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.

3. Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care.

COMMUNITY

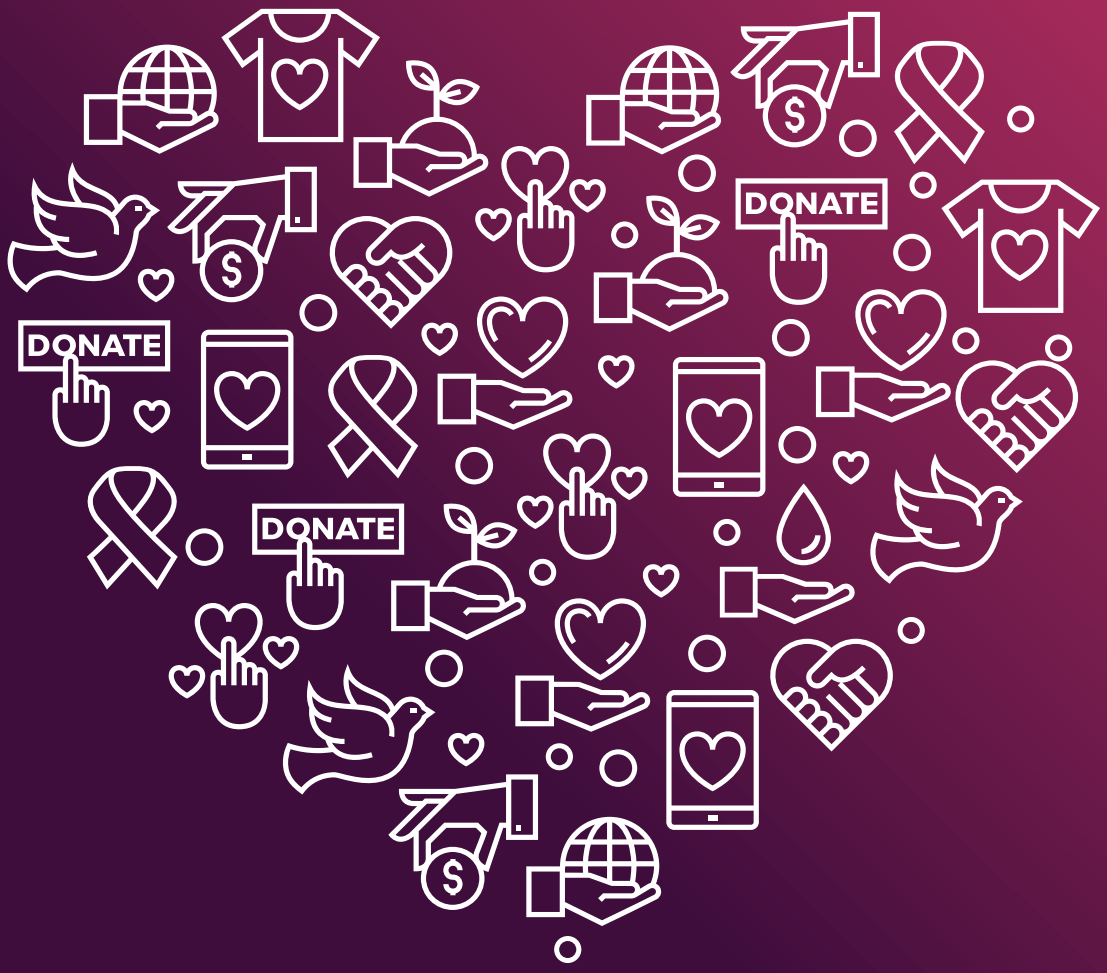
"Be recognized as a community leader"

1. Grow MCHF
    a. 2024 Harvest (Surgical Equipment)
    b. Scholarship Luncheon
    c. Sporting Clays
2. Leader Community Service Projects
3. Marketing Plan

Goal: Provide long-term sustainability for MCHD

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Major Fundraisers a. The Harvest b. Scholarship Luncheon c. Sporting Clays	Kathie			Kathie Kathie

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$



YOUR SUPPORT COUNTS!

YOUR SUPPORT OF THE MOORE COUNTY HEALTH FOUNDATION HELPS TO IMPROVE LOCAL HEALTH CARE THROUGH THE PURCHASE OF NEEDED MEDICAL EQUIPMENT, SCHOLARSHIPS TO AREA HEALTHCARE STUDENTS, AND MUCH MORE!

MOORE COUNTY HEALTH FOUNDATION
MCHF@MCHD.NET
(806) 934-7811
WWW.MOORECOUNTYHEALTHFOUNDATION.NET

@MOORECOUNTYHEALTHFOUNDATION

MCHF EVENTS

SPORTING CLAYS TOURNAMENT

APRIL

The Sporting Clays Tournament helps to raise funds for the Foundation's operations and allows us to provide additional support throughout the year.

THE MCHF HARVEST

AUGUST

Our annual Harvest event raises funds for a specific purpose to enhance local healthcare. This event has allowed us to purchase a 3D mammogram system, anesthesia machines, a resident van, and much more!

NURSING & HEALTHCARE SCHOLARSHIP LUNCHEON

MAY

Our annual Scholarship Luncheon raises funds to provide area students scholarships for nursing and other specific healthcare careers.

THE PANHANDLE GIVES PROGRAM

NOVEMBER

The Panhandle Gives program allows donors to give to the Foundation and have a percentage of their donation "amplified" by the Amarillo Area amplification fund.

SPONSOR! DONATE! PARTICIPATE!
YOU CAN MAKE A REAL DIFFERENCE!

@MOORECOUNTYHEALTHFOUNDATION

MOORE COUNTY HEALTH FOUNDATION
MCHF@MCHD.NET
(806) 934-7811
WWW.MOORECOUNTYHEALTHFOUNDATION.NET

MCHF Event Pledge Form

Contact Name:	
Contact Phone:	

Pledge Information (Please Print)

CONTACT NAME:		
BUSINESS/ORGANIZATION:		
MAILING ADDRESS:		
CITY:	STATE:	ZIP:
E-MAIL:		
PHONE:	ALT PHONE:	
FAX:		
ALT CONTACT NAME & NUMBER:		

We Pledge To (Please Check):

SPONSOR:

The Sporting Clays Tournament at:		**The Scholarship Luncheon at:**		**The MCHF Harvest Event at:**	
Station Sponsor ($200)		Clara Barton ($1,000)		Diamond ($10,000 +)	
Dove Level Sponsor ($300)		Florence Nightingale Level ($1,500)		Platinum ($5,000)	
Quail Level Sponsor ($500)		Other Amount:		Gold ($2,500)	
Duck Level Sponsor ($1,000)		In Kind Donation:		Silver ($1,000)	
Pheasant Level Sponsor ($1,500)		**The Panhandle Gives Program**		Other Amount:	
Apparel & Prizes ($2,000 2 avail)				In Kind Donation:	
Luncheon Sponsor ($3,000 1 avail)		Donation Amount:			
Equipment/Awards ($4,000 2 avail)		**MAKE OTHER GIFT:**			
Turkey Level Sponsor ($5,000)					
Event Sponsor ($10,000 1 avail)		In Memory of:			
Other Amount:		In Honor of:			

SIGNATURE	DATE

Please make checks, corporate matches, or other gifts payable to: Moore County Health Foundation, PO Box 782, Dumas, TX, 79029, phone (806) 934-7811, e-mail mchf@mchd.net, Tax ID #75-2687992

The Moore County Health Foundation thanks you for your support!

Saturday, August 23
Hacienda Garcia
839 N Dumas Ave, Dumas, TX

The Harvest Entertainment

Asleep at the Wheel

"Fifty years ago, Asleep at the Wheel's Ray Benson wrote in his journal that he wanted to form a band to bring the roots of American pop music into the present. It seemed like an ambitious goal for a 19-year-old, yet Benson has done exactly that – traversing the globe as an ambassador of Western swing music and introducing its irresistible sound to generation after generation. Although the lineup has changed countless times since its inception, Benson's mission has never wavered."

"From (the) very first out-of-town gig, Asleep at the Wheel steadily built a fan base in D.C., and opened a date for Poco a short time later. However, Benson observes that the reception back home wasn't always so warm. "We would play these little bars in West Virginia, and they thought because we were hippies, we wouldn't fight. I stared down a few shotguns," he says. "I think it was the music that saved us because we were playing real country music."

"The 1990s put Asleep at the Wheel back on the map permanently, with the band regularly playing between 180 and 200 dates a year. Benson enlisted the top country artists of that era for an outstanding pair of Bob Wills tribute albums, a move that solidified the band's focus on Western swing. When a duet version of "Roly Poly" with Dixie Chicks impacted country radio in 2000, Asleep at the Wheel became that rare country band to chart across four consecutive decades.

Fifty years in, Asleep at the Wheel represents an important cornerstone of American roots music, even though some of its members and audiences represent a new generation. That far-reaching appeal remains a testament to Benson's initial vision."

- Excerpts from **Asleep at the Wheel's** website
www.asleepatthewheel.com

The Harvest is an intimate evening shared with friends and colleagues, consisting of great food and entertainment, to encourage the philanthropy of donors who support the Moore County Health Foundation.

The Harvest will be held Saturday, August 23, 2025 at the Hacienda Garcia located at 839 North Dumas Ave in Dumas, TX. The evening will include a catered sit-down dinner, silent auction, and entertainment by Asleep at the Wheel.

Proceeds from **The Harvest** will be used to help implement the inpatient dialysis program at MCHD and assist with the establishment of a Nephrology Clinic in Moore County to better serve our community.

Please consider supporting this cause by sponsoring and attending **The Harvest!**

Thank you for generous support of both **The Harvest** and the Moore County Health Foundation!

Sponsor Levels

Diamond $10,000

- Table of 8 tickets to the event
- Premier placement in event marketing
- Premier logo placement in all event materials
- Recognition on Diamond Banner
- Special Recognition during presentation at event
- Premier Recognition in Newspaper Ad
- MCHF Website Recognition
- Social Media Recognition

Gold $2,500

- 4 Tickets to the event
- Logo placement in event materials
- Recognition on Gold Banner
- MCHF Website Recognition
- Social Media Recognition

Platinum $5,000

- 6 Tickets to the event
- Logo placement in event marketing
- Large logo placement in all event materials
- Recognition on Platinum banner
- Special recognition during presentation at event
- Recognition in Newspaper Ad
- MCHF Website Recognition
- Social Media Recognition

Silver $1,000

- 2 Tickets to the event
- Listed in event materials
- Recognition on Silver Banner
- Social Media Recognition

To complete your sponsor registration and payment online, please follow the link at this QR Code or visit: https://form.jotform.com/251553388629165

Scan Me

The Harvest

Saturday, August 23, 2025
Hacienda Garcia
839 N Dumas Ave, Dumas, TX

The Moore County Health Foundation, through overwhelming community support of its annual Harvest event, has raised in excess of $4MM for purchases to support the health of Moore County residents. To date, it has purchased ambulances, a digital mammography system, a CT radiation reduction system; equipment and furniture for the new MCHD patient care addition, anesthesia machines for surgery, oncology equipment for Moore County General Surgery, a new resident bus for the MNRC nursing home, provided over 500 scholarships for area healthcare students, and much more!

In 2025, The MCHF Harvest celebration is being held to support those in the Moore County community in need of higher levels of care due to kidney disease. Harvest proceeds will be used to help implement the inpatient dialysis program at MCHD and assist with the establishment of a Nephrology Clinic in Moore County to serve our community. Moore County has a high number of individuals who rely on life-sustaining nephrology services and by assisting the new MCHD program, these individuals may now be able to receive the care they need without having to travel far from home.

Please consider supporting this cause by sponsoring and attending The 2025 Harvest and thank you for your generous support of both The Harvest and the Moore County Health Foundation!

2025 Harvest Sponsor Form

Contact Name:	
Contact Phone:	

To register and make your payment online or visit:
https://form.jotform.com/251553388629165

Scan Me

Sponsor Information (Please Print)

CONTACT NAME:
MAILING ADDRESS:
CITY:
STATE:
ZIP CODE:
E-MAIL:
PHONE:
ALT PHONE:
FAX:
ALT CONTACT NAME & NUMBER

Sponsor Level (Please Check)

Diamond ($10,000 +)	Platinum ($5,000)	Gold ($2,500)
Silver ($1,000)		
OTHER AMOUNT:	OTHER DESCRIPTION:	
IN KIND VALUE:	IN KIND DESCRIPTION:	
WHERE/HOW WILL THE IN KIND BE USED?		

Desired Payment Method (Please Check)

CASH	CHECK	INVOICE ME	CREDIT CARD

Credit Card Info:

Name on Card	Card #	Exp	CCS#
Billing Address	City	State	Zip

Acknowledgements:

	I/We wish to have our gift remain anonymous (or)
	Please use the following name(s) in all acknowledgements:

SIGNATURE DATE

After your registration is complete, you will receive an invitation in the mail containing your event tickets and RSVP cards. The RSVP card will notate your meal choices at the event. **Please be sure to return them or contact us with your preference by the date noted on the card/invitation.**

Please make checks, corporate matches, or other gifts payable to: Moore County Health Foundation, PO Box 782, Dumas, TX, 79029, phone (806) 934-7811, e-mail mchf@mchd.net, Tax ID #75-2687992

Thank you for your support!

2025

SCHOLARSHIP Luncheon

Wednesday, May 14, 2025

Saints Peter & Paul Catholic Church
Community Room
915 S Maddox
12:00pm - 1:30pm

Event Speaker: Dr. Jamelle Conner

HEALTHCARE IS A WORK OF HEART!

Healthcare careers are some of the most crucial and in-demand careers in our nation.

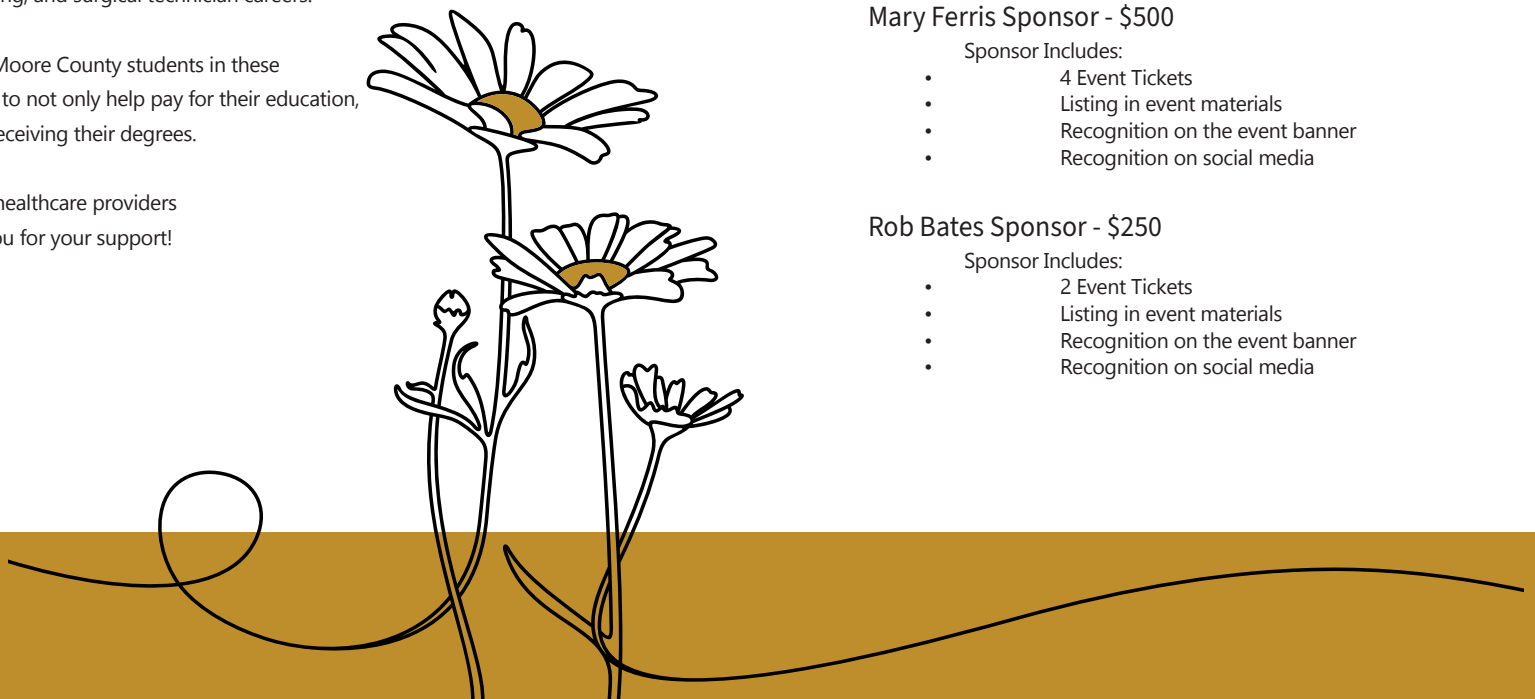
The Amarillo College - Moore County Campus RN program helps area students achieve their goals of becoming Registered Nurses without the stress of having to travel out of the county. It also provides new nurses the opportunity to develop their healthcare careers at organizations in their own community while remaining close to family and friends.

The Frank Phillips College LVN program has jump started many nursing careers in the area by providing a 1-year Licensed Vocational Nurse program. In 2019, the MCHF Board voted to include these LVN students in the scholarship program to make certain that more types of nurses are available to serve the Moore County community & surrounding areas.

In 2024, the MCHF Board voted to open the scholarship to Moore County students studying in other healthcare-related careers being offered at AC, Frank Phillips, and West Texas A&M University. These include therapy, lab, imaging, and surgical technician careers.

The MCHF Scholarship Luncheon supports Moore County students in these programs by raising money for scholarships to not only help pay for their education, but to help them stay close to home while receiving their degrees.

Please consider helping us grow our future healthcare providers by sponsoring our 2025 event! We thank you for your support!



SPONSORSHIP OPPORTUNITIES

Florence Nightingale Sponsor - $1,500

Sponsor Includes:

- 8 Event Tickets
- Premier placement in event materials
- Premier placement in event advertising
- Recognition on the event banner
- Recognition on the MCHF Website
- Recognition on social media

Clara Barton Sponsor - $1,000

Sponsor Includes:

- 6 Event Tickets
- Logo placement in event materials
- Logo placement in event advertising
- Recognition on the event banner
- Recognition on the MCHF Website
- Recognition on social media

Mary Ferris Sponsor - $500

Sponsor Includes:

- 4 Event Tickets
- Listing in event materials
- Recognition on the event banner
- Recognition on social media

Rob Bates Sponsor - $250

Sponsor Includes:

- 2 Event Tickets
- Listing in event materials
- Recognition on the event banner
- Recognition on social media

The Moore County Health Foundation
PO Box 786 | Dumas, TX 79029
(806) 934-7811
www.MooreCountyHealthFoundation.net

The proceeds raised from the Scholarship Luncheon will be used to provide Moore County residents with scholarships for Healthcare related programs at Amarillo College, Frank Phillips College, and WTAMU.

To date, the MCHF has awarded in excess of 440 Semester Scholarships to Moore County RN and LVN students attending the nursing programs at Amarillo College, Frank Phillips College, and WTAMU. This year, the MCHF has opened scholarships to other healthcare-related fields including therapy; lab, imaging, and surgical technician students.

Amarillo College
An Equal Opportunity Community College

Moore County Campus
1220 E. 1st St.
Dumas, Texas 79029
806-934-7220
www.actx.edu/Moore

MCHF Scholarship Luncheon Sponsor Form

Contact Name:	
Contact Phone:	

Sponsor Information (Please Print)

CONTACT NAME:
MAILING ADDRESS:
CITY:
STATE:
ZIP CODE:
E-MAIL:
PHONE:
ALT PHONE:
FAX:
ALTERNATE CONTACT NAME & NUMBER

Sponsor Level (Please Check)

Florence Nightingale ($1,500)		Clara Barton ($1,000)		Mary Ferris ($500)		Rob Bates ($250)	
OTHER AMOUNT:		OTHER DESCRIPTION					

Desired Payment (Please Check)

CASH	CHECK	INVOICE ME	CREDIT CARD

Credit Card Info:

Name on Card	Card #	Exp	CCS#
Billing Address	City	State	Zip

Acknowledgements:

	I/We wish to have our gift remain anonymous (or)
	Please use the following name(s) in all acknowledgements:

SIGNATURE	**DATE**

Please make checks, corporate matches, or other gifts payable to:
Moore County Health Foundation, PO Box 782, Dumas, TX, 79029, phone (806) 934-7811, e-mail mchf@mchd.net, Tax ID #75-2687992

The Moore County Health Foundation thanks you for your support!

THANK YOU

For your support and participation!

2025

Sporting Clays Tournament

Sponsor or Register to Participate online at:
www.MooreCountyHealthFoundation.net

OR

SCAN ME

JOIN US!

Moore County Health Foundation
PO Box 782
Dumas, TX 79029
(806) 934-7811
www.MooreCountyHealthFoundation.net

Moore County Crime Stoppers
700 S Bliss Ave
Dumas, TX 79029
(806) 935-8477
www.P3Tips.com/1066

Individual Shooter & Sponsor Opportunities Available

Lunch Provided

Moore County Health Foundation
2025
Moore County Crime Stoppers
Dumas, TX

Sporting Clays **Tournament**

6TH ANNUAL

SATURDAY, MAY 3RD
The Blue Ranch
3.5 miles south of Dumas on HWY 287
Dumas, TX 79029

Proceeds benefiting the Moore County Health Foundation & Moore County Crime Stoppers

The Sporting Clays Tournament

Single Shooter

SINGLE SHOOTER REGISTRATION

Ammunition provided to participants
Lunch provided to participants
Eye and ear protection required

Individual Shooter.....**$250**
Team of Four.....**$1,000**

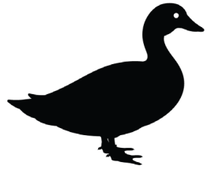
Sponsor Levels

DOVE LEVEL SPONSOR — **$1,000**

Recognition on scorecard
4 Shooter passes

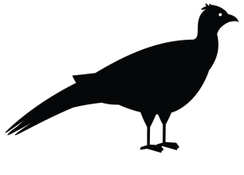
QUAIL LEVEL SPONSOR — **$2,500**

Recognition on scorecard
Recognition on event banner
6 Shooter passes



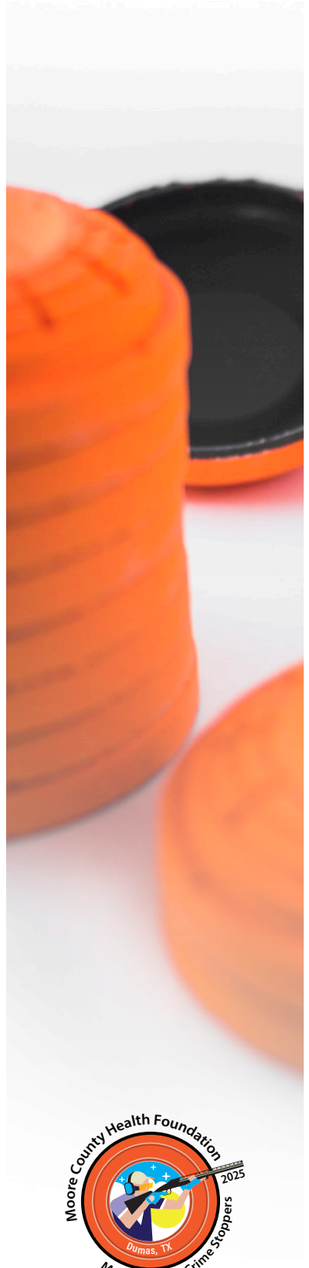
DUCK LEVEL SPONSOR — **$5,000**

Recognition on scorecard
Recognition on event banner
Recognition on MCHF website
8 Shooter passes



PHEASANT LEVEL SPONSOR — **$10,000**

Recognition on scorecard
Recognition on event banner
Recognition on MCHF website
Mention in all media materials
12 Shooter passes



Moore County Health Foundation
Dumas, TX
2025
Moore County Crime Stoppers
Sporting Clays Tournament

8:00am: Event Check Ins / Registration

9:00am: Tournament Begins

Lunch Provided After Course Completion

- Ammunition & Lunch Provided to Participants
- Pre-registration required / Space is Limited
- Hearing & Eye Protection Mandatory
- Hotel & RV Spaces available nearby
- Awards for best performance
- Guests welcome to watch for $10 (lunch included)

Proceeds of this event go towards:

◊ The Moore County Health Foundation will be purchasing a blanket/infusion warmer cabinet for the MCHD Women's Services department

◊ The Moore County Crime Stoppers will be using funds for operations and various projects

The Moore County Health Foundation

The Moore County Health Foundation promotes the Moore County Hospital District by improving community health care through fundraising, education, and support. Since its creation in 1996, the MCHF has served Moore County residents and has accomplished the following and more:

- Constructing an ambulance garage
- Purchasing new ambulances
- Purchasing mammography systems
- Upgrading CT scanner to low-dose
- Renovating the MNRC nursing home
- Scholarships for nursing students
- Purchasing anesthesia machines
- Providing breast cancer screening and equipment for the Moore County community
- A $2.3MM capital campaign for the hospital's new patient care addition
- More!

The Moore County Crime Stoppers

Established in July 1991 in Moore County Texas, Moore County Crime Stoppers is made up of a volunteer board and a law enforcement coordinator. Incorporated in 1994, Moore County Crime Stoppers currently serves all of Moore County and began serving Hartley County in 2021.

Moore County Crime Stoppers works diligently to empower, educate, and engage the community in important conversations about crime, public safety, and protecting our citizens. Reaching out to Moore County Crime Stoppers is safe and anonymous.

Moore County Health Foundation

MOORE COUNTY CRIME STOPPERS
HOTLINE 806-935-TIPS (8477)
www.P3tips.com/1066

2025 Sporting Clays Tournament
Blue Ranch Event Center ~ Dumas, TX 79029
Saturday, May 3, 2025 ~ 8:00am—12:00pm

Sponsorship Form

SPONSOR OR REGISTER ONLINE AT www.MooreCountyHealthFoundation.net

SCAN ME

I/We would like to sponsor the 2025 Sporting Clays Tournament

A. SPONSOR LEVELS (Please fill out Sections "C" & "D")

- ○ Dove Sponsor ($1,000)
- ○ Quail Sponsor ($2,500)
- ○ Duck Sponsor ($5,000)
- ○ Pheasant Sponsor ($10,000+)

B. OTHER DONATIONS (Please fill out Section "D" for recognition)

I would like to make a donation to support the event in the amount of $_____

C. SPONSOR / UNDERWRITER INFORMATION

Sponsor / Company Name:		
Contact Person:		
Address 1:	Address 2:	
City:	State:	Zip:
Contact Phone:	Contact Email:	

D. SPONSOR / UNDERWRITING PAYMENT INFORMATION

Type of Payment (circle one):	CASH	CHECK	INVOICE US	CREDIT CARD
For Credit Card Payments—Is this a company card? If so, please provide company name:				
Cardholder Name:				
Card Number:		Expiration Date:		Security Code:
Billing Address (if different from above):			State:	Zip:
Cardholder Signature:				

Please return this form to:	For more information on the MCHF:
Moore County Health Foundation	www.MooreCountyHealthFoundation.net
Attn: 2025 Sporting Clays Tournament	Phone: (806) 934-7811
PO BOX 782 ~ Dumas, TX 79029	The MCHF is a 501(c)(3) tax exempt organization #75-2687992
Please make checks payable to: The Moore County Health Foundation	*Donations made to the MCHF are tax-deductible to the extent allowed by law*

2025 Sporting Clays Tournament
Blue Ranch Event Center ~ Dumas, TX 79029
Saturday, May 3, 2025 ~ 8:00am—12:00pm

Shooter Registration Form

SPONSOR OR REGISTER ONLINE AT www.MooreCountyHealthFoundation.net

SCAN ME

I/We would like to participate in the 2025 Sporting Clays Tournament as a shooter!

A. SHOOTER REGISTRATION (Please fill out Sections "B" and "C")
Individual Shooter ($250/ each) QTY_____

B. PARTICIPANT INFORMATION					
FIRST NAME	**LAST NAME**	**CONTACT PHONE**	**CONTACT EMAIL**	**Rotation Preference (1 or 2)**	**Adult (16+) or Junior (–16)**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9					
10.					
11.					
12.					

C. PAYMENT INFORMATION FOR PARTICIPANTS				
Type of Payment (circle one):	CASH	CHECK	INVOICE US	CREDIT CARD
For Credit Card Payments—Is this a company card? If so, please provide company name:				
Cardholder Name:				
Card Number:			Expiration Date:	Security Code:
Billing Address (if different from above):			State:	Zip:
Cardholder Signature:				

Please return this form to:	For more information on the MCHF:
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Goal: To promote community service and MCHD's community reputation.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Encourage MCHD Leader participation in community activities. a. Promote community service opportunities	Bethany	→	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

MCHD Leadership Participation

GUIDELINES:

1. Only count non-paid, volunteer activities.

2. Only check National/State/Regional/Local Organization(s) if you actively participate or volunteer. You can only claim each organization once. For example:

- If you serve on a Board or committee, you must attend meetings/participate regularly.
- It does not count if you only pay dues to the organization. You may, however, list this in the credentials/ certifications field.
- If you are a member of a organization or Board, it counts as a single entry. Don't claim each individual Board meeting or conference you attend

3. Local Events: You must actively volunteer in the event. For example:

- Going to Dogie Days does not count
- Volunteering at a Dogie Days food stand does count

* You can count multiple local events that you volunteered for that were held by the same organization. For example:

- Volunteering for both the MCHF Harvest and the MCHF Luncheon would each count separately
- Volunteering to help with both the Lion's Club Dogie Days and the Lion's Club Craft Fair would each count separately
- Each time you give blood counts separately

Community participation may include, but is not limited to, the following:

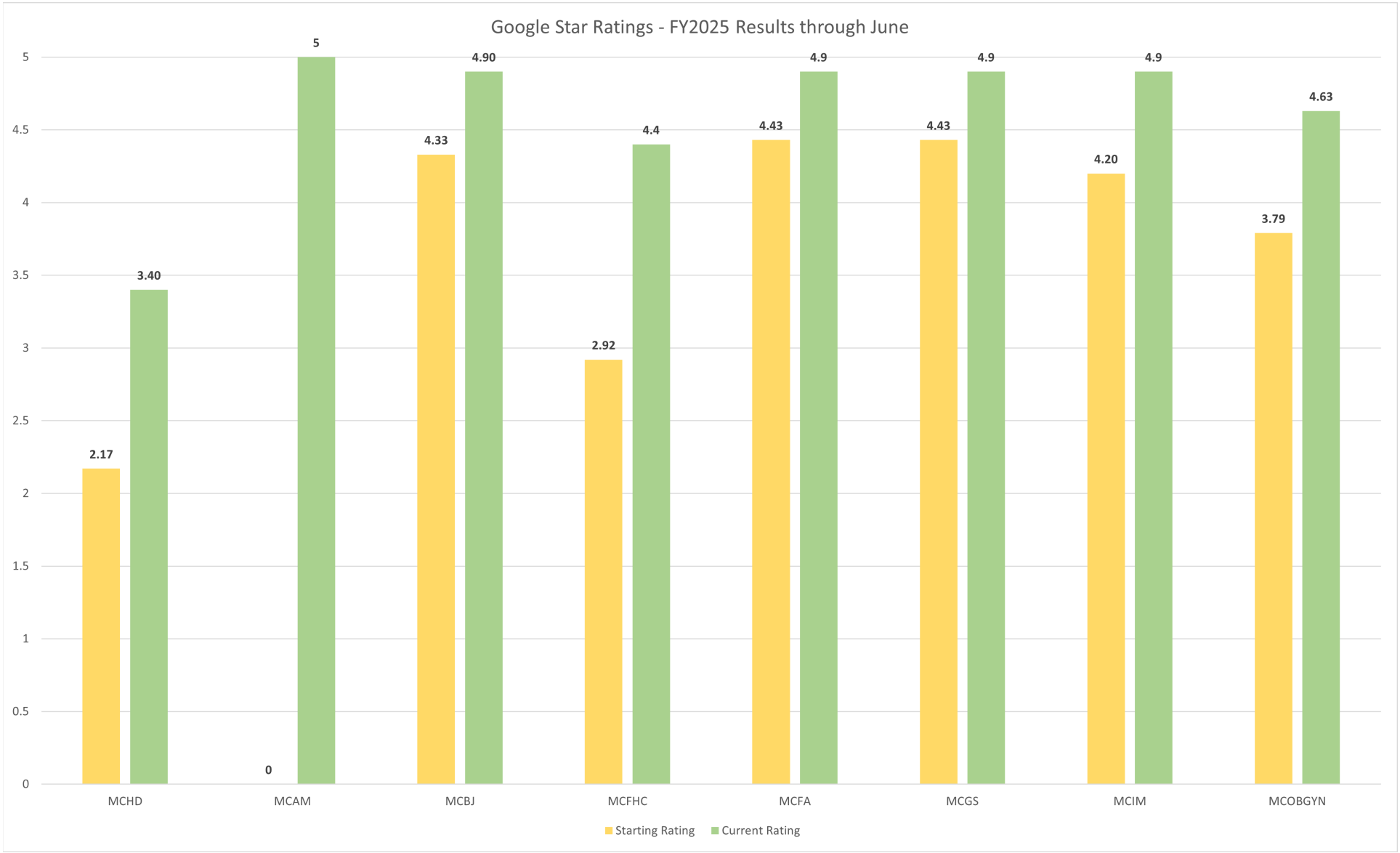
LOCAL ORGANIZATIONS	LOCAL EVENTS	REGIONAL ORGANIZATIONS & EVENTS	STATE/NATIONAL ORGANIZATIONS & EVENTS
• Meals on Wheel • Feeding Dumas • Lion's Club • Rotary Club • Moore County Chamber of Commerce • Moore County Chamber of Commerce Women's Division • Moore County Crimestoppers • Dumas Education & Social Ministries • Local Emergency Planning Committees • Moore Options (Care Net) • Moore County Child Welfare Board • Freedom Center (Safe Place) • CASA 69 • WIC • Uniting Parents • YMCA • Panhandle Children Foundation • Texas Ag Extension Advisory Committee • Dumas Downtown Association	• United Way Day of Caring • MCHF Sporting Clays • MCHF Luncheon • MCHF Harvest • Dogie Days Parade • Dogie Days BBQ • Dogie Days Midway (various) • Crime Stoppers Shop with a Cop • Relay for Life • TXT100 (YMCA) Rest Stop • Dumas Chamber BBQ Cook Off • Dumas Chamber Rodeo • Moore Options Block Party • Moore Options Back to School Drive • Snack Pack 4 Kids • Blood Donation • DESM Food Pantry Distribution	• RAC • PRPC • PONL • PHO • COHS • ACO • PCS • AC Advisory Board • Coffee Memorial Blood Council • Second Chance Foundation • Alzheimer's Walk	• TORCH • THA • THT • TSHHRAE • AORN • CISA • AONL • ASRHM • ACHE • TAHCH • TONL • HFMA • NAEMT

Goal: Increase community awareness & support of the District, Its Clinics and Services

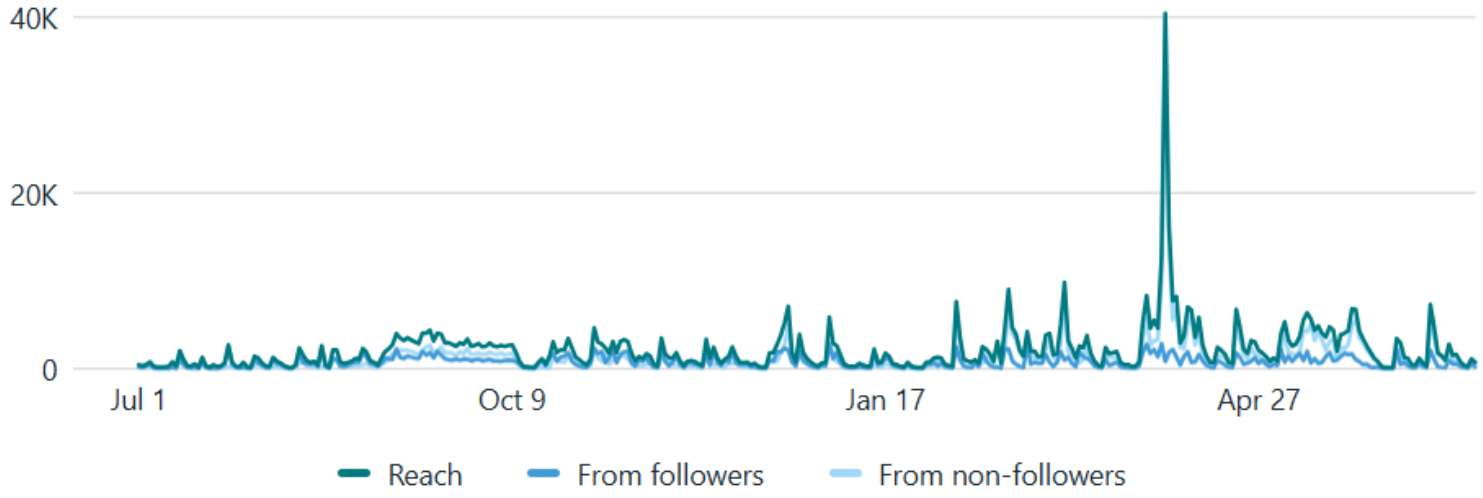
ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Continue monitoring MCHD's social ratings and governmental surveys to raise or maintain scores. Bring actionable items to committee for review/follow-up in conjunction with CLS initiative. Provide education as needed.	Ashley			
2. Continue initiative on social media integration to maintain public engagement while improving public perception of District and its services.	Ashley			
3. Develop cross media strategies focusing on customer-facing Strategic Plan initiatives including a hard push into secondary markets a. Inpatient Dialysis b. Physician Recruitment c. Mental Health Program d. New MOB e. Equipment upgrades f. CLS Initiative g. Employee Engagement Survey h. Workforce Development Program i. MCHF Events j. Community Service k. Awards	Ashley			
4. Spearhead conversion of all District websites to accommodate the inclusion of more community facing segments (blog/ vlog/ podcast/ newsletters/ educational videos, etc.)	Ashley			
5. Respond to changing District marketing initiatives as needed	Ashley			

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

GOOGLE STAR RATING PERFORMANCE – JULY 2024 THROUGH JUNE 2025



SOCIAL MEDIA PERFORMANCE – JULY 2024 THROUGH JUNE 2025



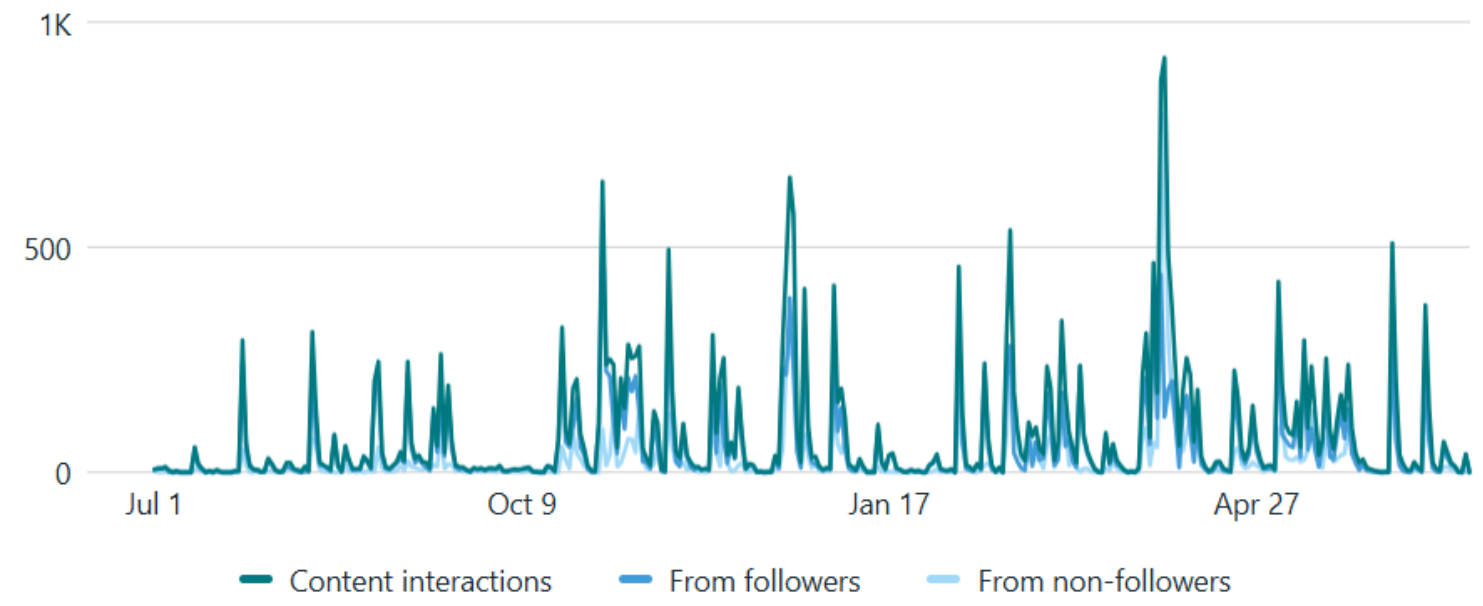
Reach breakdown

Jul 1, 2024 – Jun 24, 2025

Total
169,470 ↑ 27.6%

From followers
5,663 ↑ 8.1%

From non-followers
165,266 ↑ 28%



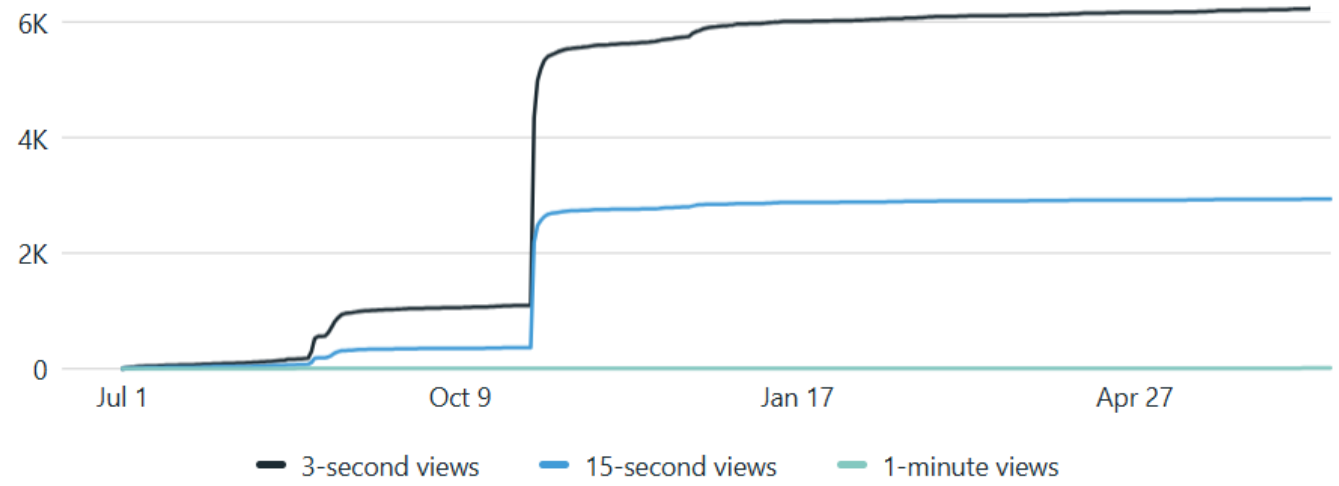
Interactions breakdown

Jul 1, 2024 – Jun 24, 2025

Total
29,346 ↑ 64.5%

From followers
19,058 ↑ 50.1%

From non-followers
10,288 ↑ 100%



47.1% 3s to 15s rate

15-second views

2,938

0.4% 15s to 1m rate

1-minute views

11

Published content

Based on up to 200 pieces of content

+6.5% vs. Jul 8, 2023 - Jun 30, 2024

Photos	186
Text	9
Videos	3
Links	2
Stories	0

Facebook reach

+27.6% vs. Jul 8, 2023 - Jun 30, 2024

Multi photo	120,798
Photos	70,992
Others	23,743
Links	16,840
Text	10,817
Videos	5,883
Multi media	70

Content interactions

+64.5% vs. Jul 8, 2023 - Jun 30, 2024

Photos	11,210
Multi photo	10,997
Others	5,460
Links	913
Videos	398
Text	368

MEDICAL STAFF

"Area Medical Staff is an integral part of the MCHD family"

1. Medical Staff Development
    a. MEC Leadership Conference
    b. Conduct Physician Engagement Survey (August 2025)
2. Deploy Chief Medical Officer Role
3. Implement Electronic Credentialing Software System

Goal: Promote medical staff relationships and leadership skills. Seek to grow Physician Engagement.

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Medical Staff Development: a. Leadership Development: Schedule MEC leaders to attend an annual Medical Staff Leadership conference b. Conduct Physician Engagement Survey (August 2025)	Dr. Apolinario/MEC Ashley	Dr. Tan/Jeff →	→	→

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

* Anticipate budgeted expense of around $30,000 to include travel and stipends.

Goal: Bring CMO Role into the decision-making structure of MCHD Administration and Medical Staff

ACTION STEPS	ESTIMATED COMPLETION			
	1st QTR	2nd QTR	3rd QTR	4th QTR
1. Deploy Role of Chief Medical Officer:	Jeff/Dr. Apolinario/MEC/Medical Staff	→		

Estimated Impact	2026	2027	2028
Capital Requests ($ in 000s)	$	$	$
Incremental Admissions			
Incremental Surgeries			
Incremental Clinic Visits			
Incremental OP Visits			
Incremental Net Revenue	$	$	$

Job Title: Chief Medical Officer (CMO)

Location: Dumas, TX

About Us: Moore County Hospital District is a Critical Access Hospital and the leading healthcare provider dedicated to serving the community of Dumas, TX, and surrounding rural areas. We are committed to delivering high-quality healthcare services with compassion, integrity, and excellence. Our team is comprised of dedicated professionals who strive to make a positive impact on the health and well-being of our patients.

Job Summary: The CMO will play a key role in providing strategic leadership and direction for medical affairs while ensuring the delivery of high-quality patient care. The ideal candidate will have a strong background in medicine, leadership, and healthcare management, with a passion for serving rural communities.

Responsibilities:

1. **Medical Leadership:**
    - Serve as a key liaison between Medical Staff, Administration, and the Board of Directors.
    - Collaborate with above to develop and implementation of medical policies, procedures, and protocols to ensure the delivery of high-quality patient care.
    - Provide medical expertise regarding need for personnel, equipment, supplies, services, and other resources.
    - Consult with CEO in matters related to contracted medical provider groups.
    - Participate in strategic planning and/or facilitate expansion of services.
2. **Quality Improvement:**
    - Collaborate with Administration, department leaders, and medical providers to improve clinical quality, patient safety, and patient outcomes.
    - Monitor and analyze clinical performance data to identify areas for improvement.
    - Develop and implement evidence-based quality improvement programs.
3. **Medical Staff:**
    - Oversee the credentialing and privileging process for Medical Staff and Advanced Practice Providers, ensuring compliance with regulatory requirements and hospital policies.
    - Provide assistance to elected Medical Staff leaders in carrying out their duties and responsibilities.
    - Mentor and guide Medical Staff in their professional development, fostering skills in leadership, administration, and clinical excellence.
4. **Provider recruitment, retention, and engagement:**
    - Assist with the development and implementation strategies for Provider recruitment and retention, with a focus on meeting the healthcare needs of the community.
    - Collaborate with the Medical Staff and Human Resources department to onboard Providers.
    - Develop a mentoring program for new Providers.
    - Foster a positive and supportive work environment to enhance Provider satisfaction and engagement.
5. **Regulatory Compliance:**
    - Ensure compliance with all federal, state, and local regulations related to medical practice, patient care, and healthcare operations.

- Stay informed about changes in healthcare regulations and standards and implement necessary changes to ensure compliance.

Qualifications:

- Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) degree from an accredited medical school.
- Board certification in a specialty relevant to hospital medicine.
- Current, unrestricted medical license in the state of Texas.
- Minimum of 5 years of clinical experience.
- Leadership experience.
- Excellent communication, interpersonal, and organizational skills.
- Proven, positive collaborative relationships with all stakeholders.
- Strong understanding of healthcare regulations, accreditation standards, and quality improvement principles.
- Experience in medical staff credentialing and privileging preferred.
- Located within the greater Moore County or Amarillo Area.

Accepted:

_____ _____

Ralph Apolinario, M.D. Date:

FORWARD THINKING

"5-10 Year Vision"

1. MCHD will construct a multispecialty rural health clinic facility: family practice, internal medicine, pediatrics, OB/Gyn. (2025 Growth #2)
2. MCHD will recruit and open a pediatrics practice (2025 Growth #2).
3. MCHD will become a telemedicine provider.
4. MCHD will seek opportunities to address mental health needs. (2025 Growth #1)
5. MCHD will pursue and develop an oncology program.
6. MCHD will expand local elder care options by either building or finding an investor for assisted living.
7. MCHD will seek opportunities to become a rural residency site.