FLORIDA DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH

GEORGE E WEEMS MEMORIAL HOSPITAL

FY18-19 FLEX GRANT PROGRAM CEO REPORT

April 17, 2019

TOPICS

Let's start with what's important to you

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MEDICARE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

The FLEX Program was established by the Balanced Budget Act (BBA) of 1997. Any state with rural hospitals can establish a FLEX Program and apply for federal funding.

- The Federal Office of Rural Health Policy (FORHP) provides the funding for the FLEX Program.

- FLEX funding is meant to encourage:
  - Development of cooperative systems of care in rural areas
  - Collaboration among CAHs, emergency medical service (EMS) providers, clinics and health practitioners to increase efficiencies and quality of care

- The FLEX Program requires states to develop rural health plans and funds their efforts to implement community-level outreach.

- **George E Weems Memorial Hospital** is one of twelve Florida Critical Access Hospitals (CAHs).

FLEX supports:

1. **Quality improvement**

2. **Financial and operational improvement**

3. Population health management and EMS integration

4. Designation of CAHs

5. Integration of innovative health care models

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CEO REPORT

The CEO Report presents the findings from the Onsite Assessment Visit and outlines recommendations for improving financial and quality performance measures.

Findings
Key take-aways from 3/27 Onsite Quality & Financial Assessment Visit and related follow up discussions

Analysis
Comparison of critical performance measures to a baseline and peer group based benchmarks

Recommendations
Actionable insights for improving financial and operational performance

Next Steps
Resources for acting on the presented recommendations

This CEO Report provides a detailed summary of the Quality & Financial Onsite Assessment Visit findings, a high-level analysis of Weems Memorial's financial health, and practical paths forward for improving the hospital's financial and operational performance.

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QUALITY ASSESSMENT

George E Weems Memorial Hospital
FY18-19 FLEX Program
April 17, 2019

COMMUNITY AND DEMOGRAPHIC DATA

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DEMOGRAPHICS: FRANKLIN COUNTY, FLORIDA

	Franklin County	*Florida*
TOTAL POPULATION	11,675	20,278,447
RACE AND ETHNICITY		
Hispanic or Latino of any race (%)	5.2	24.7
White alone (%)	82	75.7
Black or African American (%)	14.1	16.1
SEX AND AGE		
Male (%)	57.6	48.9
Female (%)	42.4	51.1
Median age (years)	44.3	41.8
20 to 24 years (%)	6.6	6.4
65 to 74 years (%)	16.1	10.7
75 to 84 years (%)	6.0	6.1

Source: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CommunityCensusProfile&pcid=001

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DEMOGRAPHICS: FRANKLIN COUNTY, FLORIDA

	Franklin County	Florida
POVERTY AND EMPLOYMENT		
Families under 100% of poverty (%)	*16.9*	*11.1*
People under 100% of poverty (%)	20.1	15.1
Civilian labor force unemployed (%)	7.9	7.2
EDUCATIONAL ATTAINMENT		
Less than High School (%)	5.3	5.1
Associate's Degree (%)	7.5	9.8
Bachelor's Degree (%)	11.2	18.2
Graduate or Professional Degree (%)	7.3	10.3
Median Household Income (dollars)	41,267	50,883
HEALTH INSURANCE COVERAGE		
Non-institutionalized no health insurance coverage (%)	*18.9*	*14.9*
Under 18 years, no health insurance	12	8.5
Employed 18 to 64, no health insurance coverage (%)	26.5	19.5
Civilian Noninstitutionalized Population, with disability (%)	20.4	13.4

Source: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CommunityCensusProfile&pcid=001

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COUNTY HEALTH RANKINGS & ROADMAPS

- RWJF (Robert Wood Johnson Foundation) publishes County Health Rankings annually.

- The County Health Rankings use an evidence-based tracking and ranking system.

- The County Health Rankings are a widely accepted resource used by communities across the Nation to help drive community improvement efforts.

PROVIDERS PER POPULATION

CLINICAL CARE	Franklin	Best in US	Florida
Ranking	45/67		
Primary care physicians (population/providers)	3,970:1	1,050:1	1,390:1
Dentists	3,910:1	1,260:1	1,700:1
Mental health providers	1,680:1	310:1	670:1

All of Franklin County is designated by HRSA as a Health Professional Shortage Areas (HPSAs), indicating that Franklin County is lacking primary care, dental, and mental health provider or services

http://www.countyhealthrankings.org/app/florida/2018/rankings/franklin/county/outcomes/overall/snapshot
https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx

CLINICAL CARE: FRANKLIN COUNTY

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

CLINICAL CARE	Franklin	Best in US	Florida
Preventable hospital stays: (rate per 100,000 Medicare enrollees) • Diabetes • Chronic obstructive pulmonary disease and asthma, • Hypertension, heart failure • Dehydration, • Bacterial pneumonia and urinary tract infection	4,520	2,765	5,066
Mammography screening	34%	49%	42%
Flu vaccinations	26%	52%	41%

Hospitalization ambulatory-care sensitive conditions, which are diagnoses treatable in outpatient settings, suggests that the quality of care provided in the outpatient setting was less than ideal. This measure may also represent a tendency to overuse hospitals as a main source of care. Preventable Hospital Stays could be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care-sensitive conditions primarily as a proxy for access to primary health care.

Mammography Screening is the percentage of female fee-for-service (FFS) Medicare enrollees, ages 65-74, that receive an annual mammogram.

Flu Vaccinations is the percentage of fee-for-service Medicare enrollees that had a reimbursed flu vaccination during the year.
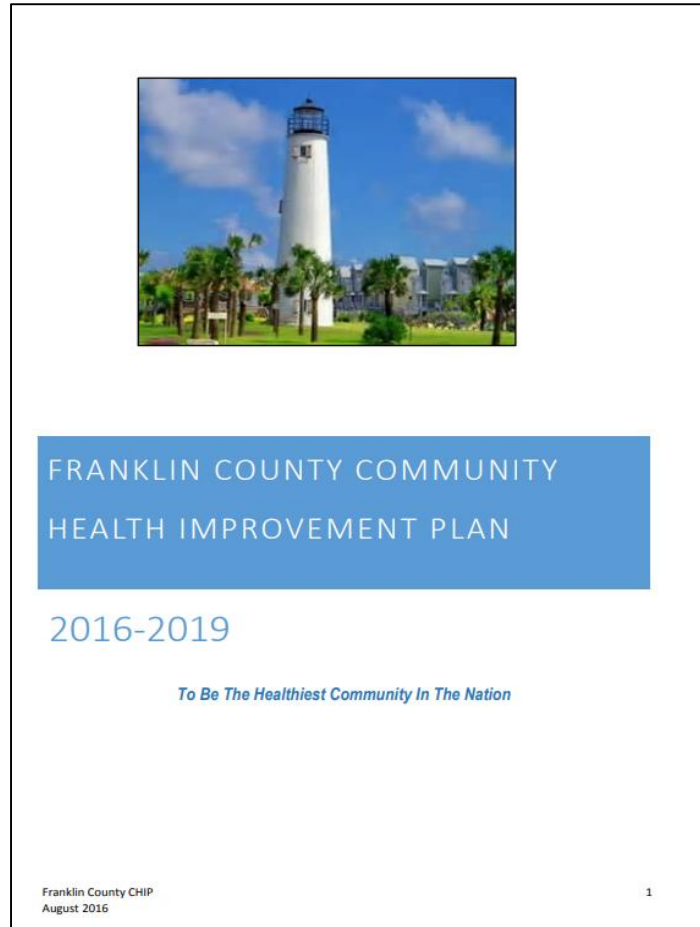
http://www.countyhealthrankings.org/app/florida/2018/rankings/franklin/county/outcomes/overall/snapshot

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HEALTH BEHAVIORS: FRANKLIN COUNTY

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

HEALTH BEHAVIORS	Franklin	Best in US	Florida
Ranking	**53/67**		
Adult smoking	18%	14%	15%
Adult obesity	34%	26%	27%
Physical inactivity	31%	19%	25%
Access to exercise opportunities	88%	91%	88%
Excessive drinking	25%	13%	18%
Motor vehicle death with alcohol involvement	36%	13%	25%
Sexually transmitted infections (per 100,000)	323.1	152.8	467.4
Teen births (per 1,000)	63	14	23

http://www.countyhealthrankings.org/app/florida/2018/rankings/franklin/county/outcomes/overall/snapshot

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County-State Profile Franklin County, Florida 2015- 2017

Indicator	Measure	COUNTY	STATE
Deaths			
Age-Adjusted All Causes 3-Year Death Rate	Age-adjusted Death Rate	820.7	685.2
All Causes Years of Potential Life Lost Under 75	Rate per 100,000 Population < 75	9784.1	7815.5
Total Tobacco-Related Cancer Deaths to Persons 35 and Over	Rate per 100,000 Population > 35	198.2	167.4
Chronic Diseases			
Age-Adjusted Coronary Heart Disease 3-Year Death Rate	Age-adjusted Death Rate	81.5	95.2
Age-Adjusted Stroke 3-Year Death Rate	Age-adjusted Death Rate	34.4	38.7
Age-Adjusted Diabetes 3-Year Death Rate	Age-adjusted Death Rate	28.6	20

http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyChronicDiseaseProfile

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COMMUNITY HEALTH IMPROVEMENT PLAN

FRANKLIN COUNTY COMMUNITY
HEALTH IMPROVEMENT PLAN

2016-2019

To Be The Healthiest Community In The Nation

Franklin County CHIP
August 2016   1

A community health improvement plan, or CHIP, is strategic listing of priority health areas with targeted outcomes and measurable indicators. The CHIP reflects the findings of the community health assessment (CHA), which is the foundation for improving and promoting the health of community members.

Franklin County CHIP Goals:
- Improve awareness of mental health/substance abuse services
- Reduce alcohol consumption among youth and adults in Franklin County
- Increase access to pediatric care in Franklin County
- Increase access to oral health care in Franklin County
- Increase the healthy weight of adults and children in Franklin County

http://franklin.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/community-health-improvement-plan/_documents/Franklin_County_CHIP_8-30-2016.pdf

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QUALITY DATA: WEEMS & PEERS

2017 Core Medicare Beneficiary
Quality Improvement Project (MBQIP)
Measures

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Patient Safety & Inpatient				George E. Weems Memorial							
HCP (formerly OP-27)	-	96%	71%	-	-	87%	-	87%	-	78%	87%	66%
IMM-2	-	-	96%	96%	-	-	-	-	-	95%	100%	100%
CDC NHSN	-	-	-	-	-	-	-	-	-	-	-	-
ED-1	-	-	240 Mins	236 Mins	-	-	-	217 Mins	-	276 Mins	305 Mins	228 Mins
ED-2	-	-	53 Mins	48 Mins	-	-	-	25 Mins	-	60 Mins	118 Mins	86 Mins
Patient Engagement												
No. of Completed HCAHPS Surveys	-	92	128	-	-	< 50	-	-	< 50	171	191	-
Care Transitions												
EDTC-1	98%	99%	98%	-	-	100%	98%	100%	100%	-	-	61%
EDTC-2	92%	99%	94%	-	-	100%	83%	100%	100%	-	-	100%
EDTC-3	100%	99%	92%	-	-	100%	100%	100%	99%	-	-	97%
EDTC-4	99%	99%	88%	-	-	100%	100%	100%	100%	-	-	96%
EDTC-5	99%	99%	99%	-	-	100%	100%	100%	99%	-	-	100%
EDTC-6	99%	99%	94%	-	-	100%	100%	100%	100%	-	-	83%
EDTC-7	100%	99%	93%	-	-	100%	100%	100%	100%	-	-	100%
All - Composite	90%	98%	84%	-	-	100%	82%	100%	98%	-	-	47%
Outpatient												
OP-2	-	-	-	-	-	-	-	-	-	-	-	-
OP-3	-	-	-	-	-	-	-	-	-	-	-	-
OP-5	-	-	5 Mins	-	-	22 Mins	-	-	-	6 Mins	8 Mins	5 Mins
OP-18	-	-	115 Mins	-	-	123 Mins	-	-	-	131 Mins	113 Mins	100 Mins
OP-22	-	-	1	-	2	1	-	-	-	2	-	0

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety/Inpatient	Patient Engagement	Care Transitions	Outpatient
Core MBQIP Measures	**HCP (formerly OP-27):** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **IMM-2*:** Influenza Immunization for inpatients **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey **Inpatient ED Measures:** • **ED-1*:** Median Time from ED Arrival to ED Departure for *Admitted* ED Patients • **ED-2:** Admit Decision Time to ED Departure Time for *Admitted* Patients	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management† • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *7 sub-measures; 27 data elements; 1 composite* • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • **All-EDTC:** Composite of All 27 data elements	**Chest Pain/AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention • **OP-5‡:** Median Time to ECG **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

*Inpatient measures IMM-2 and ED-1 are being removed by the Centers for Medicare & Medicaid Services (CMS) following submission of Quarter 4 2018 data. State Flex programs may continue to support hospitals with these as additional measures after this

†Pain Management HCAHPS questions are being removed by CMS beginning with Quarter 3 2019 surveys.

‡Outpatient measure OP-5 is being removed by CMS following submission of Quarter 1 2019 data.

QUALITY ASSESSMENT RECOMMENDATIONS

Quality Programs, Observations, and Opportunities

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EDTC REPORTING

EDTC measures are collected and reported by critical access hospitals (CAHs) as part of the Medicare Beneficiary Quality Improvement Project (MBQIP).

Emergency Department Transfer Communication (EDTC):
- Small rural hospitals frequently transfer a higher proportion of emergency department (ED) patients than larger urban facilities.
- It is the goal of MBQIP to help hospitals improve care transitions, including ED transfers, to reduce preventable hospital readmissions and adverse events in hospitals.

Current Process at Weems: EDTCs are reported. However, the process is labor intensive.

Suggestion: Work with EHR Vendors to streamline the process. Reach out to Robyn Carlson:

Robyn Carlson, RHIA, CPHQ
Quality Reporting Specialist
Stratis Health
952-853-8587
rcarlson@stratishealth.org

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OUTPATIENT REPORTING

The purpose of outpatient reporting is to stimulate and support a significant improvement in the quality of hospital outpatient care.

There are 4 measures included in outpatient reporting:

1. Fibrinolytic Therapy Received within 30 minutes (OP-2)
2. Median Time to Transfer to another Facility for Acute Coronary Intervention (OP-3)
3. Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)
4. Patient Left Without Being Seen (OP-22)

Reporting aims to refine and standardize hospital outpatient data collection, data transmission, and performance measures in order to construct one robust, prioritized, and standard quality outpatient measure set for hospitals.

Current Process at Weems: Data is collected on all metrics. For some metrics, the volume is very low (OP-2).

Suggestion: Work with HSAG representative to streamline reporting process. Reach out to:

Sophia Cherry, RPh, MPH
Senior Community Program Specialist
Health Service Advisory Group (HSAG)
813.865.3197
scherry@hsag.com

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INPATIENT/PATIENT SAFETY

Similar to all reporting, inpatient measures are designed to standardize reporting and improvement.

There are 3 measures for inpatient quality assessment:

1. Influenza Vaccination Coverage Among Healthcare Personnel (HCP; formerly OP-27)
2. Admit Decision Time to ED Departure Time for Admitted Patients (ED-2)
3. Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey

Current Process at Weems: Data is collected influenza vaccination among providers and ED-2. Antibiotic Stewardship not reported.

Suggestion: Work with HSAG representative to streamline inpatient process. Reach out to:

Sophia Cherry, RPh, MPH
Senior Community Program Specialist
Health Service Advisory Group (HSAG)
813.865.3197
scherry@hsag.com

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ANTIBIOTIC STEWARDSHIP

All resources are available at:
https://www.cdc.gov/nhsn/acute-care-hospital/aur/index.html

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HCAHPS ASSESSMENT

HCAHPS is a patient satisfaction survey required by CMS (the Centers for Medicare and Medicaid Services) for all hospitals in the United States.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):
- The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology.
- The survey is for adult inpatients, excluding psychiatric patients.
- HCAHPS are important because responses represent the "voice of the patient" and the results are public.

Current process at Weems: Surveys are provided and collected upon discharge. The survey used by Weems is very similar to the approved HCAHPS survey. An initial analysis of previous results over the past 2 years indicates that Weems would score well if survey results were reported. However, the current collection methodology used by Weems is not acceptable for reporting.

Suggestion: Continue to explore the possibility of reporting HCAHPS measures.

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PARTNERSHIP IS KEY

Issue	Support Data	Partnership
Tobacco Use	18% of Franklin County Adults report using tobacco, 3% higher than the Florida average; The tobacco related cancer death rates are higher than the Florida average rate.	Partnership with Tobacco Free Florida and Big Bend AHEC
Diabetes Community Care	Diabetes death rate higher than Florida average (28.6 vs. 20.0)	Partnership with Florida Department of Health (Bureau of Chronic Disease Prevention), Big Bend AHEC, and HSAG
Excessive drinking and Motor vehicle death with alcohol involvement	Franklin County rates of reported excessive drinking and accidents are much higher than the state average.	Franklin County Department of Health. Reduction of alcohol use is a priority in the CHIP plan.
Provider shortages	HRSA healthcare provider shortage area.	DOH, Health Service Corp.
Prevention (flu shots and mammography)	RWJF report; Florida Charts data	Franklin County Health Department; DOH

FINANCIAL ASSESSMENT

George E Weems Memorial Hospital
FY18-19 FLEX Program
April 17, 2019

FINANCIAL DATA: WEEMS & PEERS

2017 & 2018 Core Financial Indicator Measures

Indicator	Your '17 Value	Your '18 Value	Benchmark	'17 US Median	'17 Your Peers	'17 FL CAH Median
Profitability						
Total Margin	-0.62	2.01	3	1.78	-3.82	-2.15
Cash Flow Margin (%)	-30.29	-29.34	5	6.08	-0.58	2.89
Operating Margin (%)	-34.08	-32.14	2	0.23	-6.2	-6.64
Return on Equity (%)	-1.36	4.88	4.5	4.35	-5.21	16.05
Liquidity						
Current Ratio (times)	1.44	1.27	2.3	2.53	3.05	1.50
Days Cash on Hand	24.81	35.25	60	77.18	51.47	24.81
Days Revenues in Net AR	92.37	73.59	53	50.74	52.01	42.66
Capital Structure						
Equity Financing (%)	65.38	62.22	60	59.21	72.67	30.23
Debt Service Coverage (times)	32.79	-	3	3.74	5.46	3.53
LT Debt to Capitalization (%)	N/A	0	25	31.28	13.7	61.75
Revenue						
Medicare OP Cost to Charge (times)	46.88	-	55	43.86	54.43	25.08
Cost						
Average Age of Plant (years)	7.34	9.01	10	10.97	9.51	9.63
FTEs per Adjusted Occupied Bed	7.46	8.44	-	5.49	5.38	3.42
Average Salary per FTE/ Salaries to Net Pt Revenue	$40,764.97/ 65.71	$44,021.22/ 64.80	-	$57,906.25/ 44.95	$46,258.87/ 57.55	$57,470.05/ 45.42
Utilization						
Average Daily Census Swing-SNF Beds	0.26	0.11	-	2.04	1.03	4.12
Average Daily Census Acute Beds	1.09	0.93	-	3.1	0.78	4.29

Peer Group Criteria: <10m Patient Revenue Category, No LTC, Yes RHC, Government Owned

YEAR TO YEAR CHANGES

From 2017 to 2018, Profitability indicators were trending in the right direction. However, Current Ratio and Equity Financing measures were moving in the wrong direction.

Positive Trends	
Total Margin	Increased from -0.62 to 2.01
Cash Flow Margin	Increased from -30.29 to -29.34
Operating Margin	Increased from -34.08 to -32.14
Return on Equity	Increased from -1.36 to 4.88
Days Cash on Hand	Increased from 24.81 to 35.25
Days Revenue in Net AR	Decreased from 92.37 to 73.59

Negative Trends	
Current Ratio	Decreased from 1.44 to 1.27
Equity Financing	Decreased from 65.38 to 62.22

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George E Weems Memorial
2017 Florida CAH Percentiles

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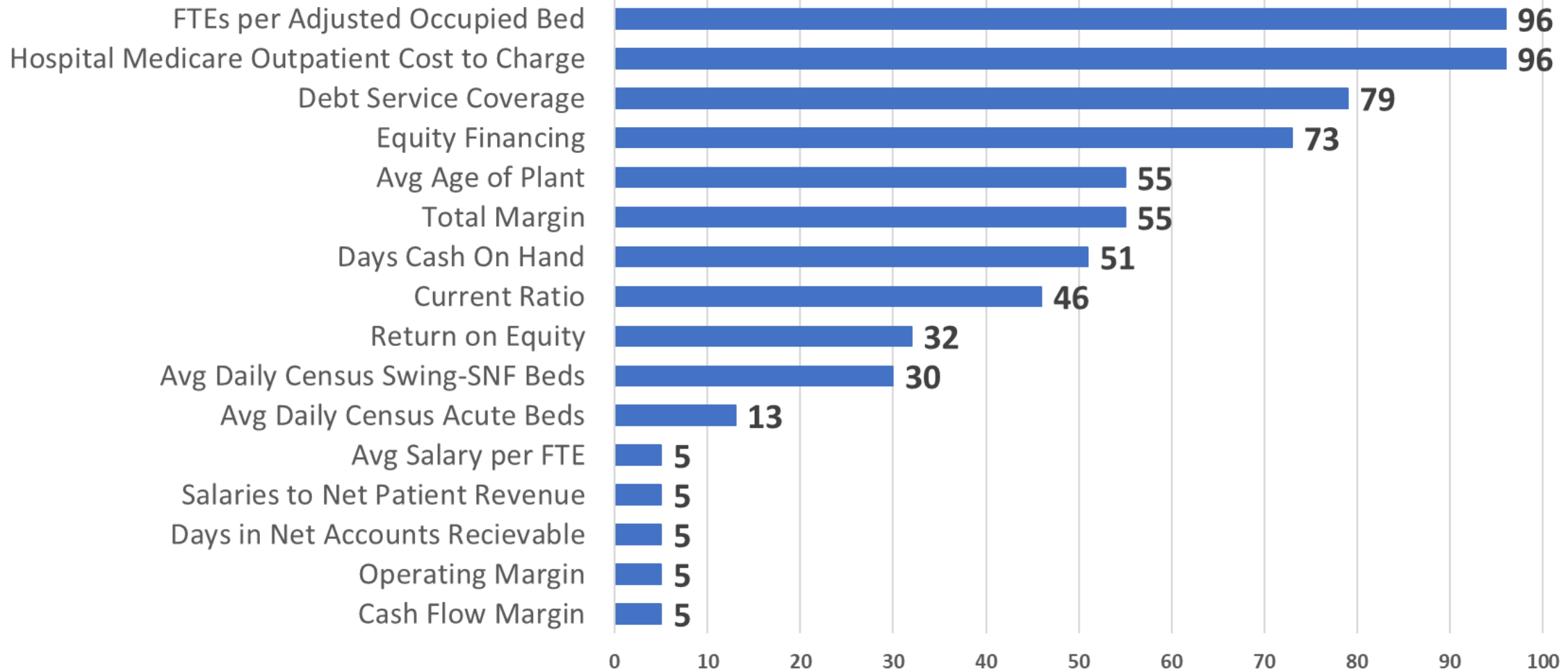
DAYS CASH ON HAND

Days Cash on Hand measures the number of days an organization could operate if no cash was collected or received.

- **Observations:**
  - Increased from last year, but remains low
  - About 50% of the benchmark
  - Below national median, but above FL CAHs

- **Considerations & Recommendations:**
  - Analyze billing and collection procedures, including making financial payment arrangements or doing financial counseling before discharge
  - Pay attention to consultant's suggestions related to coding procedures, charge master change rollout, and clean claim rate

Path Forward:

- ✓ Speak to Lake Butler Hospital CFO

- ✓ Connect with Madison County Memorial leadership

- ✓ Document successes

Cash + Temporary investments + Investments / (Total expenses-Depreciation) / Days in period

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FTEs PER ADJUSTED OCCUPIED BED

FTEs per Adjusted Occupied Bed measures the number of full-time employees per each occupied acute care bed.

- **Observations:**
  - Increased from last year, and remains high
  - Above national median and FL CAHs

- **Considerations & Recommendations:**
  - Very high values may indicate low volume and a potential opportunity to evaluate staff productivity

Path Forward:

✓ Connect with Hendry Regional Medical Center or with Northwest Florida Community Hospital to talk about staffing efficiency levels and how this is monitored and altered to control costs

Number of FTEs / (Inpatient days - NF swing days - Nursery days) * (Total patient revenue / (Total inpatient revenue - inpatient NF revenue - Other LTC revenue)) / Days in period

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AVERAGE DAILY CENSUS – SWING/SNF BEDS

Average Daily Census – Swing/SNF Beds measures the average number of swing beds occupied per day.

- **Observations:**
  - Decreased from last year, and remains low
  - Below national median and FL CAHs

- **Considerations & Recommendations:**
  - Drive swing bed census levels up as much as possible
  - Increase swing bed availability
  - Promote swing bed options and partnerships with other hospitals
    - Target rehabilitation centers

Path Forward:

- ✓ Formalize an MOU with Tallahassee Memorial Hospital

- ✓ Reach out to Lake Butler Hospital, Northwest Florida Community Hospital, or Wauchula about ways to promote swing bed services in the community

SNF swing-bed days/ Days in period

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FINANCIAL ASSESSMENT RECOMMENDATIONS

Financial Measures, Observations, and Opportunities

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RECOMMENDED NEXT STEPS

1 Connect with Lake Butler and Madison County Memorial Hospital Leadership for **collection procedure best practices**

2 Reach out to Hendry Regional Medical Center or Northwest Florida Community Hospital about **monitoring staffing efficiency levels to control costs**

3 Formalize swing bed program with Tallahassee Memorial Hospital by **executing a MOU**
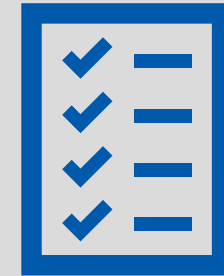
4 Document successes coming out of charge master review and **share lessons learned with other CAHs**

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APPENDIX

MBQIP DATA REPORTING REMINDERS

Upcoming Data Submission Deadlines

April 30, 2019
Emergency Department Transfer Communication (EDTC)
Patients seen Q1 2019 (January, February, March)
Submission process directed by state Flex Program

May 1, 2019
CMS Population and Sampling (optional)*
Patients seen Q4 2018 (October, November, December)
Inpatient and outpatient
Entered via the Secure Portal on QualityNet

May 1, 2019
CMS Outpatient Measures:
Patients seen Q4 2018 (October, November, December)
CMS Hospital Outpatient Reporting Specifications Manual version 11.0b
Submitted to the QualityNet warehouse via CART or by vendor
CART version – 1.17

May 15, 2019
CMS Outpatient Web-based Measures:
Includes measure OP-22: Patient Left Without Being Seen – full calendar year 2018
CMS Hospital Outpatient Reporting Specifications Manual version 11.0b
Entered via the Secure Portal on Quality Net

May 15, 2019
CMS Inpatient Measures:
Patients seen Q4 2018 (October, November, December)
CMS Hospital Inpatient Reporting Specifications Manual version 5.4a
Submitted to the QualityNet warehouse via CART or by vendor
CART version – 4.22

May 15, 2019
Healthcare Personnel Influenza Vaccination – HCP/IMM-3 (formerly OP-27)
For data October 1, 2018 – March 31, 2019
Submitted through the National Healthcare Safety Network (NHSN)

MBQIP Data Reporting Reminders: For use by Flex Programs in helping CAHs with quality data reporting by reminding them of upcoming data submission deadlines, corresponding collection time periods, and submission tools. The Reporting Reminder Template can be found here:
https://www.ruralcenter.org/tasc/resources/mbqip-data-reporting-reminders.

*Population and sampling refers to the recording of the number of cases the hospital is submitting to the QualityNet warehouse, this is done directly thru the QualityNet Secure Portal.

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RESOURCES

- **CAHMPAS Data Query Tool**
  - ✓ Critical Access Hospital Measurement and Performance Assessment System
  - ✓ Website: http://www.flexmonitoring.org/cahmpas/
  - ✓ Includes a tutorial for accessing comparison data
  - ✓ Login by scrolling to bottom of page
  - ✓ Obtain logins from your Flex Coordinator

- **National Rural Health Resource Center**
  - ✓ Website: https://www.ruralcenter.org/tasc/flex

- **Flex Monitoring Team**
  - ✓ Website: http://flexmonitoring.org

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BENCHMARKS

Why were these benchmarks created?

- Benchmarks are a key component of many performance measurement systems because they help to identify good financial performance and provide specific targets for improvement. CAH Chief Executive Officers (CEOs) and Chief Financial Officers (CFOs) are most knowledgeable about the financial management of CAHs. When the 3rd issue of the CAH Financial Indicators Report was distributed in Summer 2006, CEOs and CFOs were asked to complete a questionnaire about benchmarks for five key financial indicators. A benchmark was defined as a high but attainable level of financial performance by CAHs. *By April 11, 2007, 192 CAH CEOs and CFOs completed the questionnaire, and these responses were used to create benchmarks for five of the indicators* included in the 5th issue of the CAH Financial Indicators Report issued in Summer 2007. After they downloaded the 4th issue for their facility, CEOs and CFOs were prompted to complete an on-line questionnaire about the five benchmarks. Respondents were asked whether each benchmark was "much too low," "too low," "about right," "too high," or "much too high." The vast majority of respondents considered each of the benchmarks "about right," so the benchmarks were retained for the 5th issue of the CAH Financial Indicators Report. This method was repeated in 2011 to create benchmarks for seven additional indicators.

- *The intent of the benchmarks is to provide a relevant and useful basis to assess the financial performance and condition of CAHs. Medians change over time but benchmarks provide a constant basis on which to judge financial performance and condition.*

How were benchmarks created?

The median proposed benchmark value was used to create benchmarks. For some indicators, CEOs and CFOs of hospitals in different peer groups varied in their proposed benchmark values. However, in general, proposed benchmark values were not systematically influenced by whether a respondent's hospital historically performed well or poorly on the twelve indicators.

What should be kept in mind when evaluating hospital performance against benchmarks?

- There is year-to-year variation in indicator values.
- Capital projects, medical staff changes, and other circumstances may affect your hospital's value.
- Errors or other data quality problems may be present in the Medicare Cost Report submitted by your hospital.
- Few hospitals perform better than benchmark on all twelve indicators.

Source: CAH Financial Indicators Report Team (2015) CAH Financial Indicator Report 12th Issue. Chapel Hill, NC.

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PROFITABILITY INDICATORS:

Total Margin = Net income / Total revenues

- ➢ Total Margin measures the control of expenses relative to revenues. A positive value indicates total expenses are less than total revenues (a profit). Very high positive values may indicate higher patient volumes, which drive down the cost per unit of service. A negative value indicates total expenses are greater than total revenues (a loss). Very high negative values may indicate financial difficulty.

Cash Flow Margin= Net income - Contributions, investments and appropriations + Depreciation expense + Interest expense /Net patient revenue + Other income - Contributions, investments and appropriations

- ➢ Cash Flow Margin measures the cash inflow per dollar of revenue from providing patient care services. A positive value indicates cash outflows are less than cash inflows. A negative value indicates cash outflows are greater than cash inflows.
  - ▪ Data Quality/Exclusion Criteria: There may be variations in non-cash items included in net income. Hospitals with net patient revenue, other income, and contributions, investments, and appropriations that sum to zero were excluded from the calculation of medians.

Operating Margin= Net patient revenue + Other revenue – Total operating expenses/ Net patient revenue + Other revenue

- ➢ Operating Margin measures the control of operating expenses relative to operating revenue (net patient and other revenue). A positive value indicates operating expenses are less than operating revenue (an operating profit). Very high positive values may indicate higher patient volumes, which drive down the cost per unit of service. A negative value indicates operating expenses are greater than operating revenues (an operating loss). Very high negative values may indicate financial difficulty.
  - ▪ Data Quality/Exclusion Criteria: Operating margin can be calculated in different ways. Given the data constraints of the Medicare Cost Report, the definition used in this report is the best match between operating revenues and operating expenses. For a full explanation, see Flex Monitoring Team Briefing Paper 17: Differences in Measurement of Operating Margin (FMT Briefing Paper Number 17).

Return on Equity= Net income / Net Assets

- ➢ Return on Equity measures the net income generated by equity investment (net assets). In a not-for-profit entity, the equity represents the sum of federal, state, and local grants, contributions, and the accumulated earnings of the hospital. A positive value indicates net income was generated by equity investment. Very high positive values may indicate an opportunity for debt financing. A negative value indicates a net loss was generated by equity investment. Very high negative values may indicate financial difficulty.

Source: CAH Financial Indicators Report Team (2015) CAH Financial Indicator Report 12th Issue. Chapel Hill, NC.

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LIQUIDITY INDICATORS:

Current Ratio= Current assets / Current liability

- ➤ Current Ratio measures the number of times short-term obligations can be paid using short-term assets. A value greater than 1.0 indicates current assets are greater than current liabilities. Very high values may indicate underinvestment in longer-term assets that usually yield higher returns. A value less than 1.0 indicates current assets are less than current liabilities. Very low values may indicate financial difficulty.

Days Cash on Hand= Cash+ Temporary investments + Investments/(Total expenses – Depreciation) / Days in period

- ➤ Days Cash on Hand measures the number of days an organization could operate if no cash was collected or received. A low value indicates only a few days of cash on hand. Very low values may indicate financial difficulty. A high value indicates many days of cash on hand. Very high values may indicate under-investment in longer-term assets that usually yield higher returns. Days Cash on Hand is calculated at fiscal year end, which does not reflect uneven cash flows throughout the year.

Days in Net Accounts Receivable= Net patient accounts receivable/ (Net patient revenue)/ Days in period

- ➤ Net Days Revenue in Accounts Receivable measures the number of days that it takes an organization, on average, to collect its receivables. A high value indicates many days to collect receivables. Very high values may indicate a need to review collection policies and procedures. A low value indicates only a few days to collect receivables and may indicate a more efficient system for processing accounts receivable, higher Medicare and Medicaid payer mix, offering of long-term care services, or some combination.

Days in Gross Accounts Receivable= Gross patient accounts receivable / (Gross patient revenue) / Days in period

- ➤ Days in gross accounts receivable compared to days in net accounts receivable measures revenue cycle performance. Days in gross and net accounts receivable that are close in value indicate good revenue cycle performance. Days in gross accounts receivable greater than days in net accounts receivable may indicate that the allowances for doubtful accounts require analysis and possible adjustment.

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CAPITAL STRUCTURE INDICATORS:

Equity Financing= Net assets/Total assets

> Equity Financing measures the percentage of total assets financed by equity. In a not-for-profit entity, equity represents the sum of federal, state and local grants, contributions, and the accumulated earnings of the hospital. A value greater than 50 percent indicates that more of the assets are financed by equity than by debt. Very high values may indicate opportunities for debt financing. A value less than 50 percent indicates that more of the assets are financed by debt than by equity. Very low values may indicate exposure to financial risk because debt service is a fixed charge.

Debt Service Coverage= Net income + Depreciation + Interest expense / Notes and loans payable (short term) * (365 / Days in period) + Interest expense

> Debt Service Coverage measures the cash inflow per dollar of principal payments and interest expense. A positive value greater than 1.0 indicates cash flow greater than current fixed charge payments. Very high positive values may indicate an opportunity for debt financing. A positive value less than 1.0 or a negative value indicates cash flow less than current fixed charge payments. Very low values may signal a need to reassess debt policies. Refinancing may be an option if interest rates are lower in the current period than when the original debt financing occurred.

Long-Term Debt to Capitalization= Long-term debt / Long-term debt + Net assets

> Long-Term Debt to Capitalization measures the percentage of total capital that is debt. A value greater than 50 percent indicates that a majority of capital is debt. Very high values may indicate exposure to financial risk because debt service is a fixed charge. A value less than 50 percent indicates that the majority of capital is equity. Very low values may indicate opportunities for debt financing.

Source: CAH Financial Indicators Report Team (2015) CAH Financial Indicator Report 12th Issue. Chapel Hill, NC.

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REVENUE INDICATORS:

Hospital Medicare Outpatient Cost to Charge = 100* Hospital Medicare Outpatient Costs

- ➤ Hospital Medicare Outpatient Cost to Charge measures the outpatient Medicare costs per dollar of Medicare outpatient charges. A value less than 0.5 indicates that Medicare outpatient costs are less than one half of Medicare outpatient charges. Very low values may indicate patient volume is relatively high, gross charges are relatively high, costs are relatively low, or some combination of these factors. A value greater than 0.5 indicates that Medicare outpatient costs are greater than one half of Medicare outpatient charges. Very high values may indicate low volume, an inadequate rate structure, an opportunity to review operating costs, or some combination.

UTILIZATION INDICATORS:

Average Daily Census Swing-SNF Beds

- ➤ Average Daily Census Swing-SNF beds measures the average number of swing beds occupied per day. A high value indicates high use of swing-SNF beds. A low value indicates low use of swing-SNF beds. Average Daily Census Swing-SNF Beds is influenced by the number of swing-SNF beds available.

Average Daily Census Acute Beds

- ➤ Average Daily Census Acute Beds measures the average number value indicates high use of acute care beds. A low value indicates low use of acute care beds. Average Daily Census Acute Beds will be influenced by the number of acute care beds available.

Source: CAH Financial Indicators Report Team (2015) CAH Financial Indicator Report 12th Issue. Chapel Hill, NC.

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COST INDICATORS:

Salaries to Net Patient Revenue= Salary expense / Net patient revenue

- Salaries to Net Patient Revenue measures the percentage of net patient revenue that is labor costs. A value greater than 50 percent indicates that the majority of net patient revenue is for salaries. Very high values may indicate labor intensive organizations, employment of medical staff, or old plant and equipment. A value less than 50 percent indicates that the majority of net patient revenue is for supplies, equipment, and other expenses. Very low values may indicate capital-intensive organizations or new plant and equipment.

Average Age of Plant= Accumulated depreciation / Depreciation expense * (365 / days in period)

- Average Age of Plant measures the average accounting age in years of the fixed assets of an organization. It may differ from the average chronological age because of depreciation practices. Higher values indicate greater amounts of older assets. Very high values may indicate a need for fixed asset replacement. Lower values indicate greater amounts of newer assets. Very low values may indicate a new building or recent replacement of fixed assets.

FTEs per Adjusted Occupied Bed= Number of FTEs / (Inpatient days - NF swing days - Nursery days) * (Total patient revenue / (Total inpatient revenue - inpatient NF revenue - Other LTC revenue)) / Days in period

- FTEs per Adjusted Occupied Bed measures the number of full-time employees per each occupied acute care bed. A high value indicates many employees per bed. Very high values may indicate low volume and a potential opportunity to evaluate staff productivity. A low value indicates a few employees per bed. Very low values may indicate high volume or a high level of staff productivity.

Average Salary per FTE= Salary expense / Number of FTEs

- Average Salary per FTE measures the price and mix of labor. A high value indicates that a hospital pays above average wages / salaries and/or employs relatively more high-skill occupations and/or experienced staff. A low value indicates that a hospital pays below average wages / salaries and / or employs relatively fewer less high skill occupations and/or experienced staff.

Source: CAH Financial Indicators Report Team (2015) CAH Financial Indicator Report 12th Issue. Chapel Hill, NC.

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Thank you!

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