

Executive Report Summary

8/14/2024

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Updates and New Items:

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 - **Tele-Hospitalist Program**
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- **Cardiopulmonary**

Update on our cardiopulmonary rehab department progress.

The cardiopulmonary department is off and running. Stephanie Drum is working the referral sources as well as reaching out through Janae as she serves in her new role as medical services coordinator. Through the department startup we have discovered processes and training that is required to offer a higher level of services as well as necessary equipment to better serve our patient population. The interrelated referrals such as referring these patients into our radiology department for cancer screening with David's new program is being developed through the sharing of information and brochures while our patients are here. We want to inform patients that are currently undergoing treatments here of other services that we have that they might benefit from is an excellent way to expand our market share in other areas aside from cardiopulmonary rehab. I am working with Dr. Schmidt and Dr Khaled's on the oversight supervisory contract which will work within Dr. Khaled's educational payback relationship she currently has with us. The increasing support for the program continues to show promise as our referrals continue to rise. Currently in the first 10 days we have seen X number of patients and have X number of referrals in process.

CP Rehab Update – Provided by Stephanie Drum, CPR Director

The first couple weeks of Cardiopulmonary Rehab have not gone off without a hitch but are picking up speed and we are so glad to be able to provide these services for our community. The group of girls we have staffing the department has been great at helping identify places that we can improve to help the patients flow through the department much smoother.

The first place we have identified is our admissions process we must go through for us to monitor them on the computer. The process currently consists of the girls having to place the monitor on the patient, taking a sticker and going over to the MSN monitor hub to admit them. The girls must be on the phone with someone in rehab so that they can print a first time EKG strip while at rest. They can then come back to rehab to sit and monitor the patients on a screen that mirrors the monitor hub, we cannot hear alarms on this monitor so someone must always be behind the counter watching the monitor. We also need to add training for other monitor techs to be able to watch monitors so that when the girls need a break or are gone, we have backup.

The second process we have noticed that needs improvement is the flow of patients through the gym. We cleaned out a room for initial patients to go in and go over folder and have initial measurements done. We need a second space for the flow of other patients coming in so that during hookup they are not out in the gym having to lift their shirts. We are working on cleaning out the other office for this purpose but are limited because line of sight is a big deal for monitoring the patients. We have ordered some convex mirrors so that we can see someone when they are on the other side of the wall in the gym.

We need to add an elliptical and another treadmill those alone will run us about \$2000 for those pieces of equipment. We are also looking at the ability to admit patients to monitoring over here in the gym but that will require a hefty price tag and a piece of equipment from Spacelabs so that we can have our own hub to admit to. We have a blind in the works to cover the skylight because during these hot summer days we have noticed the gym is about 15-20 degrees hotter than the rest of the hospital, we do have stand fans that are currently going however they are having a hard time keeping up with the heat. We are also looking at having some PT oversight to expand our services.

➤ **CT Down & Radiology Update**

Our radiology department experienced something unique two weeks ago last Friday when both our, elk cities, and Weatherford CT system went down. We are unsure if there was regional hack or what caused a trifecta of filing or skin each of our CT Systems. Weatherford was able to piece theirs back together swiftly while elk city and we took a little bit longer. The problem with our CT being down is it does affect all other areas of our business. ROR needed to go on cardiac divert because without a CT to provide images for diagnostic purposes for the cardiovascular system it is impossible to stabilize or treat a patient much less determined if we need to transfer to the city or to hold the patient for observation overnight under the council of a cardiologist. One good thing about this situation is that as of right now our CT system has been virtually rebuilt from the ground up to include software generators imaging program upgrades and interfaces between all pieces of the system. The team that came out of Dallas was beyond spontaneous as they arrived within hours of the phone call and worked through the first weekend and completely through the next weekend going back and forth accessing parts from all over the country as well as service representatives from Oklahoma City. Although no one could be happier with their response and efforts I have yet to receive their invoice. As we came back to full operation all EMS and facilities were notified that we are back online. Because we have not had the extra cash flow to bring our MRI system up and running at full speed, we rely heavily on our CT equipment to provide adequate diagnostics.

Overall Update Provided by David our Radiology Director

CT:

As of 8/8 I am awaiting the service ticket that will detail the specific issues, likely causes, and repairs that were incurred, but there were three main phases of the repair, computer repair, gantry communication issues, and X-ray production issues.

The processing computer had hard drives replaced and then was driven to Dallas to have the motherboard rebuilt by a specialist. The engineer drove back from Dallas Monday evening to reinstall the computer. This was Thursday night through Monday night.

1. Tuesday morning, after the computer repair was completed the communication issue was tackled. The CT software was reinstalled, and remote service was looped in to run diagnostics on the gantry. The engineer made a trip to OKC for parts and worked into Tuesday night.
2. Wednesday morning, we got our X-ray production diagnosis, and a filament control module was ordered and shipped overnight, and cathode assembly was located and placed on standby. It was hoped that the

much less expensive control module was the issue instead of the cathode assembly. Thursday morning after the control module was replaced, the problem was not solved. The CEO of the company drove to Dallas, picked up the cathode, delivered and installed it. We were able to go off of divert at 11 pm that night, after just over a week of being down.

US:

On August 6th we hosted a Samsung application specialist to perform training and very in-depth customization and optimization of the machine to meet our needs. We had two technologists attend training and we were able to scan two outpatients during the time she was here. The machine we purchased was a demo unit for Samsung, so it had every option and measurement turned on by default. The specialist was able to interview the techs, observe the exams and parse the multitude of options down to only what we need. This will be a huge quality of life improvement for users of the machine. Each tech also got several hours of 1 on 1 training to become much more familiar with the machine. Going forward this will allow techs to perform exams more efficiently, acquire better images, and allow us to expand our ultrasound coverage. One tech is a full-time employee who hasn't performed an ultrasound in two years due to our closing. This training has equipped her to be able to perform exams when she is here, which currently is three nights a week.

Future wants and needs:

MRI:

MRI has two needs: a reconstruction server and a dewar of liquid helium. The server is a holdover from the Alliance days, it was running off one hard drive and the week before we planned on opening the service it crashed. The repair for that is \$7000 and is an upgrade to replace the server. This will reduce scan times by nearly half and allow us to scan more patients in a day. We are just below the recommended level of helium to scan patients at. We were quoted two different amounts of helium bringing our total cost (including server repair) for MRI to \$21,000 or \$30,000 respectively.

Mammo:

The cheapest option that we have found to upgrade our machine to 3D mammograms, which is the industry standard is about \$82,000. The other option is to replace it, and that cost would run \$200,000 to \$300,000. We have not moved forward with reopening this department because we did not feel that it was worth the time or investment to offer subpar imaging to our patients.

Nuclear Medicine:

We have obtained our materials license allowing us to open that modality, we are currently establishing pricing through our GPO with the Cardinal nuclear pharmacy in OKC to establish what our costs will be to operate the department.

Service contracts:

As our CT issue has proven, service contracts for maintenance and emergency issues will be an important cost to consider going forward. A service contract will act as insurance to help offset costs when things go wrong and break. However, like insurance we will be spending money for something that we hope to not have to use except for annual service.

➤ **Financial Projections Update due to discoveries**

Well, I will let Rachel speak to the overall efforts processes and projections in the financial disclosure suffice it to say that an extraordinary effort has been put forth into determining what monies and the cleanliness of each money in the form of charges exist and have existed in each one of the quote UN quote buckets. Our weekly phone calls through bridge have become increasingly unproductive as the weeks have gone on. They have either chosen to not answer questions about age to accounts receivables, outstanding patient payments that have not been posted to accounts, and a plethora of other in general revenue cycle management questions. When they have been asked about these issues their answers are silence followed by, we will have to get with our team. I will defer to Rachel for discovery and projections at this point.

➤ **Trubridge – Action to Terminate**

the last 16 days have been interesting with no communication from true bridge evident or CPS I. Three business days ago Rachel and I requested a conversation with Teresa to determine if there are steps required to terminate the relationship at the end of 30 days. Recognize that Rachel's team has imported and staged all aspects of our revenue cycle and billing verticals. Some of which have already triggered claims for payment and or adjudication which would include write-offs and contractual allowances. But at this point we have heard nothing from management, sales, or anyone from any level of their organization. While we have seen some level of uptick in activity it has been unremarkable and does not change our position.

➤ **Recruitment of Providers and Key Staff Progress Report**

I continue to have conversations and work towards recruiting physicians in our marketplace, one of which has ended in them renewing a contract with their current employer with some level of hesitation. We will keep this position on our radar. Two other physicians continue to be in conversation as they wait to determine what can be offered to them in a current contractual relationship as well as a bonus or recruiting incentive.

➤ **Medicare Part B Process & Timeline**

For Medicare and Blue Cross and Blue Shield credentialing has been completed, the EDI process for filing claims has been completed and these claims or in the process of being triggered. An interesting note, even though that we told true bridge not to trigger these claims because we are working on credentialing, we were told during a conversation with Teresa from Trubridge that they had filed all these claims call upon further discussion it was clear that they simply moved them to yet another bucket. While this was no surprise it continues to be unmistakable evidence that they are incapable of performing even the smallest of processes. Rachel's team has triggered these claims.

➤ **Telehealth – Clinton, Arapahoe, and Taloga Public Schools**

Janae Chittum has transferred into her new role as medical services coordinator. We are excited about this role as it puts someone that is educated and remarkably familiar with our system with decades of experience onto the street to promote and build certain programs one of which is the telehealth program with our school system here in Clinton as well as Arapahoe and Taloga.

➤ **Community Telehealth**

Beyond that we are utilizing the telehealth platform to reach out to businesses and other entities in our market they offer the same program. This not only provides security for employers allowing their employees to take 10 minutes out of their workday to be treated and seen by a provider but it also provides stability in the workplace so the provider does not have to have absentees and can continue their workflow while increasing their productivity.

➤ **Tele-Hospitalist Program**

Janae also leads this setup process as I collaborate with both Carl and Jeff's group to secure coverage of the new hospitalist program. I will be deciding on the end of next week as to which group we do go with and begin the process of conversion and startup of the telephone specialist services. It must be noted that once this program is instituted, we can contact specialists in Oklahoma City or other areas to consult with our patients while on the floor. This is a great advantage as we can expand our service platform through this form of media.

➤ **Staff Realignment**

Recently we have decided to realign some of our key staff members to optimize their skill sets and the efficiency of hospital operations. As a reflection of this increased efficiency, we have recognized the decrease in overall staff costs by converting PRN nursing to full-time are in nursing. Further, Brendon is working with Anita Ford, the new director of our ER department, and assuring that all ER staff is cross trained for Med surge and all Med surge staff is cross trained to cover in the ER. This also increases our staff efficiencies by removing the isolation of our team to only work in one area.

➤ **REH – Rural Emergency Hospital**

Over the last couple of months, I have investigated the potential relicensing of Clinton Regional Hospital from a Med surge hospital offering full services to REH Designation. Most recently yesterday our entire leadership team sat through a two-hour information webinar explaining to us services that would have to be cut out for us to become and take advantage of the REH status. This in summary includes all inpatient services. Where we can designate a couple of our ER suites as observation we cannot admit patients into our Med surge floor for observation. This would also negate our potential to do swing bed, mental health, and Geri-psych. We continue to be in the process of evaluation but have not received a confirmation letter that states we can refile our 855 A to reflect a change in patient licensure, nor have we been given the authority to move forward with the state of Oklahoma to change our license designation. This designation also comes with an assured survey within nine months after we begin operating as an REH to assure that we comply with all criteria set forth in the REH grant guidelines. While there are opportunities to sub out to other companies carrying Medicare contracts and EIN numbers it would have to be done in such a way that partitions our first line service core while removing all other none granted services through an under a different organization carrying a different Medicare license and license number. Complicated but not impossible. The other caveat, if we are granted this status and move through the conversion process, it will take about 90 to 120 days to receive our first stipend check of \$276,167, which translates to \$3,314,000 per year. In summary, we will further discuss this option if it is established that we qualify.