Independent Special District Operational Performance Review

Prepared for
North Brevard County Hospital District d/b/a Parrish Medical Center

June 3, 2024

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I. EXECUTIVE SUMMARY

In 2021, the Florida Legislature passed the Uniform Special District Accountability Act (s. 189.0695, F.S.) (the Act) which mandated all Florida Independent Special Districts (FISD), including hospitals, conduct – utilizing independent, objective third parties experienced in the evaluation of hospital/health system operating performance to do reviews of their operating performance as defined by the Legislature in the Act.

The North Brevard County Hospital District (d/b/a Parrish Medical Center) (the District, Parrish, and/or PMC) engaged PYA, P.C. (PYA), a national healthcare advisory and accounting firm, to evaluate its operating performance in accordance with the directives of the Act. PYA conducted a thorough review of available data and analyses related to the District's operating performance against established, best practice metrics and criteria, both over time and relative to defined peer organizations. In addition, PYA interviewed a number of District stakeholders to ensure it understood and was able to represent PMC's operating performance in the context of historic and current market realities.

PYA evaluated the District's operating performance against its own historic trends, as well as relevant peer organizations, across the following, industry standard domains:

- Quality
- Access
- Community Benefit
- Cost
- Financial Performance

Highlights associated with the evaluation performed by PYA are summarized below.

Findings

- PMC excels in delivering safe, high quality care to its community. Quality improvement is a primary focus of PMC leadership. PMC has achieved marked improvement in quality over the years within those areas where PMC has invested its focus and resources. Most notably, according to the Leapfrog Group, PMC has moved from a C safety grade in Fall 2023 to an A grade by Spring 2024, a grade consistent with PMC's pre-pandemic safety performance levels.
- From an access perspective, PMC provides a broad set of services for a community the size of North Brevard County and is making investments to improve upon the access to care within the community. Specifically, PMC has added over 50 new healthcare providers and over 30 new programs since 2020. Further demonstrating its commitment to North Brevard County, PMC has invested over $221 million through charity care, community building, and other benefit initiatives over the past decade. PMC has also contributed over $9 million to the community through cash and in-kind donations and sponsorships during that period.

- Even though PMC can tax its community, the Board of Directors, in its desire to not burden local taxpayers, has chosen not to seek tax support as a means of supporting hospital operations for the past 29 years. Since 2017, FISD hospitals have levied $2.3 billion in *ad valorem* taxes collectively. Over the past 29 years, PMC, in its decision to not levy taxes on the community, has forgone $42 million in potential tax revenue.

Like most hospitals nationally, PMC faces a set of challenges that management has identified and is working to improve. Some examples include longer than desirable wait times in the emergency department (ED) and select areas of financial performance. These challenges were largely exacerbated by the COVID-19 pandemic, but are also the product of local market realities, including socioeconomic disadvantages inherent in the community and the state's historic underinvestment in community health infrastructure and capabilities. PMC management recognizes the challenges associated with being an FISD in an economically challenged, highly competitive /regional healthcare marketplace and actively initiates mitigation and/or contingency plans when performance is not meeting expectations.

Recommendations

Based upon our 40 years of relevant industry experience, deep familiarity with the state of Florida, and the analysis detailed herein, PYA believes the District is mission-oriented, actively managed by an experienced, professional team, dedicated to the service of the residents of North Brevard County, and demonstrates a reasonable recovery in the aftermath of the COVID-19 pandemic. As such, we offer no statutory and/or budgetary recommendations to improve PMC's program operations at this time.

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The above summary findings and recommendations are highlighted and discussed in detail in this report and constitute PYA's professional estimation of the District's operating performance as a health system.

II. INTRODUCTION

As enacted by the Florida Legislature in 2021, the Uniform Special District Accountability Act (s. 189.0695, F.S.) (the Act) mandates all FISDs, including hospitals, conduct and submit performance reviews of their operations, inclusive of all programs, activities, and functions they provide to their communities.

The reviews are to be completed by independent entities with at least five (5) years of experience conducting comparable reviews of organizations similar in size and function to the FISD in question and in accordance with applicable industry best practices. The entity conducting the review must have no affiliation with or financial involvement in the reviewed FISD.

The final reports are to be delivered to the governing board of the FISD, the Auditor General, the President of the Senate, and the Speaker of the House of Representatives no later than nine (9) months from the beginning of the district's fiscal year commencing after October 1, 2023 (and every five (5) years thereafter). In the case of the District, which operates on an October 1 fiscal year, the due date for its initial operational performance review is June 30, 2024. This document, dated June 3, 2024, serves as the final report for the District.

The Act specifies the performance reviews incorporate research and analysis of:

a) The special district's purpose and goals as stated in its charter;

b) The special district's goals and objectives for each program and activity, the problem or need that the program or activity was designed to address, the expected benefits of each program and activity, and the performance measures and standards used by the special district to determine if the program or activity achieves the district's goals and objectives;

c) The delivery of services by the special district, including alternative methods of providing those services that would reduce costs and improve performance, including whether revisions to the organization or administration will improve the efficiency, effectiveness, or economical operation of the special district;

d) A comparison of similar services provided by the county or municipal governments located wholly or partially within the borders of the special district, including similarities and differences in services, relative costs and efficiencies, and possible service consolidations.

e) The revenues and costs of programs and activities of the special district, using data from the current year and the previous 3 fiscal years;

f) The extent to which the special district's goals and objectives have been achieved, including whether the goals and objectives are clearly stated, are measurable, adequately address the statutory purpose of the special district, provide sufficient direction for the district's programs and activities, and may be achieved within the district's adopted budget;

g) Any performance measures and standards of the special district's programs and activities using data from the current year and 3 previous fiscal years, including whether the performance measures and standards:

    1. Are relevant, useful, and sufficient to evaluate the costs of programs and activities;

2. Are being met; and/or
3. Should be revised.

h) Factors that have contributed to any failure to the special district's performance measures and standards or achieve the district's goals and objectives, including a description of efforts taken by the special district to prevent such failure in the future; and

i) Recommendations for statutory or budgetary changes to improve the special district's program operations, reduce costs, or reduce duplication, including the potential benefits to be achieved and the potential adverse consequences of the proposed changes.

In April 2024, the District engaged PYA, P.C. (PYA), a national healthcare consulting and advisory firm with 40 years of experience serving healthcare providers, to perform the independent, third-party evaluation of District operations mandated by the Legislature through the Act. The report addresses the Legislature's requests as delineated above and other relevant factors that influence PMC's performance. PYA believes this analysis was developed and is summarized in accordance with industry best practices. A detailed overview of PYA is included in Appendix A to this report.

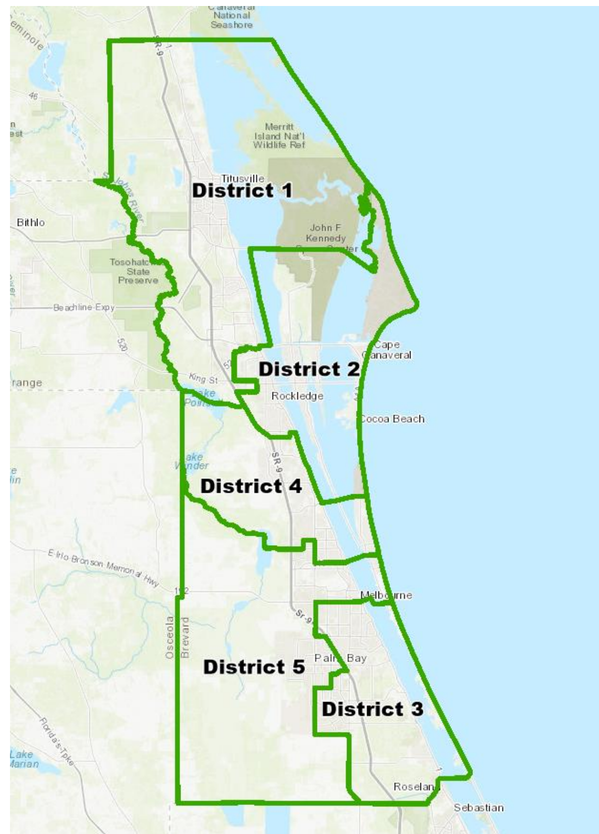
PMC OVERVIEW[1]

The District, an FISD established in 1953, serves a portion of the northernmost Commission district (District 1) in Brevard County. The District is bounded by the Volusia County line to the north, to approximately the middle of the community of Port St. John to the south, and from the Atlantic Ocean to the east to the St. Johns River to the west. This geographic region includes the city of Titusville and the towns of Mims, Scottsmoor and Port St. John.

The distance between Titusville, the largest city in District 1 and Merritt Island, the largest city in District 2, is 25 miles with an approximate 45-minute drive time, whereas the drive times between PMC and Cape Canaveral Hospital and Rockledge Regional Medical Center, PMC's two closest hospital competitors, are 43 minutes and 35 minutes, respectively. Figure 1 on the following page illustrates the boundaries of District 1 and, for reference, the other four (4) districts in Brevard County.

[1] CS/HB 739 North Brevard County Hospital District, House of Representatives Local Bill Staff Analysis. (2024, February 25). https://m.flsenate.gov/session/bill/2024/739/analyses/h0739d.shi.pdf.

Figure 1 – Brevard County Districts



Source: Official Website for Brevard County Government

A FISD is a unit of local government created for a particular purpose, with jurisdiction to operate within a limited geographic boundary. A FISD may be created by general law, special act, local ordinance, or rule of the Governor and Cabinet. The District was created by an act of the Florida Legislature in 1953.

A FISD has only those powers expressly provided by, or reasonably implied from, the authority provided in the District's charter.

FISD's are governed by boards whose members may be elected and/or appointed by the Governor, the Legislature, or other specified entities. In PMC's case, the board consists of nine (9) members who serve staggered, four-year terms and must reside within the District:

- Three members appointed by the Titusville City Council;
- Three members appointed by the Brevard County Board of County Commissioners; and
- Three members appointed by the Brevard County Board of County Commissioners, subject to confirmation by the Titusville City Council

The District operates Parrish Medical Center, the sole general acute care hospital in North Brevard County. First opened as North Brevard Hospital in 1958 with 28 patient beds, PMC experienced a number of expansions over the years, first to 96 beds in 1966 and then renovated in 1981. The renovation included the build out of the 6th and 7th floors for additional clinical and educational programing, as well as an ancillary services wing, surgery suite updates, an 8-bed ICU, and an expanded emergency department. In 2002, the original hospital was replaced with the 371,000-square-foot facility the community enjoys today. PMC is currently licensed for 208 beds and staffs 160 of the total licensed number.

The District operates related support services as further discussed in Section III of this report. PMC has been in continuous operation in the North Brevard area of Florida's Space Coast since PMC's inception in 1958 and has been designated by the National Aeronautics and Space Administration as an official medical receiving facility.

REVIEW APPROACH

The delivery of healthcare services is a complex, multi-faceted undertaking. To effectively and efficiently deliver care, resources typically must be organized from different, unrelated professionals, institutions, and information technology systems; siloed knowledge must be coordinated; byzantine regulations and business models must be navigated; and external, often indirectly-related factors (e.g., social determinants of health, prevalence and type of insurance coverage, provider supply) must be factored into every care decision. The knowledge necessary to generate favorable outcomes and sustainable operating performance, as a result, is rarely attributable to any one specific action a care provider is or is not taking.

In the face of such complexity and opacity, no single industry standard has emerged to definitively characterize the relative level of operating performance of care providers (i.e., hospitals, health systems, physician practices). Likewise, neither PMC's enabling legislation nor the Act specify the metrics on which its operating performance should be quantified and/or measured. It is critical, however, that the public and the Legislature understand, and be assured by, the degree to which their public institutions are serving them with respect to effectiveness and efficiency. PMC is not an exception to that standard.

The Act directs the FISDs to engage an independent advisor to "…conduct the review according to applicable industry standards," which, as it has done in numerous other situations for numerous other similarly situated hospitals, PYA has endeavored to do on behalf of the District herein.

To evaluate the District's operating performance, PYA employed what it believes is a best practice approach to illustrating and, where possible, quantifying PMC's performance in areas that, individually and in aggregate, are recognized across the industry as being correlated with effectiveness, efficiency, and sustainability. The domains in which PYA evaluated PMC and its performance for purposes of adhering to the mandate in the Act include:

- Quality

- Access
- Community Benefit
- Cost
- Financial Performance

In each domain, PYA reviewed hospital and publicly-available information and performed a variety of qualitative and quantitative analyses to assess PMC's performance, understand its trended performance over time, and where possible compare to like or peer institutions. PYA endeavored to create an objective, transparent, data-driven evaluation that incorporates concepts and metrics that are generally viewed as industry-standard gauges of hospital performance. Detailed descriptions of the evaluation approaches undertaken are included in the subsections of Section III of this report.

To enable the development of an objective, data-driven set of findings and recommendations, PYA obtained publicly-available data and received internal performance data from the District that enabled the trending of its operating performance.

Where applicable, the District's performance across the domains listed above was measured against a range of peers, defined as similarly situated facilities based on defined criteria. Peer groups were defined utilizing community and hospital characteristics (e.g., population, hospital beds, race/ethnicity, socioeconomics, insurance coverage, financial health) that are similar to those present in North Brevard County. Three (3) peer groups were developed to ensure accurate comparisons were as reasonable as possible. Each are defined in Section III.

PYA's rationale and/or reservations associated with each peer group are also explained in the narrative of Section III. Viewed together, however, PYA believes they represent an appropriate complement of organizations that can be considered peers to PMC. Complete methodologies and definitions of peer groups are provided in Appendix B to this report.

Other important factors essential to the analyses include:

- The evaluation and analyses contained herein, where appropriate, have been expanded beyond the Legislature's stated 3-year retrospective time period. In some instances, data and comparisons go back to 2018. This was done to ensure the impact of the COVID-19 pandemic on District performance would be best understood relative to pre-pandemic performance.
- Given lags in data availability, some comparisons are only possible through 2022.
- When dictated by data availability, differing comparison periods may be utilized. All such instances are noted.
- When dictated by data availability, some peer organizations may be excluded from comparative calculations. All such instances are also noted.

Despite these limitations, PYA believes we have developed an accurate representation of PMC's performance and objective comparison to its peers.

PYA further conducted informational interviews with key District and physician leaders. The interviews helped PYA understand stakeholders' qualitative perceptions of the District's purpose, capabilities, and performance, as well as to assess whether the facts identified through the data metrics and comparisons to peer groups match the reality of individual experiences. A list of the stakeholders interviewed for this report can be found in Appendix C.

Finally, it is important to underscore that, in developing an evaluation of this nature, events of recent years (e.g., COVID-19 pandemic) have had considerable, largely negative, impacts on hospital performance, locally and nationally. In PYA's experience, the impact is disproportionally represented in public, safety net, and non-urban providers – all of which apply to PMC. These entities lacked material financial and other resource "cushions" prior to their onset. Where appropriate, PYA reflects on such realities and their impact on PMC operating performance throughout the report.

REPORT LIMITATIONS

Report limitations of which the reader should be aware include:

- Reliance on publicly-available data – it is recognized that publicly-available data sources are often based on voluntary participation by hospitals and may vary in their timeliness and accuracy.
- Rankings – some hospitals choose to prioritize performance excellence efforts on specific, well-known ranking programs, such as US News & World Report, the Centers for Medicare & Medicaid Services (CMS) star ratings, or Leapfrog Group Hospital Quality and Safety Grades. These ranking systems are built on proprietary criteria and methodologies. PYA did not attempt to vet/validate any such assumptions and/or methodologies.
- Event recency – the impact of the COVID-19 pandemic was (and is) largely negative to hospital performance. Where able, PYA attempted to address variances in operating performance by extending the evaluation period prior to the pandemic's onset.
- Differences in definitions – data sources sometimes differ in their definitions of operating performance metrics. PYA made its best effort to ensure data comparability.
- Differences in accounting methods – organizations account for certain financial information differently based on their legal structure and/or the guidance of their auditing firms. These differences may result in one organization capturing a set of financial charges or costs in one category differently than another organization. For instance, organizations may treat charity care, community benefit, bad debt, depreciation expense, or other information differently. While the Medicare Cost Reports may be asking for certain categories of data, the inputs may be derived differently.

- Timing – Time periods vary based on metrics and data sources, with some reporting individual years, while others aggregate the years provided.

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The remainder of this report constitutes the entirety of PYA's findings and recommendations associated with the District's operating performance as required by the Legislature under the Act.

III. OPERATIONAL PERFORMANCE REVIEW – PARRISH MEDICAL CENTER

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a. DISTRICT PURPOSE AND GOALS

As interpreted by PYA, Section 5 of the District's enabling legislation/charter[2] states its designated purpose as:

"…a necessity for the preservation of the public health and for the public use and for the welfare of the district and the inhabitants thereof."

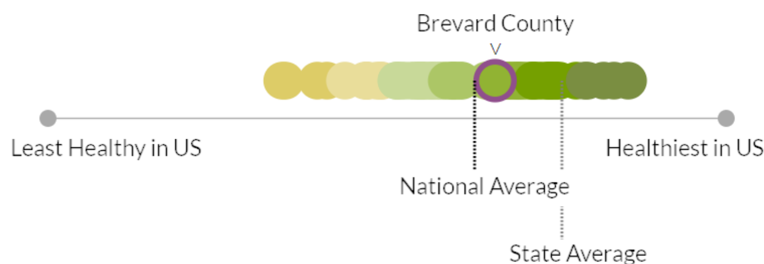
PMC's enabling legislation/charter does not specify discrete, quantifiable operating performance goals and objectives beyond its designated purpose.

In the absence of specific, quantifiable goals and objectives, PYA conducted an objective, best practice-based operating performance review across the typical, industry-recognized evaluation domains described in detail in Section III.c. The results of those analyses are discussed in detail there.

To quantify and better understand "the public health" and the factors that influence it, PYA utilized information from County Health Rankings & Roadmaps (CHR&R), a program of the University of Wisconsin Population Health Institute, a nationally recognized source of objective community health measures.[3]

CHR&R measures Health Outcomes (how long people live on average within a community, and how much physical and mental health people experience while alive) and Health Factors (indicators of the future health of communities, comprised of health behaviors (30%), clinical care (20%), social determinants of health (40%), and physical environment (10%)). As calculated by CHR&R, Brevard County Health Outcomes are slightly above the average US county and moderately below the average Florida county (Figure 2). Overall, Brevard County ranks 28th out of 67 Florida counties with respect to Health Outcomes.

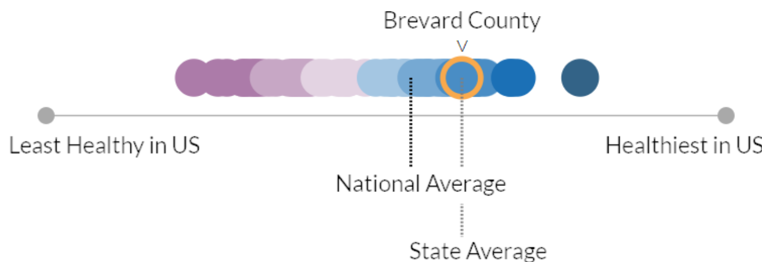
Figure 2 – Brevard County Health Outcomes



[2] *Florida House of Representatives: House Bill 1219* (2003).
[3] *County Health Rankings & Roadmaps.* https://www.countyhealthrankings.org/.

When looking at Health Factors, Brevard County is addressing the components that drive future health at a level equal to the average Florida county and exceeding the US average county (Figure 3). Overall, Brevard County ranks 9th of 67 Florida counties when considering Health Factors metrics.

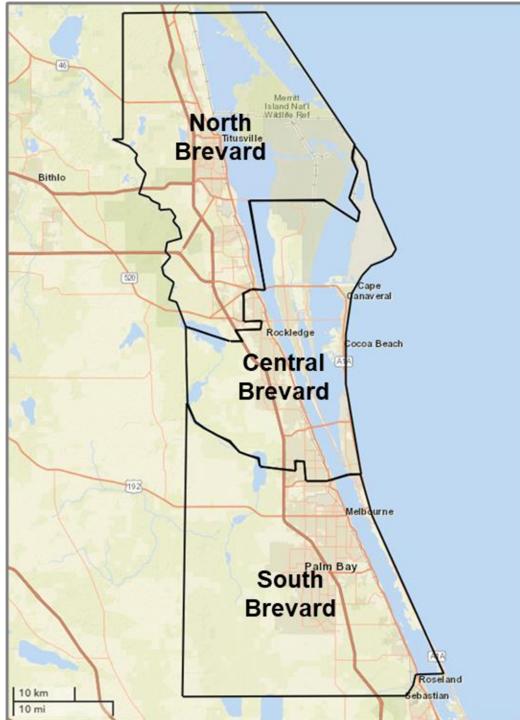
Figure 3 – Brevard County Health Factors



In the case of Health Factors, Brevard County has experienced positive trends in recent years. Specifically, Brevard County has trended positive in four (4) of the six (6) contributing metrics (uninsured rate, primary care physicians/population ratio, dentists/population ratio, preventable hospital stays) that comprise CHR&R's overall ranking.

It is important to recognize, however, that while it is not possible to attribute community health-related statistics to individual provider organizations, given the data are aggregated at the county-level, it is also possible to overlook important differences within sub-geographies within counties, especially in counties as large (1,105 sq. miles in area) and as diverse (Figure 4 on the following page) as Brevard County. As the data show, there are material demographic and socioeconomic differences between the three (3) regions of Brevard County that likely indicate distinct, region-specific health needs, as well as different resource bases to address differing needs.

Figure 4 – County Region Comparison[4]



	North Brevard (District 1)	Central Brevard (District 2&4)	South Brevard (District 3&5)
Population 2023	122,474	242,960	261,645
Expected Population 2028	124,860	245,327	268,492
Expected 5-year Population Growth	1.9%	1.0%	2.6%
Median Household Income	$ 61,277	$ 78,757	$ 60,247
Population 16+ Unemployment Rate	5%	3%	4%
% Non-white	24%	24%	31%
Educational Attainment (Bachelor's or higher)	25%	43%	31%

Despite the differences in needs and resources across regions of the county, local healthcare providers, PMC primary among them, are contributing to a brightening outlook for community health in North Brevard County as measured by CHR&R.

[4] PYA has combined districts to include three distinct regions to compare demographic and income profiles of different parts of the county.

b. GOALS AND OBJECTIVES OF DISTRICT PROGRAMS AND ACTIVITIES

As noted above, PMC's enabling legislation/charter does not specify program-/activity-specific operating performance goals and objectives beyond its designated purpose. In the absence of such guidance, PYA endeavored to evaluate program and activity-specific goals and objectives qualitatively through a review of objective, external perspectives on the District's array of services.

PMC delivers a broad range of healthcare services to its community, spanning both the site of care (i.e., home-to-physician office-to-outpatient-to-inpatient) and intensity (i.e., low-to-high acuity) continua. It has primarily chosen to provide the range of services it does to ensure it fulfills its mission of providing *Healing Experiences for Everyone All the Time®*.

For purposes of this report, PYA considered the District's "programs and activities" to include all clinical and non-clinical services provided to the community. These services include, but are likely not limited to, those represented in Figure 5 below:

Figure 5 – PMC Programs and Services

Healthcare for Everyone.

Our Locations, Partners, Programs, and Services

Parrish Medical Center
Parrish Healthcare Centers
Parrish Cardiovascular Center
Parrish Oncology Center
Parrish Occupational Health Centers
Parrish Health & Wellness Center
Parrish Senior Consultation & Solutions Center (Geriatric Care)
Parrish Sleep Disorders Center
Parrish Wound Healing & Hyperbaric Medicine Center
The Children's Center
Jess Parrish Medical Foundation (JPMF)

Parrish Medical Group

Primary Care
Behavioral Health
Cardiology
Endocrinology
Gastroenterology
General Surgery
Urology
OB/GYN
Oncology
Orthopedics
Sports Medicine & Athletic Training
Podiatry

Parrish Health Network

Space Coast Healthcare Centers
Skill Nursing Facility Partners
Dialysis Centers
Hospice Partners
Independent Providers
Insurers

Programs and Services

Acute Care
Emergency Care
Geriatric Care
Maternity Care
Care Navigation
Cardiac Rehabilitation
Diagnostic Imaging
Diabetes Care
Lung Screening
Interventional Cardiology
Interventional Radiology
Physical Therapy
Occupational Therapy
Speech Therapy
Surgical Services
Robotic-Assisted Services
Infusion Services
Healing in Motion Van
Parrish Early Care and Pre-K

Source: Parrish Medical Center: Decades of Benefit to North Brevard

It would be extremely difficult, if not impossible, to evaluate the discrete goals and objectives of each of the programs and activities listed above. It is possible, however, to gain a better understanding of how well the District fulfills its mission of delivering healing experiences to all those who present themselves at PMC for service by looking to how well those very clinical programs are viewed through the lens of those organizations that evaluate clinical and/or other healthcare program quality on a national basis.

In US healthcare, there is an established cohort of organizations that specialize in aggregating and evaluating and/or ranking specific healthcare programs of distinction for use by patients and consumers in their healthcare decision-making processes. These organizations range from governmental (e.g., CMS, Agency for Healthcare Research and Quality (AHRQ)) to proprietary (e.g., The Leapfrog Group, The Joint Commission). Since 2021 (and well before), the District has been recognized for providing superior quality, service, and patient experience across many of its services. Figure 6 below represents a sampling of the accolades the District has earned in recent years:

Figure 6 – PMC Awards/Accolades

The recognition the District has received indicates a reality that leadership actively seeks to identify and quantify community health needs; implements programming to meet identified needs; and administers the programming in a manner that, when measured against the proprietary criteria and algorithms that nationally-recognized, objective arbiters of quality employ in making their judgements, is frequently determined to be delivering programs and activities that are superior relative to their peers nationally.

As the reader contemplates the breadth of PMC's service mix, it is also important to recall that, in many cases, PMC delivers the breadth of services it does because it is mandated by its enabling legislation to ensure "…the preservation of public health…" in the District.

While it is true there are other entities – public and private, local and regional – that could provide services similar to those provided by PMC (often to its economic detriment), and those entities are free to do so given the absence of barriers to competition (e.g., Certificate of Need law) in Florida, the reality in North Brevard County and the District is that there have not historically been organizations choosing to enter as alternatives to PMC for many services. PYA hypothesizes that, in many instances, PMC is the only provider of care in the market because the service itself is viewed by potential competitors as unattractive, either economically or otherwise.

c. SPECIAL DISTRICT SERVICES DELIVERY

The Legislature requested all FISD's evaluate "The delivery of services by the special district, including alternative methods of providing those services that would reduce costs and improve performance, including whether revisions to the organization or administration will improve the efficiency, effectiveness, or economical operation of the special district."

To comprehensively address the Legislature's request in the absence of guidance on which criteria to utilize, PYA evaluated District operations against a range of evaluation domains generally-accepted within the healthcare industry as indicating effectiveness, efficiency, and sustainability in operations. As mentioned above, PYA utilized the following evaluation domains, an accounting for each of which is included in this section:

- Quality
- Access
- Community Benefit
- Cost
- Financial Performance

In addition to the specific evaluation domain-based reviews, PYA also addressed the Legislature's specific requests around "alternative methods of providing those services," etc., in this section.

Where applicable, the District's performance for the criteria listed above was measured either against similarly situated facilities, or against its own performance trends. Peer groups were defined utilizing community and hospital characteristics as follows:

- PYA Peer Group: independent hospitals in the southeast region of the country of similar size and similar county demographics (i.e., population, median household income, persons in poverty, etc.).

- Regional Peer Group (Vizient Southeast): peers identified through the Vizient[5] member network in the southeast region of the country.
- County Peer Group: two closest hospitals in Brevard County (Cape Canaveral Hospital and Rockledge Regional Medical Center).

Complete methodologies and definitions of peer groups are provided in Appendix B to this report.

Quality

The term "quality" in healthcare, while ubiquitous, is frequently defined and measured differently by different, well-meaning people. Likewise, a plethora of public and private quality reporting organizations – the AHRQ, CMS, the Institute of Medicine (IOM), the Institute for Healthcare Improvement, the Leapfrog Group, many others – all with their own, often proprietary, approaches to defining, sourcing, and measuring quality, abound.

To evaluate the District's relative quality, PYA utilized elements of the IOM's six (6) dimension definition: safe, effective, patient-centered, timely, efficient, and equitable.[6] Those dimensions on which the Legislature requested the District's performance are included herein, while those that fall outside the request have been excluded. The rationale behind exclusion is as follows:

- Effective(ness) – in PYA's estimation, is a product of all the evaluation domains, rather than a single element.
- Efficiency – measured elsewhere in this report.
- Equity – outside the Legislature's request.

The remaining three (3) quality dimensions – safe, patient-centered, and timely – were evaluated utilizing generally-accepted and comparable data elements from several sources, including:

Quality Dimension	Data Measures
Safe	30-Day All Cause Hospital-Wide Readmission Rate
	Deaths Among Patients with Serious Treatable Complications After Surgery Leapfrog Group Safety Rating
Patient-Centered	HCAHPS Star Rating
Timely	Average Time Patients Spent in the ED Before Leaving from the Visit

[5] Vizient Southeast, a membership organization, is a national, healthcare performance improvement company (www.vizientinc.com).

[6] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

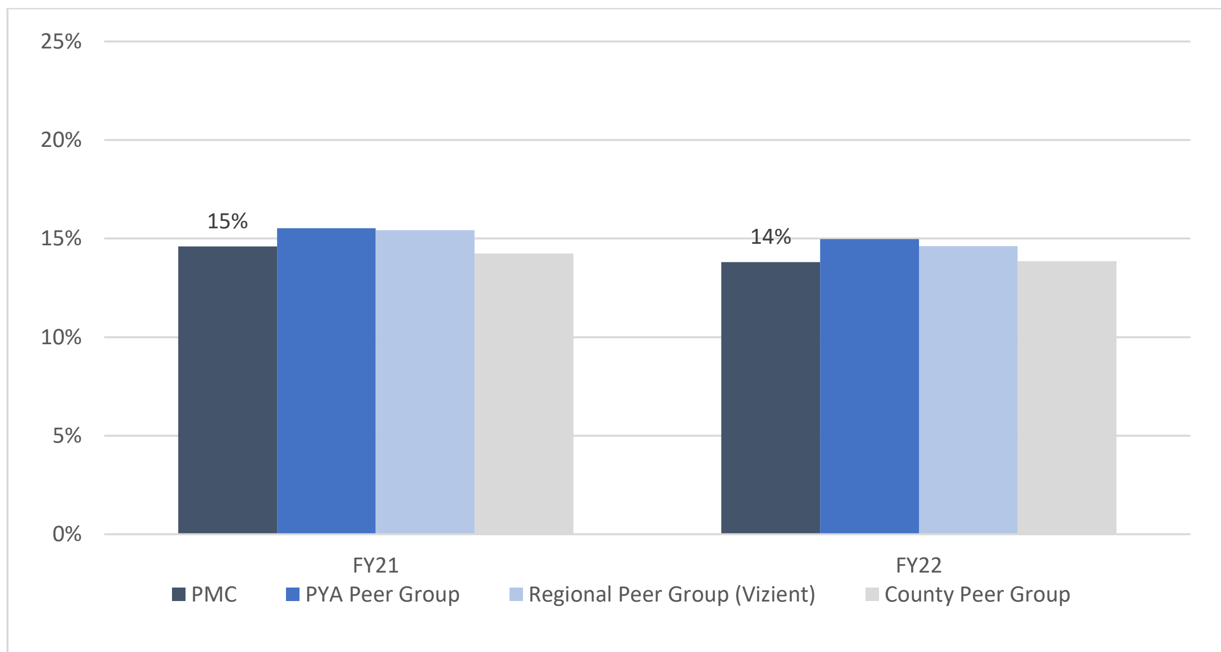
Safe

30-DAY ALL CAUSE HOSPITAL-WIDE READMISSION RATE (MEDICARE FEE-FOR-SERVICE ONLY)[7]

While most readmissions are unavoidable, some result from lapses in care quality, inadequate communication/coordination, or lack of effective care transition and discharge planning. A hospital's 30-day All Cause Hospital-Wide Readmission Rate is a standard, widely recognized CMS safety benchmark. The measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute-care hospital and experienced an unplanned readmission for any cause to any acute care hospital within 30 days of discharge.[8]

As shown in Figure 7 below, PMC's all cause readmission rate declined from 15% to 14% between FY21 and FY22[9]. In both years, PMC is below PYA and regional peer group readmission rates.

Figure 7 – 30-Day All Cause Hospital-Wide Readmission Rate (Medicare Fee-For-Service Only), FY21-22



[7] *Definitive Healthcare*. https://www.defhc.com./.

[8] Measures Inventory Tool – All-Cause Hospital Readmission, Centers for Medicare & Medicaid Services (CMS), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf>, accessed on April 30, 2024.

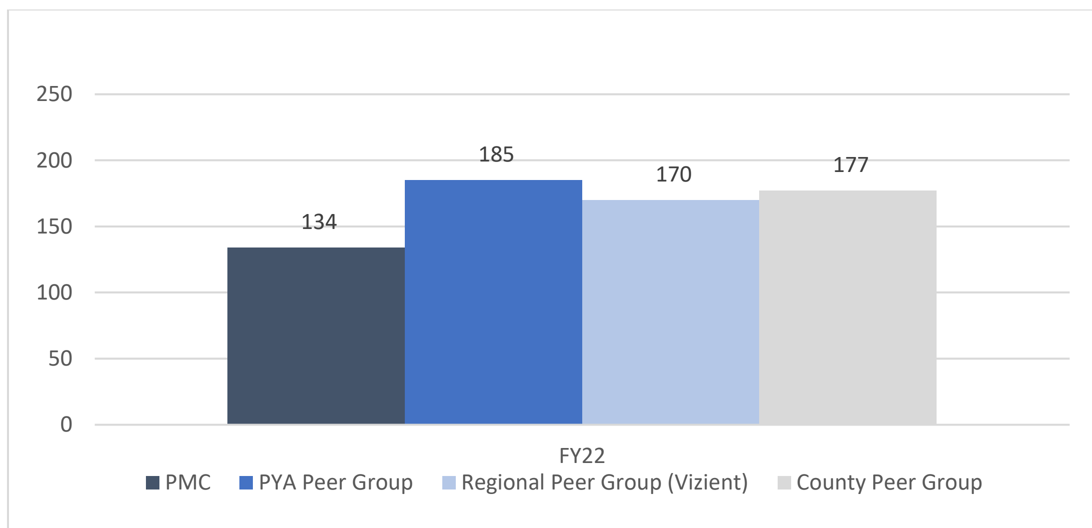
[9] Throughout this report, reporting time frame dates reflect the 12-month Medicare cost reporting period end date.

DEATHS AMONG PATIENTS WITH SERIOUS TREATABLE COMPLICATIONS AFTER SURGERY[10]

Deaths Among Patients with Serious Treatable Complications After Surgery refers to the number of deaths per 1,000 surgical patients who died after developing serious complications that could have been treated, thus preventing an avoidable death. Post-surgery complications are always a risk. Some deaths may be unavoidable, but higher death rates from complications may be a sign that patients suffered fatal consequences from lapses in care, coordination, and/or communication throughout the course of treatment.[11]

As shown in Figure 8 below, for FY22, PMC had 134 deaths per 1,000 patients with serious treatable complications after surgery, materially outperforming peer group rates.

Figure 8 – Deaths Among Patients with Serious Treatable Complications After Surgery, FY22



Note: Average Number of Deaths Among Patients with Serious Treatable Complications After Surgery data unavailable for one PYA peer and two Regional peers and have been excluded from Figure 8 for comparison purposes.

THE LEAPFROG GROUP HOSPITAL SAFETY GRADES PROGRAM

PMC has made it a priority in recent years to focus on safety improvements through its voluntary participation in the Leapfrog Group Hospital Safety Grades program. Most recently, PMC has moved from a C safety grade in Fall 2023, which was likely a result of pandemic era challenges to hospital operations, back to an A grade by Spring 2024, a grade consistent with PMC's pre-pandemic safety performance levels, as illustrated in Figure 9 on the following page.

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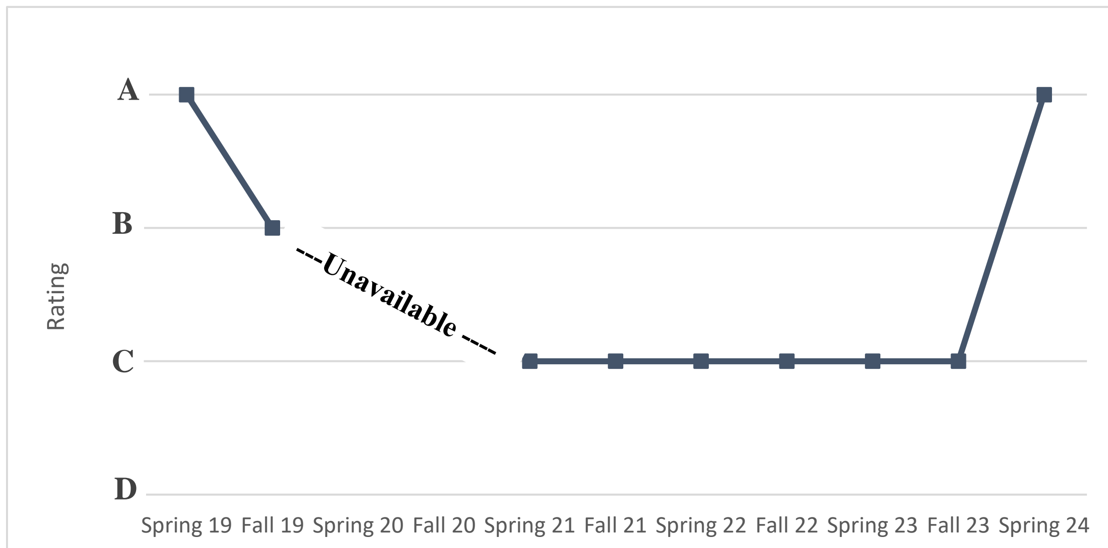
[10] *Definitive Healthcare.* https://www.defhc.com/.

[11] Complications & deaths, Centers for Medicare & Medicaid Services (CMS), <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths/>, accessed on May 1, 2024.

Figure 9 – PMC Leapfrog Group Safety Grades, 2019-2024



Note: Leapfrog did not conduct ratings for Spring 2020 and Fall 2020.

Patient-Centered

HCAHPS STAR RATING[12]

CMS, along with the AHRQ, developed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to standardize a tool and data collection methodology for measuring patients' perspectives on their hospital care.

The HCAHPS survey's 29-questions[13] are administered to a random sample of adult patients (not restrictive to only Medicare beneficiaries) across medical conditions between 48 hours and 6 weeks after discharge. CMS cleans, adjusts, and analyzes the data, then publicly reports hospital-level results four (4) times a year. HCAHPS results are based on four (4) quarters of data on a rolling basis and published on CMS's Hospital Compare website.[14]

Since 2019, PMC consistently received a 2 or 3-star rating as shown in Figure 10 on the following page. In the most recent reporting period, PMC increased from a 2-star to a 3-star rating. Per CMS, a 3-Star rating means the organization provides good quality of care. A rating of 2 stars means that the agency's performance was below the average of other organizations measured but does not necessarily mean care is poor.

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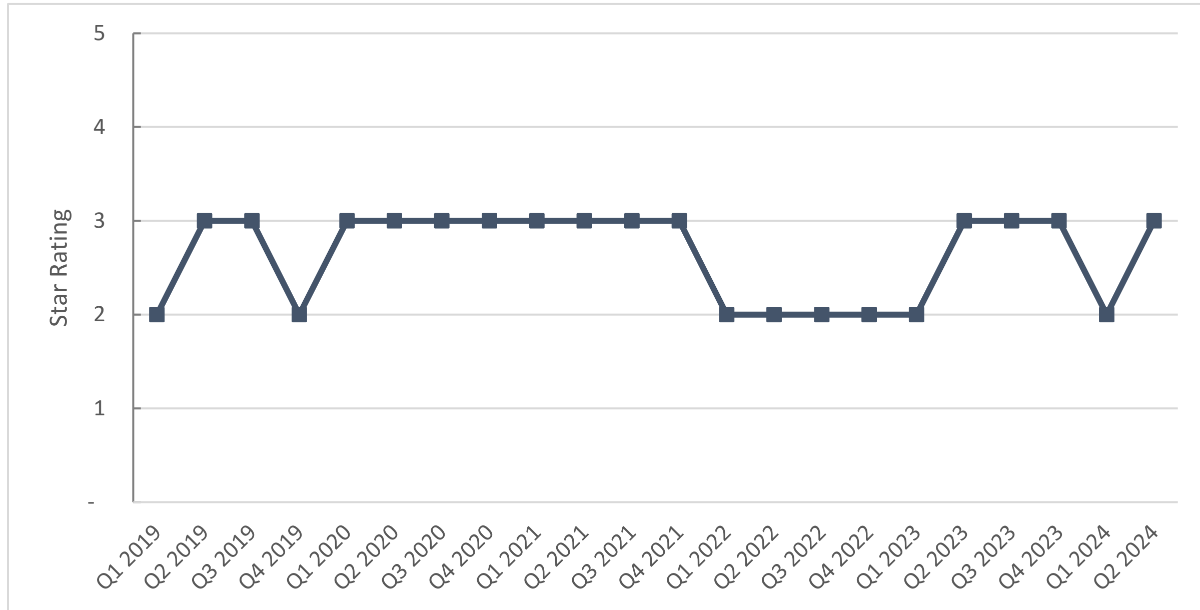
[12] *Centers for Medicare and Medicaid Services (CMS) Archives. https://data.cms.gov/provider-data/archived-data/hospitals.*

[13] Assesses varying aspects of the hospital experience including: nurse communication, doctor communication, responsiveness of hospital staff, communication about medicines, discharge information, care transition, cleanliness of hospital environment, quietness of hospital environment, and willingness to recommend hospital.

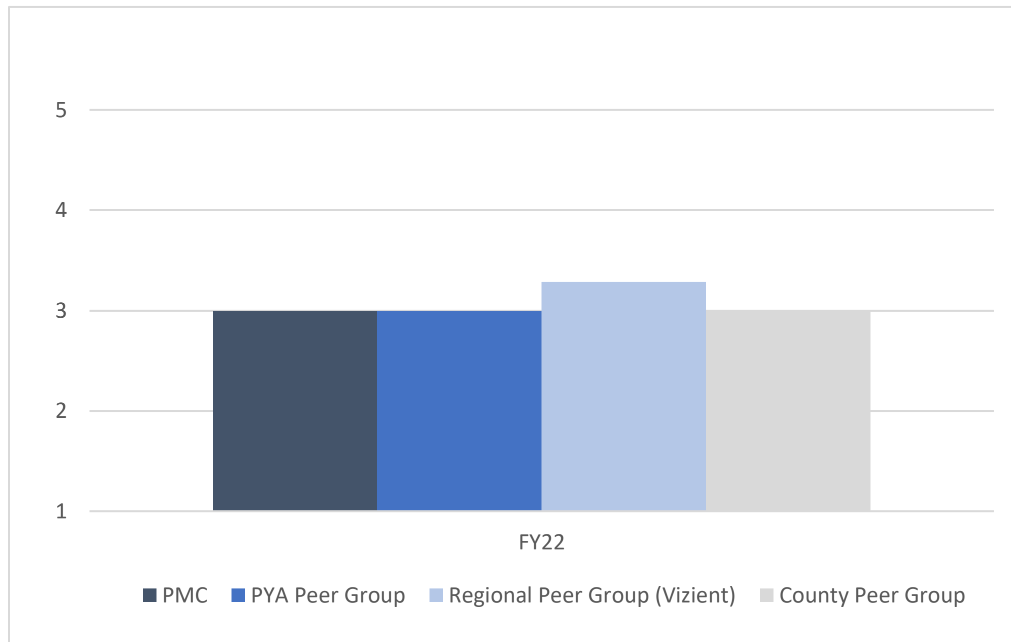
[14] Survey of patients' experiences (HCAHPS), Centers for Medicare & Medicaid Services (CMS), <https://data.cms.gov/provider-data/topics/hospitals/hcahps>, accessed on April 30, 2024.

Figure 10 – PMC HCAHPS Star Ratings, 2019-2024



When measured against its peers on HCAHPS ratings, PMC is rated at relative equivalence as shown in Figure 11 below.[15]

Figure 11 – HCAHPS Star Ratings, PMC vs. Peers, FY22



[15] Peer comparison HCAHPS rating based data pulled through Q1 2024.

Timely

AVERAGE TIME PATIENTS SPEND IN THE ED BEFORE LEAVING FROM THE VISIT[16]

Often, communities utilize EDs as a hospital's front door. This is especially true in communities that lack sufficient primary care resources to provide lower acuity services in accessible, convenient, lower cost settings. North Brevard County is one such community, characterized in interviews as having too few private primary care options, limited availability (i.e., hours of service) within the primary care options that do exist, and a public health system drastically limited in the amount of primary care it can provide. Specifically, an independent study[17] of local healthcare manpower needs commissioned by PMC in April 2022 cited a need for more pediatric, internal medicine, and family medicine physicians in PMC's service area.

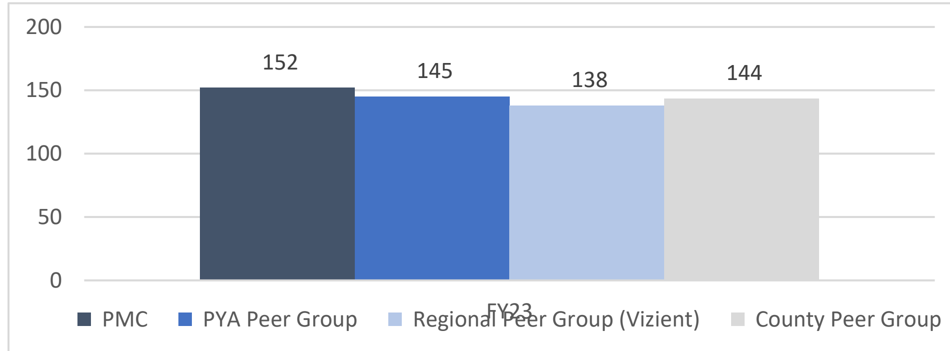
As communicated by CMS, delays before getting care in the ED can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Long ED stays before treatment and release may be a sign that the ED is understaffed or overcrowded. While higher levels of patient acuity may also be associated with increased ED times, more time is thought to indicate treatment delays and, in turn, lower quality.

This measure reports the average time in minutes that patients spent in the ED – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.[18]

As displayed in Figure 12 on the following page, in FY23, PMC patients averaged 152 minutes in the ED. This is slightly higher than, though similar to, PMC's peers. As previously mentioned, this measure does not adjust for patient acuity, which data limitations preclude.

[16] *CMS Hospital Compare and Provider Data Catalog.* https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-compare.
[17] Lifton Associates Manpower Plan – April 2022.
[18] Emergency department care, Centers for Medicare & Medicaid Services (CMS), https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care#emergency-department-care, accessed on April 30, 2024.

Figure 12 – Average Time Patients Spend in the ED Before Leaving from the Visit, PMC vs. Peers, FY23



Takeaways

In any operational performance improvement exercise, success is measured by key results. As observed, a key strategic objective is to "provide safe, quality patient care consistent with our mission and in accordance with regulatory expectations." Key results associated with safety of care and mortality as measured by CMS[19] are:

- Safety of Care – PMC Target: 80% | PMC Current Score: 85.7%
- Mortality Index – PMC Target: 80% | PMC Current Score: 83.0%

Additionally, PMC tracks key, quality and safety related results:

- Internal readmission rate[20] – PMC Target: 14.6% | PMC Current Score: 9.1%
- Leapfrog Group Safety Grade above average (B or better) | Current Grade – A

After assessing PMC relative to the quality criteria presented, we believe the organization is committed to providing quality care as stated in its mission, vision, and values statements as well as submitted performance data, and is delivering comparable or better quality than its peers in many areas. The importance of quality and quality improvement is recognized across PMC leadership, including, and most importantly, in those areas where improvement is required. PMC has achieved marked improvement in quality over the years within those areas where PMC has invested its focus and resources.

[19] Information regarding CMS quality rankings can be found at *Centers for Medicare & Medicaid Services: Overall Hospital Quality Star Rating. https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/#measure-included-by-categories.*

[20] PMC's internal readmission rate differs from CMS all cause readmission rates as it is a monthly measure, is not risk adjusted, and captures readmissions to PMC only. For PMC's internal readmission rate the numerator is readmissions to PMC and the denominator is the eligible population.

Access

The National Academy of Medicine defines access to health care as "the timely use of personal health services to achieve the best health outcomes." As listed in Healthy People 2020, released by the U.S. Department of Health and Human Services, access to health care consists of four components: coverage, services, timeliness, and workforce. While coverage (i.e., health insurance) falls outside the control of the District, providing convenient, consistent, reliable, and affordable access to care within the community both in terms of access points (e.g., physical locations) as well as programs and services, is the duty of providers, including hospitals and the overall healthcare system. PYA also notes that cost of care is also considered by many to be a determinant of access and is discussed later in this section.

To assess the degree to which the District provides appropriate access to care, the following measures were evaluated:

Access Dimension	Data Measures
Geographic Distribution	PMC Access Points in Brevard County
Scope of Services and Programs	PMC Clinical Services Additions within the Past 5 Years

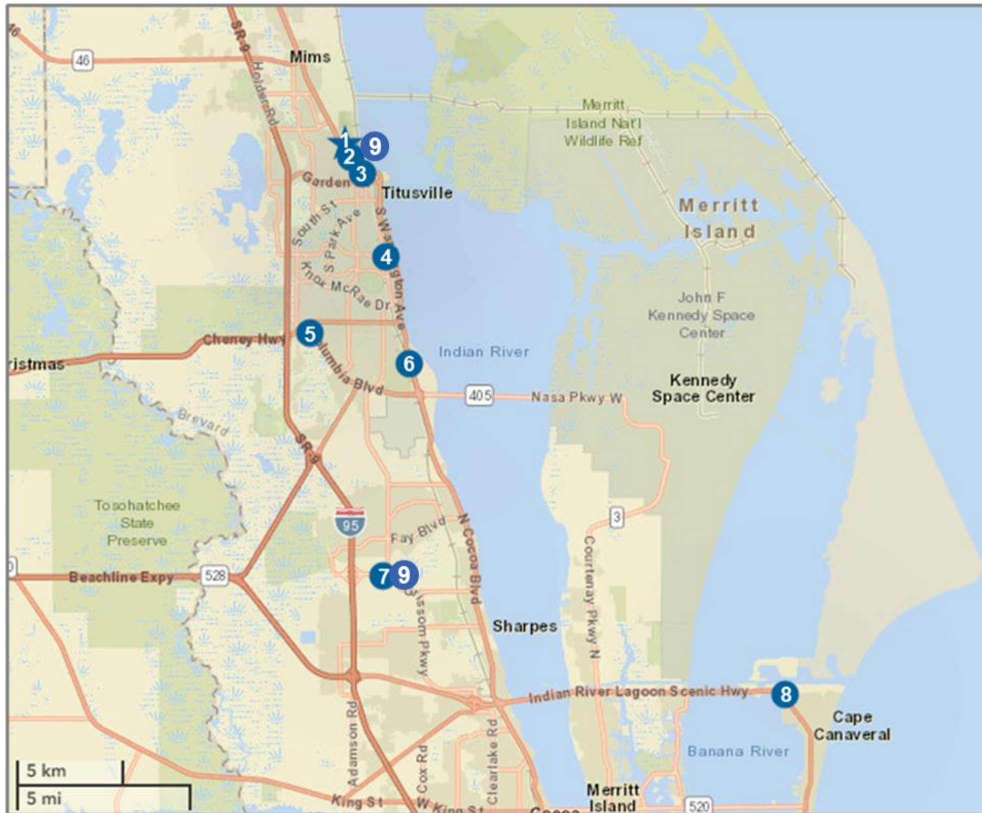
Geographic Distribution

PMC ACCESS POINTS IN BREVARD COUNTY[21]

In addition to its primary physical location in the District, PMC operates clinical locations in Cape Canaveral and Port St. John, Florida. Figure 13 on the following page maps the District's locations across Brevard County, both owned and supported. Locations are approximate and may overlap due to facilities/services being located in close proximity to one another.

[21] Per PMC management team.

Figure 13 – PMC Brevard County Access Points



Key	Location
1	Parrish Medical Center (includes Parrish Oncology Center)
2	Parrish Home Health; Senior Consultation Center
3	Parrish Occupational Health
4	Parrish Healthcare Center at Titus Landing (primary care and multi-specialty care)
5	Parrish Health and Wellness at Cross Roads
6	The Children's Center including Pediatric Outpatient Subspecialty Clinic
7	Parrish Healthcare Center in Port St. John (primary care and multi-specialty care)
8	Parrish Healthcare Center at Port Canaveral (primary care)
9	Space Coast Health Center

Scope of Services and Programs

In addition to its geographic footprint, the District offers a wide range of primary and specialty clinical services, many of which have been added in recent years to serve demonstrated community need. PMC primary and specialty clinical services include the following[22]:

[22] Services, https://www.parrishhealthcare.com/our-services/, accessed on May 2, 2024.

PMC CLINICAL SERVICES[23]

For an independent FISD of moderate scale in terms of its asset and revenue base, PMC provides a broad array of community-appropriate services:

Figure 14 – PMC Clinical Services

PMC Clinical Services		
Acute Care	Geriatric Services	Orthopedics
Behavioral Health	Healing in Motion Van	Physical Therapy
Cardiac Rehabilitation	Hospice	Podiatry
Cardiology	Infusion Services	Primary Care
Care Navigation	Interventional Cardiology	Robotic-Assisted Services
Diabetes Care	Interventional Radiology	Skilled Nursing
Diagnostic Imaging	Lung Screening	Speech Therapy
Dialysis	Maternity Care	Sports Medicine
Emergency Care	OB/GYN	Surgical Services
Endocrinology	Occupational Therapy	Urology
Gastroenterology	Oncology	

For services that PMC does not offer, as well as higher-acuity levels of service that PMC is not equipped to offer and lower volume services for which resource requirements (e.g., personnel costs) would be prohibitively expensive, it seeks to partner with other regional health systems to ensure District residents have access to a full range of clinical services. Select clinical services partnerships include:

- Ongoing work with the Cleveland Clinic for development of the following service lines:
  - Cardiovascular
  - Oncology
  - Orthopedics
- Staffing of call centers to assist with patient care coordination through 211 Information Helpline
- Joint ventures with DaVita for End-Stage Renal Disease services and LHC Home Healthcare for home health services, respectively
- Pediatric specialty/subspecialty partnership with Orlando Health

CLINICAL SERVICES ADDITIONS WITHIN THE PAST 3 YEARS[24]

PMC has added over 50 new healthcare providers and over 30 programs since 2020. The following programs and services have recently been added at PMC:

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[23] Per PMC management team.
[24] Per PMC management team.

- Implantable device to treat sleep disorders.
- Peer recovery specialist program for addiction patients.
- Residency program for psychologists to improve inpatient and outpatient access to behavioral health services.
- Interventional cardiology services:
  - New offering of cardiac ablations for treatment of atrial fibrillation and cardiac resynchronization therapy devices.
  - Restarted cardio-pulmonary therapy program.
  - Endoscopic vascular aortic repair procedures.
  - Hemodialysis circuit maintenance.
  - Shockwave intravascular lithotripsy (IVL) – advanced heart disease treatment for the prevention of heart attack or stroke.
  - Same-day ablations for atrial fibrillation patients (Brevard County's first hospital to do so).
  - Introduced and began performing Micra Pacemaker for treatment of atrial ventral block.
  - Rapid blood clot aspiration from arteries and veins of various sizes.
  - Advanced percutaneous cardiac assist device that pumps for the heart.
  - Rapid blood clot busting/removal for quick restoration of blood flow.
- Interventional Radiology:
  - Biliary (percutaneous placement of drains, biliary stent placement, internal biliary biopsy).
  - Hysterosalpingogram.
  - Myelograms.
  - Nephrostomy.
  - Peripheral arteriograms.
  - Radio-frequency ablations (renal, lung and liver tumors).
- Radiology:
  - 3D mammography across three locations.
- Surgery:
  - Robotic assisted total joint replacement (knee and hip).
  - Robotic assisted surgery (general, gynecology, urology).
    - Procedures include but not limited to hernia repair, cholecystectomy, colon resection, hysterectomy, prostatectomy.

  - Vasectomy Reversal.
- Rehabilitation:
  - Lymphedema clinic.
  - Voice therapy.
  - Wheel chair clinic.
  - Ehler-danlos syndrome and hyper-mobility program.
  - Pelvic floor program.
  - Hand therapy and splinting program.
  - Oncology Rehabilitation program.
  - Parkinson's disease therapy.

Takeaways

PMC provides a broad and deep set of primary care and comprehensive specialty services for a community the size of North Brevard County. In recent years, PMC has continued to add an array of new programs and services. Specific to access, PMC identified physician availability, primary care physician ratios, ED utilization, and local healthcare ratings as key areas of opportunity identified through its 2022 Community Health Needs Assessment (CHNA). Overall, it is apparent that PMC is making investments to improve the access to care within the community.

Community Benefit

Per its website, PMC's mission is "Healing Experiences for Everyone All the Time." As Brevard County's only independent, public, not-for profit community medical center, PMC reinvests all available resources into advancing programs, services, technology, and health professionals dedicated to improving the health and wellbeing of North Brevard residents. To assess PMC's contributions to the benefit to the North Brevard County community, the following measures were assessed:

Community Benefit Dimension	Data Measures
Financial Assistance and Community Benefit	Indigent/Charity Care Charges as a Percentage of Gross Revenues

CHARITY CARE CHARGES AS A PERCENTAGE OF GROSS REVENUES[25]

Charity care represents that portion of health care services provided to individuals from whom payment is not expected. The Florida Hospital Association defines charity care as "free" or "discounted" medically necessary care that hospitals offer to uninsured and insured patients that cannot afford to pay for their care. This includes both inpatient and ED services. Under Florida

[25] *PMC Audited Financial Statements. https://www.parrishhealthcare.com/about-us/financial-health/.*

state law, charity care is defined as a portion of hospital charges for care provided to a patient whose family income for the 12 months preceding the determination is equal to or less than 150% of the current federal nonfarm poverty guideline or the number of hospital charges due from the patient which exceeds 25% of the annual family income and for which there is no compensation.[26]

To measure the amount of "free" or "discounted" medically necessary care that PMC provides to patients who cannot afford to pay for their care, we divide total charity care charges by the total amount of gross patient charges generated during that time period. Figure 15 displays this metric for the past five fiscal years from available finalized audited financial statements.

Figure 15 – PMC Trended Charity Care Charge Ratio, FY18-FY22

Parrish Medical Center (Dollars in Thousands)

	FY18	FY19	FY20	FY21	FY22
Charity Charges	$ 16,522	$ 14,377	$ 27,633	$ 51,212	$ 30,863
Gross Charges	$ 624,816	$ 607,528	$ 567,648	$ 602,267	$ 615,977
Charity Care % of Gross Charges	*2.6%*	*2.4%*	*4.9%*	*8.5%*	*5.0%*

Source: PMC Audited Financial Statements

PMC nearly doubled the amount of charity care provided from FY18 to FY22. It is also important to note that while charity care at PMC is recognized by the amount of charges forgone for services, charity care is also provided through reduced price services and fee programs offered throughout the year based on activities such as wellness programs, community education programs, and health fairs. Such costs to PMC, while real, are not accounted for in the above calculation but, if they were, would increase its ratio.

To further meet the needs of North Brevard County residents, in accordance with federal health reform legislation for non-profit hospitals, PMC participates in a countywide CHNA development process every three years. The recent Brevard County CHNA was developed in 2022.

PMC evaluated the findings of the countywide CHNA, performed by a county non-profit and, based on its first-hand understanding of North Brevard County health needs, determined the local market required its own CHNA. Through a CHNA exercise that PMC funded and administered, the countywide areas of focus were narrowed to three (see below). PMC believed that, given the underrepresentation of District residents in the countywide CHNA development process (only 40 of 1,200 completed resident surveys were from residents of the District, whereas the PMC-led process touched over 300 District residents), a more focused effort was necessary.

Countywide and PMC-led CHNA priorities included:

- Heart Disease and Stroke ***PMC Strategic Area of Focus***
- Access to HealthCare ***PMC Strategic Area of Focus***
- Potentially Disabling Conditions

[26] Section 394.4787(3), Florida Statutes.

- Cancer
- Respiratory Disease
- Diabetes ***PMC Strategic Area of Focus***
- Nutrition, Physical Activity/Weight
- Mental Health
- Substance Abuse
- Tobacco Use
- Injury and Violence
- Oral Health

PMC developed a comprehensive list of planned actions, anticipated impacts, and planned resources for each of the strategic areas of focus. Further, PMC planned for collaboration with partner agencies to include city and county government, federally qualified health clinics (FQHC), schools, churches, charitable organizations, behavioral health locations, fundraising collaborations, and others. Lastly, PMC provided key metrics to measure progress for each strategic area of focus. The 2022 CHNA and associated implementation strategies can be found on PMC's website.

Takeaways

PYA is aware that organizations invest in their communities not just through the amount of charity care they provide, but also through the development of programs and services focused on demonstrated community needs. Over the past decade, PMC has invested over $221 million through charity care, community building, and benefit initiatives. PMC has contributed over $9 million to the community through cash and in-kind donations and sponsorships. Lastly and no less importantly, as a FISD, PMC has the ability to ask its community to assess *ad valorem* taxes to support hospital operations. Since 2017, FISD hospitals have levied $2.3 billion in *ad valorem* taxes collectively. Over the last 29 years, PMC has forgone $42 million in potential revenue. In the interest of not placing additional burden on District taxpayers in an already economically-depressed community, for the past 29 years the PMC Board of Directors has chosen not to seek tax support as a means of funding the District. As stated by a District Board member recently:

> *"PMC serves the community's health through compassionate and exceptional care and is recognized as one of the nation's finest healing environments. We are pleased to continue to take this position on behalf of the community we serve while also investing tens of millions of dollars back into North Brevard each year in charity care and services."*
>
> -Robert Jordan, PMC Board Chairman

Cost

It is important to recognize that definitions of and perspectives on the cost of care varies by the party that is incurring the expense. Quantifying and comparing the cost that is the responsibility of the individual receiving care is not easily done. The American Medical Association defines cost as follows:

- To providers: the expense incurred to deliver health care services to patients.
- To payers: the amount paid to providers for services rendered.
- To patients: the amount paid for out-of-pocket for health care services.

Cost amounts are impacted by the relationship that a patient may have to an insurer and the insurer's relationship to the providers that deliver that care. However, by reviewing general measures of cost and spending for care that a hospital or major insurer such as Medicare incurs, one can reasonably assume that the higher or lower it costs to deliver care translates to a higher or lower cost borne by the patient.

The following data measures related to cost of care were analyzed for the District and its peers:

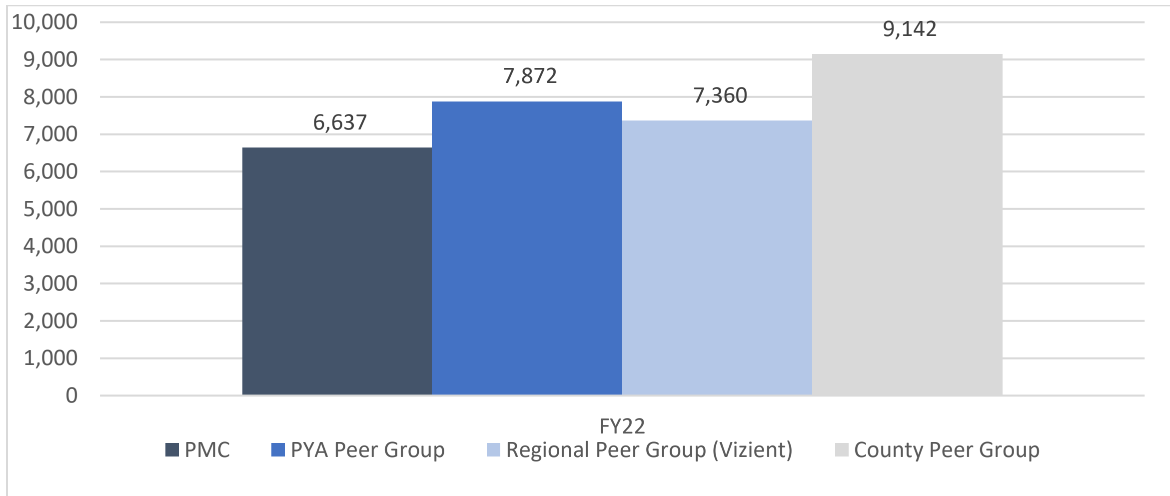
Cost Dimension	Data Measures
Cost of Care	Case-Mix Adjusted Cost per Discharge
	Medicare Spending per Beneficiary

CASE MIX ADJUSTED (CMI-ADJUSTED) COST PER DISCHARGE[27]

Applying a case mix- and wage index-adjusted cost per discharge allows us to remove the effect of patient acuity (severity of illness) and geography on the values being measured, which makes comparison to District peers more relevant. As Figure 16 on the following page shows, PMC's CMI-adjusted cost per discharge in FY22 was 10 to 37% lower than the three peer group averages, with the Brevard County facility peers reporting significantly higher CMI-adjusted cost per discharge.

[27] *Definitive Healthcare*. https://www.defhc.com/.

Figure 16 – PMC CMI-Adjusted Cost Per Discharge vs. Peers, FY22



MEDICARE SPENDING PER BENEFICIARY[28]

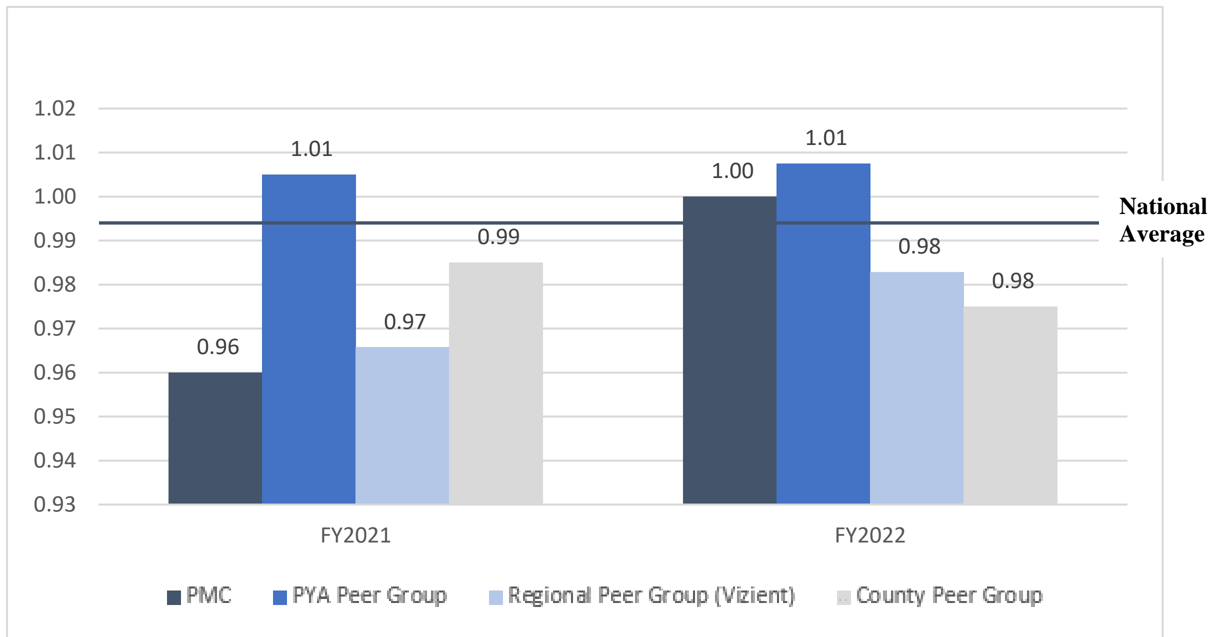
Medicare Spending Per Beneficiary (MSPB) measures whether Medicare spends more, less, or about the same for an entire episode of care delivered to a Medicare patient. This measure includes all Medicare Part A and Part B payments made for services provided to a patient during an episode of care, which includes the three days prior to the hospital stay, the inpatient hospital stay, and the 30 days after discharge from the hospital.

The MSPB is calculated by dividing the amount Medicare spent per patient for an entire episode of care initiated by the District by the median (or middle) amount Medicare spent per episode of care nationally. These payments are adjusted to remove variances due to factors such as geography, patient age, and health status.

The national average MSPB was 0.99 for 2021 and 2022. As shown in Figure 17 on the following page, PMC had a rate of 0.96 and 1.00 for FY2021 and FY2022, respectively, indicating Medicare spent less per patient in the District's care for an episode of care than across all inpatient hospitals nationally in FY2021 and slightly more in FY2022. PMC's MSPB is materially similar to its peers.

[28] *Centers for Medicare and Medicaid Services (CMS) Archives. https://data.cms.gov/provider-data/archived-data/hospitals.*

Figure 17 – PMC Medicare Cost per Beneficiary vs. Peers, FY21-FY22



Takeaways

On a measurable cost basis, PMC performs largely as well or favorably to its peer groups. PMC's spending on Medicare patients appears to be consistent with all peer groups, while its CMI-adjusted cost per discharge is lower, sometimes materially, than similarly-situated hospitals.

Financial Performance

Like any other business, a hospital's financial performance is a key indicator of overall sustainability. Hospitals typically use standard financial measures to assess three key aspects of the business's financial health: profitability, liquidity, and capitalization. Profitability measures an organization's ability to generate enough excess of revenue over expenses to invest in growth; liquidity measures an organization's ability to weather unexpected economic or other downturns and meet short-term obligations; and capitalization measures a company's financial leverage, or whether its debt levels inhibit the organization's ability to invest in growth.

The following industry-standard data measures were assessed to measure the District's financial performance:

Financial Performance Dimension	Data Measures
Profitability	Earnings before interest, taxes, depreciation, and amortization (EBITDA) Margin
Liquidity	Days Cash on Hand
Capitalization	Debt-to-Capitalization Ratio

Profitability

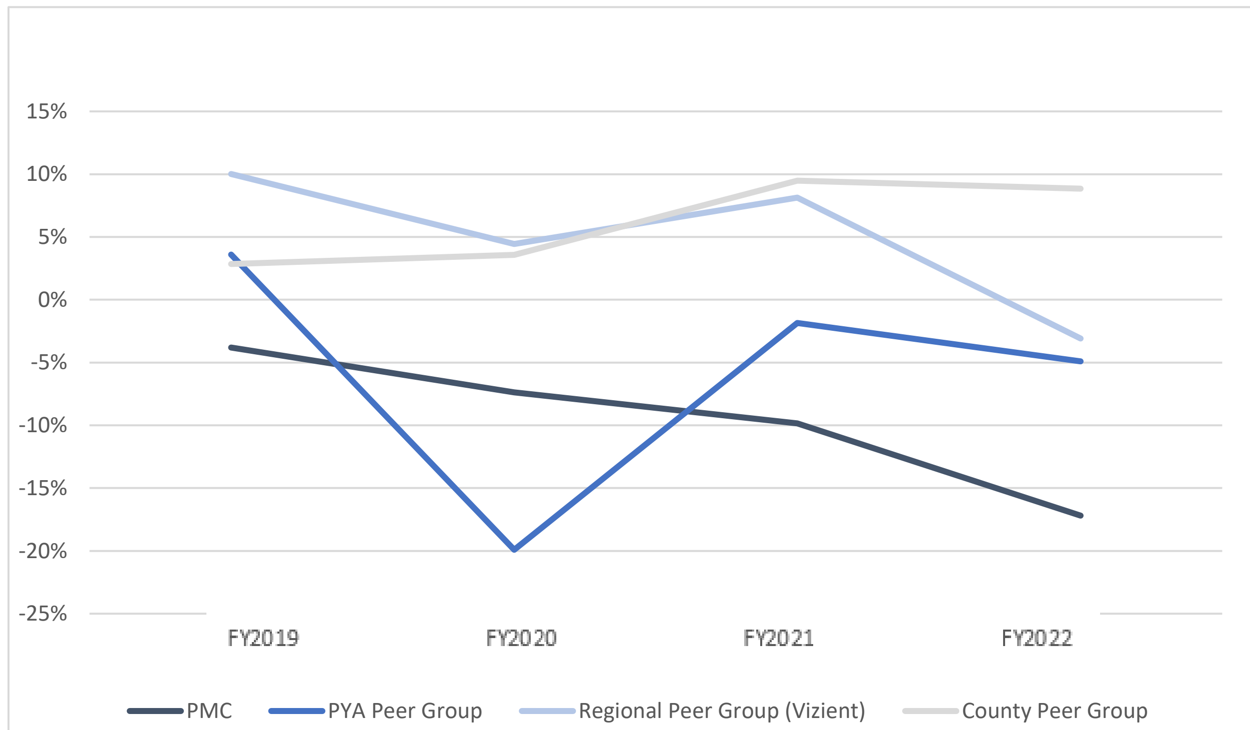
EBITDA MARGIN[29]

EBITDA margin, which measures cash flow before interest, tax, depreciation, and amortization as a percentage of total revenue is considered a standard financial ratio in U.S. healthcare. Since EBITDA is calculated before any interest, taxes, depreciation and amortization, the EBITDA margin measures overall financial performance or profitability.

Note: Reported EBITDA margin as reported by Definitive Healthcare is not consistent with rating agency (e.g., Moody's, Fitch, and S&P) calculations. Accordingly, any comparison to agency benchmarks may not be appropriate. Due to data limitations of peer groups, PYA has utilized Definitive Healthcare's calculation of EBITDA margin.

As shown in Figure 18 below, according to data submitted in the Medicare Cost Reports and as reported by Definitive Healthcare, PMC has experienced a decline in EBITDA margin from FY2019 to FY2021, while peer groups have experienced mixed results.

Figure 18 – PMC EBITDA Margin vs. Peers, FY19-22



It is likely that the outsized impact of the COVID-19 pandemic on hospital operating performance is the main driver for depressed EBITDA margin among PMC and its peers during the evaluation period.

[29] *Definitive Healthcare*. https://www.defhc.com/.

Liquidity

DAYS CASH ON HAND[30]

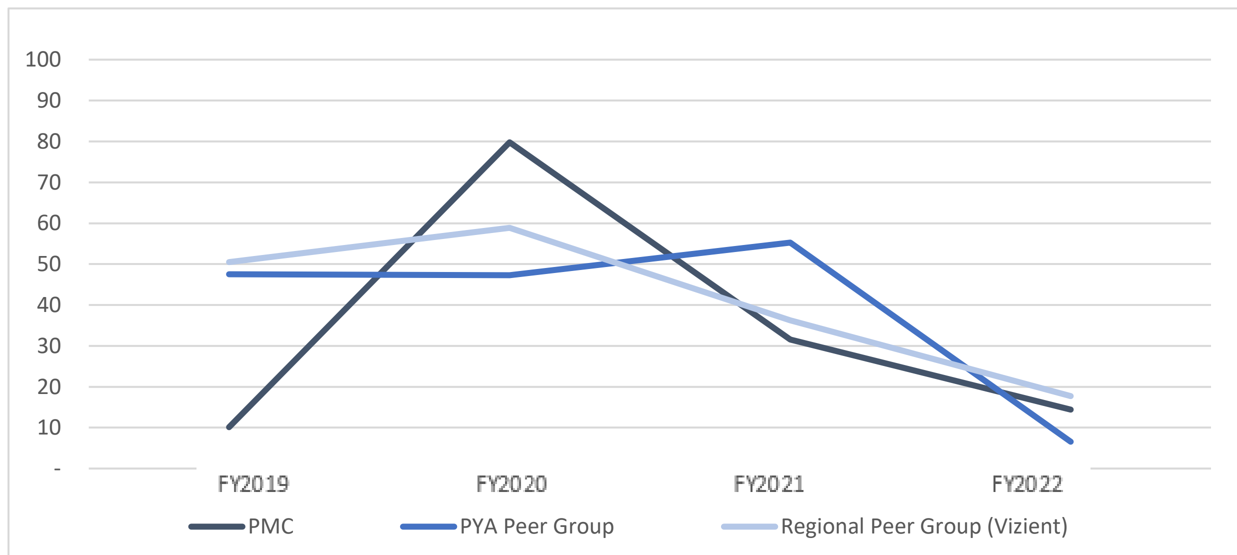
Days Cash on Hand (DCOH) is a measure of the duration of time in days an organization could meet its obligations and continue operations if cash receipts ceased. Higher values indicate high liquidity and greater stability. DCOH is calculated as follows:

(Cash on Hand + Temporary Investments) / ((Total Operating Expenses – Depreciation Expense) / 365)).

As shown in Figure 19 below, since FY2019, PMC appears to perform at relative levels consistent with its peers. PYA notes, however, that DCOH as reported by our source[31] appears depressed across peer organizations and PMC. (In its FY22 audited financial statements, as a point of reference, PMC reported DCOH of 245 days, which is more typical of what PYA would expect to see for an organization of similar size, scope, and location.)

PYA believes that the source data and algorithm(s), while excluding elements of "cash" we would expect to be included and therefore return depressed figures, nonetheless are likely calculated in the same manner for all peers and PMC, and thus provide a reasonable reflection of the District's relative performance to its peers, and have therefore been included. In this case, the County peer group was omitted from consideration given extremely wide, inexplicable variation in year-to-year reported numbers.

Figure 19 – PMC Days Cash on Hand vs. Peers, FY19-22



[30] *Definitive Healthcare.* https://www.defhc.com/.
[31] Definitive Healthcare. https://www.defhc.com/.

Capitalization

DEBT-TO-CAPITALIZATION RATIO[32]

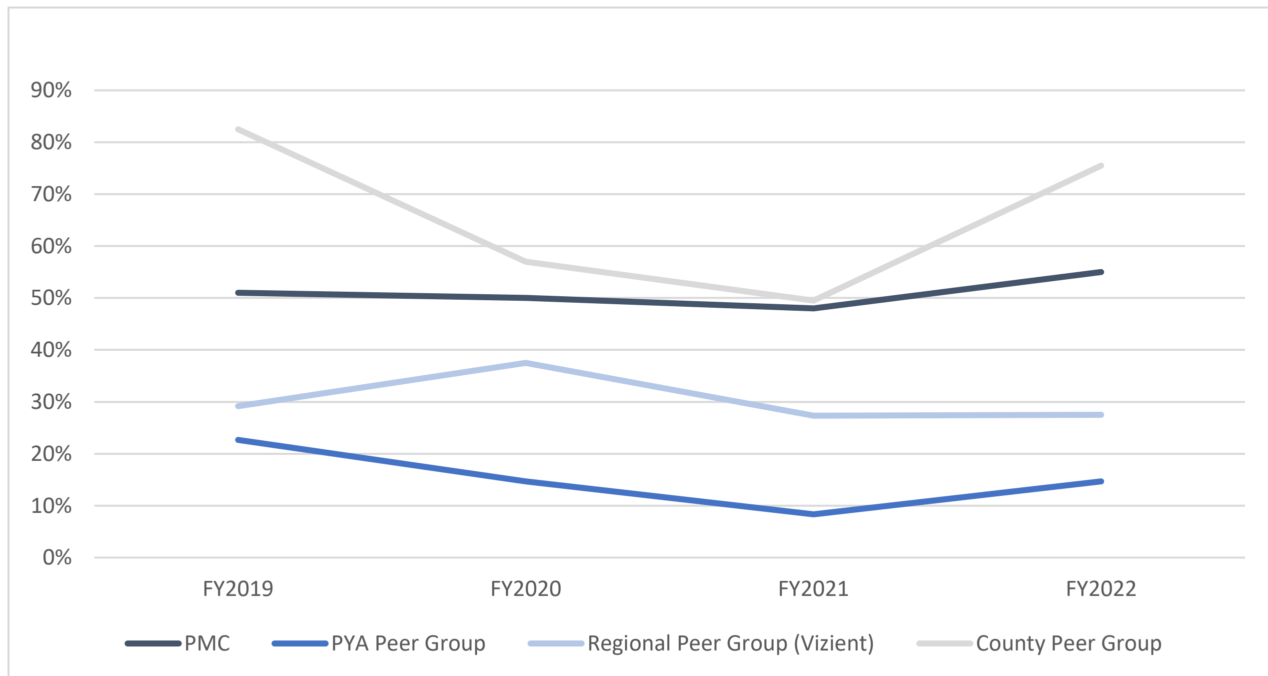
The Debt-to-Capitalization ratio measures the degree to which a company is financing its operation through debt versus equity. Lower values are preferable, whereas higher values imply a greater reliance on debt financing and may indicate high interest costs to service debt and a reduced ability to take on additional debt at favorable terms. Debt-to-Capitalization is calculated as follows:

Total Debt / (Total Debt + Total Equity)

Note: Reported Debt-to-Capitalization Ratio as reported by Definitive Healthcare is not consistent with rating agency (e.g., Moody's, Fitch, and S&P) calculations. Accordingly, any comparison to agency benchmarks may not be appropriate. Due to data limitations within peer groups, PYA has utilized Definitive Healthcare's calculation of Debt-to-Capitalization Ratio.

As shown in Figure 20 below, according to data submitted in the Medicare Cost Reports and as reported by Definitive Healthcare, PMC has had a higher debt-to-capitalization ratio compared to PYA and Regional peers, but lower than its County peers. PMC's ratio has remained steady at over 50% for the four-year period.

Figure 20 – PMC Debt-to-Capitalization Ratio vs. Peers, FY19-22



[32] *Definitive Healthcare*. https://www.defhc.com/.

Takeaways

One of PMC's core operating tenets, as described to PYA, is to "operate with fiscal stewardship without taxation." PMC tracks its results in this area through a variety of indicators, including budgeting scores, operating margin, purchasing compliance, and operating as a "low-cost" provider. To date, PMC is meeting most, if not all, of its internal expectations. It is important to highlight that PMC and all peer groups experienced depressed EBITDA margins and DCOH. Similar to many not-for-profit hospitals nationwide, the impact of the COVID-19 pandemic has been the main driver of this observed financial underperformance. That all said, building cash on its balance sheet should be a primary focus for PMC as it moves forward.

d. COMPARISON TO SERVICES PROVIDED BY THE COUNTY AND/OR MUNICIPAL GOVERNMENTS

The Florida Department of Health in Brevard County (FDHBC) is one of 67 departments of the Florida Department of Health. It provides public and community health support services to the citizens of Brevard County. Established as the Brevard/Osceola Health Department in 1947 and split in 1959 to better address the needs of two fast-growing counties, FDHBC today is positioned to serve the public health needs of the over 500,000 residents of Brevard County.

In recent decades, the Florida Department of Health and, in turn, FDHBC has undergone a material transformation in its function and focus. Where FDHBC once served as a front line provider of healthcare services to the underserved in Brevard County, today it largely serves as an information aggregator, public health issue identifier, and coordinator of public healthcare delivery efforts in partnership with the providers such as PMC and other community health support entities (e.g., churches, foundations, volunteer organizations) in the county.

FDHBC delivers an array of important services, including vital statistics documentation, clinical/nutritional education, wellness programming, community health planning and statistics, environmental and public health, and emergency preparedness and response services to the citizens of Brevard County. Its role in delivering clinical care to the community, however, has diminished over time.

Today, FDHBC operates three (3) clinic locations across Brevard County: Melbourne, Titusville, and Viera. Figure 21 on the following page represents FDHBC's clinic footprint:

Figure 21 - Florida Department of Health in Brevard County Clinic Locations

FDHBC clinics deliver helpful educational and support services to especially underserved residents of the county. Unfortunately, however, the FDHBC of today is only able to deliver true clinical care in certain locations, none of which are located in North Brevard County. In recent years, for example, both the highly successful and busy pediatrics and dental clinics at FDHBC's Titusville location have ceased serving patients. To receive care in these specialties today, residents must travel to FDHBC's Viera clinic, approximately 30 miles away, which can prove challenging to individuals and families that lack transportation options.

Figure 22 below highlights the clinical services FDHBC cites it provides at each of its clinic locations:

Figure 22 - Florida Department of Health in Brevard County Clinic Services

Titusville Clinic	Viera Clinic	Melbourne Clinic
Family Planning Immunizations Maternity Women, Infants, and Children Sexually Transmitted Diseases School Health	Family Planning Immunizations Maternity Women, Infants, and Children Sexually Transmitted Diseases Dental Space Coast Volunteers in Medicine Tuberculosis	Family Planning Immunizations Maternity Women, Infants, and Children Sexually Transmitted Diseases

Today's market reality is that the District and FDHBC provide very few, if any, of the same services to the citizens of Brevard County. While the organizations continue to collaborate together and in partnership with other community support organizations, there is little overlap in their scopes of service. As such, there are no readily apparent opportunities to consolidate services within either entity to more efficiently and effectively serve the community.

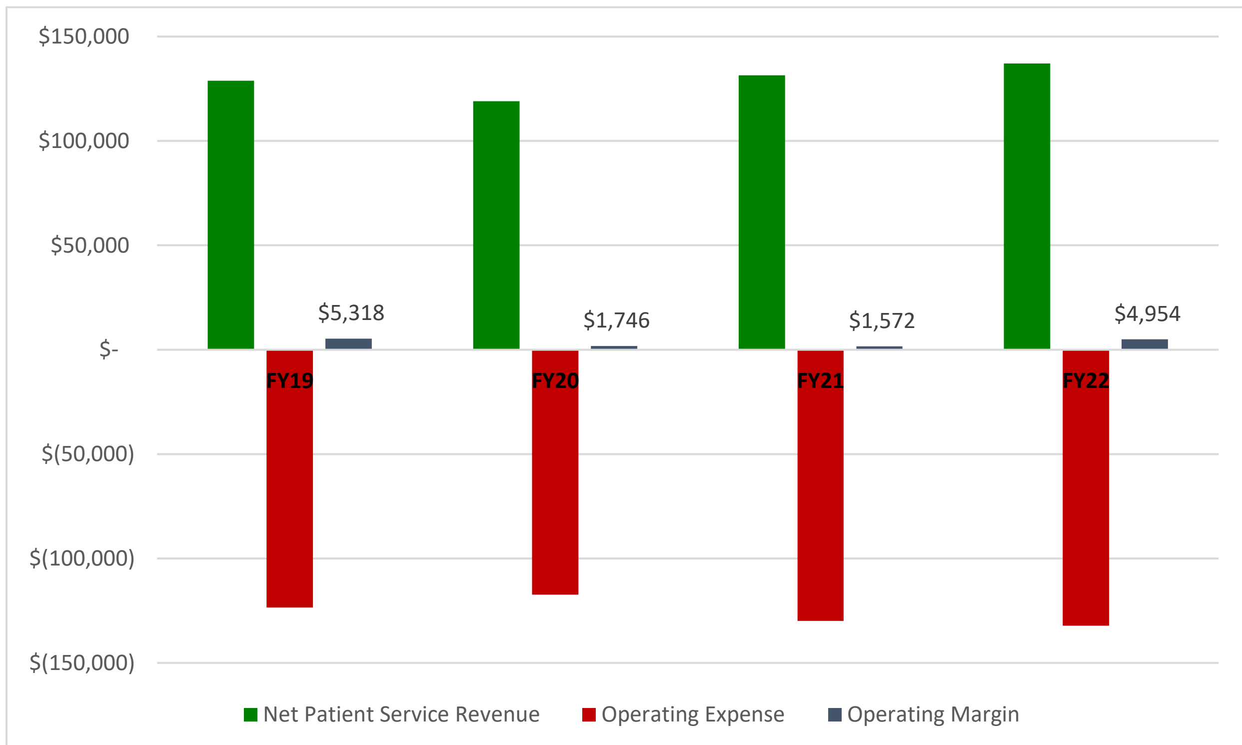
Likewise, to FDHBC, local municipalities such as Titusville do not directly provide clinical services to residents that could be evaluated in relation to the District's service mix.

e. REVENUES/COSTS OF DISTRICT PROGRAMS AND ACTIVITIES

Hospital financial health and sustainability are largely determined by an organization's ability to generate a financial margin on operations that can be then re-invested in the maintenance and growth of the assets, programs, and people.

Figure 23 presents trended PMC net patient service revenue and operating costs over its past four fiscal years. Program/activity-level revenues and costs are unavailable for inclusion in this report, though overall operating margin is considered a proxy for institutional financial performance. In PMC's case, that performance has been positive, despite a historically adverse operating environment in recent years. Additional information regarding costs and financial performance can be found in section III.c.

Figure 23 –PMC Net Patient Service Revenue, Operating Expenses and Operating Margin, FY19-22



While audited FY23 PMC financial statements[33] were not available as of the date of this report, PYA does understand that PMC had a historically poor financial performance that year. It is our belief the challenges were associated with longer-term impacts of the pandemic. PYA believes management has put in place plans and initiatives to improve the District's financial performance in future years and is committed to following through on those initiatives.

[33] Given proprietary nature of audited financial statements, PYA would neither have been able to collect nor calculate financial ratios on peer organizations.

There are a variety of actions the District could take to improve its operating margin position, up to and including eliminating clinical services, many of which history indicates would not be filled by competing health systems. Given its purpose and mission, PMC has chosen to provide the community with services based on a balance of need and financial realities, as opposed to basing programming decisions on economic considerations first, or only.

f. EXTENT TO WHICH PMC GOALS HAVE BEEN ACHIEVED

As referenced in section III.b., PMC's enabling legislation/charter does not specify program/activity specific operating performance goals and objectives beyond its designated purpose. PMC utilizes its mission, vision and values to communicate its overarching goals and objectives to the communities it serves:

- Mission: Healing Experiences for Everyone All the Time.
- Vision: Healing Families—Healing Communities.
- Values: Safety, Loyalty, Integrity, Compassion, Excellence, Stewardship.

While not easily quantifiable, the preponderance of data contained within this report would, PYA believes, lead the reasonable observer to the conclusion that, despite its challenging circumstances, PMC is working diligently to improve health in the community, improve patient access and experience, deliver high quality care and outcomes, and to do all of those things in a financially-prudent manner.

Based on results shown in Section III.c., PMC compares or outperforms its peers across most evaluation domains. Additionally, the organization has demonstrated resilience in the face of generational challenges and shows signs of improvement as it moves beyond the pandemic.

g. DISTRICT PERFORMANCE MEASURES & STANDARDS

As reported by leadership and demonstrated in operating/financial information provided to PYA, PMC is committed to the utilization of key performance indicators (KPI) and improvement across all relevant performance measures. Management consistently tracks KPIs to understand individual and collective performance against strategic goals, and actively initiates mitigation strategies and/or contingency plans when performance is not meeting expectations. A select number of PMC's KPIs, many of which PYA independently utilized as part of this evaluation, include:

- People
  - Vacancy rates
  - Turnover rates
- Services
  - HCAHPS ranking
  - ED patient experience
- Quality and safety
  - CMS quality rankings
- Growth
  - CHNA development
  - Implementation plan development
- Finance
  - Budgeting
  - Operating margin

While most KPIs are being achieved, some are not, which for organizations in constant pursuit of improvement, as PMC is, should always be the case. As noted above, for those metrics that are not being met, PMC has contingency plans in place to ensure performance improvement. After reviewing material provided by the District, PYA views PMC's KPIs as appropriate and comprehensive in number and nature and therefore does not recommend revision at this time.

h. FACTORS THAT HAVE CONTRIBUTED TO UNMET PERFORMANCE STANDARDS AND/OR GOALS AND OBJECTIVES

As highlighted in Section III.c., the District has largely maintained a respectable level of operating performance in recent years despite the negative impacts of a global pandemic. While there have been some challenges in Financial Performance, the District has maintained or improved its performance in the areas of Quality, Access, Community Benefit, and Cost, while it has shown resilience in the area of Financial Performance.

The financial challenges faced by PMC in recent years and any associated unmet performance standards are, in reality, more typical of health systems nationally given the burdens of a challenging national and healthcare economic environment and escalating competitive pressures. These challenges are playing out in real time in Brevard County, as illustrated by Steward Health, the corporate owner of Rockledge Regional Medical Center and Melbourne Regional Medical Center, which in May 2024 filed for federal bankruptcy protection, announcing its intention to sell all its hospital assets. In PYA's experience, sudden, disruptive market events of this nature also frequently have the "long tails" associated with external economic shocks and market structural considerations detailed below.

The past two decades have also visited a number of external macroeconomic shocks on the North Brevard County healthcare economy, each of which can be classified as long tail (i.e., unforeseen impacts that play out over extended timeframes) events. The first was the Great Recession of 2009 that followed the US housing market implosion that hit Florida particularly hard. The second was the end of NASA's space shuttle program in 2011, which resulted in over 20,000 job losses that are still being recouped to this day. Third, and most important, was the COVID-19 pandemic, which impacted health system demand in ways never previously experienced by the industry.

District operating performance has also been hampered by the absence of a supportive, high-performing public health function in North Brevard County.

Covid-19 Pandemic

As a result of the COVID-19 pandemic and its continuing aftermath, PMC and hospitals nationally suffered severe economic challenges, driven by reductions in elective procedures and overall inpatient acuity, which drove revenue down while the fixed-nature of hospital costs remained high.

In 2020, the District experienced a material decrease in net patient service revenue (-8%). This decrease was largely due to the suspension of elective procedural volumes through most of 2020. Given many elective procedure patients are commercially-insured patients, having to suspend service delivery negatively impacted District profitability.

Another measure of health system reimbursement levels is patient acuity, which is measured by CMI (defined above). In normal times, higher CMI is correlated with higher revenue. During the pandemic, however, the traditional correlation did not hold. Given the suspension of elective volumes, which are typically low CMI but relatively highly profitably, PMC's overall CMI went

up as fewer low acuity cases contributed to the overall average. So while CMI increased, it did so at the cost of profitability.

The pandemic had a negative impact on the cost side, as well. Much of what comprises a health system's costs are fixed in nature and cannot be varied in a timely fashion as volume changes occur. Additionally, the necessity of utilizing agency or "traveler" staff during the depths of the pandemic caused labor costs to soar. These factors in combination negatively impacted overall organizational performance.

Community Health Infrastructure

The absence of high-functioning, care delivery-focused community health infrastructure in the district places the District in a challenging position. Rather than, as in many communities across the US, serving as a primary provider of care to underserved populations, the FDHBC largely serves as an aggregator of data and convener of initiatives to serve the underserved. This reality places a significant burden on other public and private healthcare providers in the district, including and especially PMC.

While there is a licensed FQHC in Brevard County, Brevard Health Alliance (BHA), it does not effectively serve the District. Studies performed by PMC indicate BHA has consistently failed to meet federal guidelines for the percentage of community need an FQHC is expected to meet, as well as consistently exceeds the recommended maximum threshold for commercially-insured patients served by an FQHC.

As a result, PMC led the effort to establish a "lookalike FQHC," Space Coast Health Center (SCHC), developed in accordance with federal regulations to assist in serving the underserved in North Brevard County. With its current investment in SCHC exceeding $2 million, the District has clearly demonstrated its desire to stabilize services to the underserved in the district.

Mitigating Strategies

While it was impossible to predict the macroeconomic shocks that PMC has experienced in the past several decades, the District's efforts to build resilience in the face of potential future market volatility are evident. One need only look to the investment in the lookalike FQHC as a demonstration of the District's commitment to the market, though there are others. As mentioned, the District actively partners with larger, regional health systems to ensure that the highest-acuity care is accessible to residents of the district. It has also, after a rigorous evaluation process of its own, secured a strategic relationship with the Cleveland Clinic to provide access to world-class healthcare and healthcare providers close to home. These and other initiatives epitomize District leadership's focus on strengthening the organization to deal with future market volatility.

It is apparent to PYA that the District has sought, and continues to seek, to persevere in the face of the economic and other challenges it faces. While management and Board efforts have not yet brought the District back to its historic levels of financial performance across all measures, and there are still repercussions of national and global events being felt, their actions demonstrate

leadership's ability to identify and address the challenges of an increasingly difficult operating environment.

i. RECOMMENDATIONS FOR STATUTORY OR BUDGETARY CHANGES

In PYA's estimation, PMC, given its market and operating circumstances, is a well-managed, largely effective, and essential provider of healthcare services to the residents of the District. Given PMC's operating and financial performance trends, resilience in the face of industry and market challenges discussed herein, as well as its ongoing rebound from the COVID-19 pandemic, PYA believes the District has begun to strengthen its overall position in the market.

As in all healthcare organizations, and as the District recognizes, there are always opportunities (and challenges) to improve the effectiveness, efficiency and, in turn, sustainability of operations. Many of the opportunities (and challenges) have been identified by PMC leadership and plans to exploit opportunities and/or mitigate challenges are already underway.

In light of the District's current market and organizational realities, PYA does not recommend *per se* statutory or budgetary changes to the District at this time.

In the spirit of ensuring the District maintains rigor and focus in its operational improvement efforts, however, PYA does recommend it:

1. Establish a process to develop comprehensive, long-term, enterprise-level financial projections to determine whether operating margins can be maintained in PMC's current operating environment with its current resources, or if additional revenue sources and/or cost efficiencies may need to be sought.
2. Continue to evaluate regional provider partnership opportunities, as appropriate, to ensure high quality, efficiently delivered services are accessible to North Brevard County residents, (especially in clinical areas where PMC's patient population is insufficient to ensure minimum volume thresholds).
3. Evaluate breadth of clinical programming for continued provision by PMC; seek to identify partners as able to alleviate impact of dilutive programs on PMC financials.
4. Continue to support the development of a high-performing public health infrastructure utilizing the lookalike FQHC model.

APPENDIX A:
ABOUT PYA

PYA BACKGROUND

YEAR FOUNDED **1983**

SIZE OF FIRM **250+** WE ARE A TOP ACCOUNTING & CONSULTING FIRM

OFFICE LOCATIONS
Atlanta
Charlotte
Helena
Kansas City
Knoxville
Nashville
Tampa

WE SERVE A MULTITUDE OF INDUSTRIES

Community Banks | Not for Profit Organizations | Industrial Development Boards | Entrepreneurial Start-Ups | High Wealth Individuals | Privately Owned Small Businesses | Academic Medical Centers | Diagnostic Centers | Dialysis Centers Health Plans | Health Systems | Home Health Agencies Hospices Hospitals | Independent Practice Associations (IPAs) Maternity Centers | Medical Groups | Mental Health Centers Nursing Homes | Physical Therapy Centers | Physicians Psychiatric Hospitals | Rural Health Centers | Surgery Centers Title Insurance | Urgent Care Centers

CLIENT LOCATIONS

IN AN INDUSTRY DRIVEN **BY CREDENTIALS,** OUR TALENTED TEAM HAS THE ALPHABET **COVERED...**

AAPC ICD-10-CM INSTRUCTOR, ABV, AM, AMLP, ASA, ASC-EM, BSN, CBA, CCE, CCIM, CCM, CCS, CCSFP, CCVTC, CCVTS ICD-10-CM TRAINER, CEMC, CFA, CFE, CFP, CFF CHC, CHCA-F, CHP, CHQP, CIA, CIRA, CISA, CMA, CMPE, COSC, CPA, CPC, CPC-I, CPHQ, CPM, CPMA, CRCM, CRE, CRMA, CVA, FACHE, FHFMA, IACCP, JD, LLM, MAcc, MAFF, MBA, MC, MHA, MPA, MPH, MS, MSHA, MSHI, MST, PCMH, PHR, PMP, RHIA, RN, SHRM-CP, SHRM-SCP

WHY PYA?

PYA understands its 40 years of success is a direct result of highly motivated and experienced people.

From its establishment 40 years ago, PYA has grown to a full-service healthcare advisory and accounting firm 50 Principals and a team of more than 200 professionals. Our people have backgrounds and degrees in nursing, healthcare administration, public health, medicine, economics, finance, management, accounting, tax, and law. Several have extensive prior experience with other healthcare-related organizations, and have specialized training in clinical medicine, clinical coding, and regulatory matters.

Because of our focus on client service and the highly motivating environment in which we operate, we have been very successful in recruiting dedicated and experienced people from national consulting firms and healthcare organizations.

Leveraging the diverse experience and expertise of our people allows us to gain a unique perspective on the industry and marketplace. We call it "Vision Beyond the Numbers®". We use this perspective to develop tools and methodologies that help our clients identify opportunities and creative solutions where other consultants have only found problems. We value most the integrity and objectivity of our people. These values enable us to continuously deliver and maintain the quality of service that clients require. Additionally, we offer the following compelling reasons for selecting our firm:

- PYA has built one of the largest dedicated healthcare consulting practices in the nation.
- PYA utilizes experienced professionals to achieve superior results in a cost effective and timely manner.
- PYA determines success not by completion of individual projects, but by the ultimate success of its clients. We feel that this, combined with our unmatched knowledge of the strategies and operational goals being implemented today by healthcare providers and businesses, makes us the firm of choice.

APPENDIX B:
PEER GROUPS

PYA Peer Group Criteria

Criteria	Regional Peer Group
Hospital Type	Short Term Acute Care Hospital / Independent
State	AL, FL, GA, MS, NC, SC, TN
Staffed Beds	100-500
Discharges	Less than 7,500
CBSA Population	250,000 – 999,999
Ownership	Governmental & Voluntary Non-Profit
Median Household Income	<125% and >75% of Brevard County ($71,308)
Persons in Poverty	10% - 20%

PYA Peer Group

Hospital Name	County	City	State
Conway Medical Center	Horry	Conway	SC
Singing River Gulfport	Harrison	Gulfport	MS
Tidelands Waccamaw Community Hospital	Horry	Murrells Inlet	SC
Blount Memorial Hospital	Blount	Columbus	TN

Regional Peer Group Criteria

Criteria	Regional Peer Group
Peers identified through Vizient member network	Medium Community in Southeast

Regional Peer Group Membership

Hospital Name	County	City	State
Baptist Medical Center East	Montgomery	Montgomery	AL
Helen Keller Hospital	Colbert	Sheffield	AL
Marshall Medical Center South	Marshall	Boaz	AL
Thomas Hospital	Baldwin	Fairhope	AL
T.J. Samson Community Hospital	Barren	Glasgow	KY
South Lake Hospital	Lake	Clermont	FL
Health Central Hospital	Orange	Ocoee	FL

Regional Peer Group Criteria

Criteria	Regional Peer Group
Geographic proximity to PMC	Closest general acute care hospitals.

Brevard County Peer Group Membership

Hospital Name	County	City	State
Cape Canaveral Hospital	Brevard	Cocoa Beach	FL
Rockledge Regional Medical Center	Brevard	Rockledge	FL

APPENDIX C:
INTERVIEW LISTING

Interview Listing

Individual	Role
George Mikitarian	President/Chief Executive Officer
Mark Liston	Interim Chief Financial Officer
Christopher McAlpine	Senior Vice President/Chief Transformation Officer
Michael Sitowitz	Controller
Matthew Graybill	Assistant Vice President, Operations
LeeAnn Cottrell	Assistant Vice President
Natalie Sellers	Senior Vice President, Communications
Christopher Manion, MD, MBA	President/Chief Medical Officer, Parrish Health Network
Aluino Ochoa, MD	Internal Medicine
Kevat Patel, MD	Primary Care