Evaluation of the Amended and Restated Lease and Transfer Agreement Between the Hospital Authority of Albany - Dougherty County and Phoebe Putney Memorial Hospital Dated as of August 1, 2012

Prepared for:
Hospital Authority of Albany - Dougherty County

May 17, 2021

VISION BEYOND the Numbers®

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Executive Summary

Introduction

In January 2021, the Hospital Authority of Albany-Dougherty County, Georgia ("the Authority") engaged PYA, P.C. ("PYA") to perform an independent, third party evaluation of Phoebe Putney Memorial Hospital's ("PPMH" or "the Hospital") compliance and performance under the *Amended and Restated Lease and Transfer Agreement Between the Authority and the Hospital Dated as of August 1, 2012* ("the Lease"), as well as additional key metrics requested by the Authority. The most recent evaluation of the Lease was conducted in 2008, and the Authority determined than an updated assessment was due.

According to the Authority website, the Authority was created in 1941. Through the years, the Authority maintained operating control of PPMH, overseeing expansions of the Hospital in the mid-1940s and again in the 1960s. In the late 1980s, recognizing the limitations imposed by Georgia's Hospital Authorities Law, the Authority began to consider alternatives that would let the Hospital have more flexibility and growth potential in a changing healthcare environment. Therefore, the Hospital was restructured in 1990, and Phoebe Putney Memorial Hospital Inc. ("PPMH, Inc.") was created and leased the hospital assets from the Authority. At that point, the Authority handed over day-to-day operations of the Hospital to PPMH, Inc., while maintaining an oversight or supervisory role the assets, and to ensure the terms of the Lease and the requirements of the Hospital Authorities Law are met.[1]

With the restructuring in 1990, PPMH, Inc. created the Phoebe Putney Health System ("PPHS") to enable PPMH's growth beyond the borders of Dougherty County. PPHS in total includes four acute care hospital facilities, which serve a six-county service area including, Dougherty, Lee, Mitchell, Sumter, Terrell, and Worth counties. Two of PPMH Inc.'s hospitals, Phoebe Putney Memorial Hospital and Phoebe Putney North, are under the Lease with the Albany-Dougherty County Hospital Authority. This report concerns itself only with the facilities under the control of PPMH, Inc.

Evaluation Approach

When discussing the approach of the engagement with the Authority, PYA noted that the Lease neither defines nor quantifies expected areas and/or levels of Hospital performance, with the exception of a few specific areas (e.g., Charity Care No Less Than 3% of Gross Revenues).[2] Where the Lease does define performance expectations, it does not specify the data sources to be utilized for measurement of the specified criteria. Additionally, per the Lease and as described above, the Authority maintains Hospital asset ownership and oversight responsibility, as well as fiduciary supervision authority only. Day-to-day operational responsibility resides with the Hospital.

Therefore, in the spirit of developing a thorough, objective evaluation of the Hospital's performance in the absence of documented, Lease-defined performance metrics and thresholds, PYA endeavored to create an objective, transparent, data-driven evaluation framework that incorporates, where possible, concepts and metrics that are generally viewed as industry-standard gauges of hospital performance.

At the highest level, PYA worked with the Authority to identify a set of "evaluation domains," or areas that, based on firm experience, represent credible operating, financial, and other measures against which hospital performance can be relatively measured. As we understand the Authority's needs and

[1] "About Us," http://www.haadc.org/HospitalAuthority_AboutUs.html, accessed on April 28, 2021.
[2] The lease definition specifically notes that *funds for charity care should be no less than 3% of the gross revenues of the Hospital after provisions for bad debt and Medicaid and Medicare adjustments have been deducted.*

desired information with respect to the evaluation, these domains best capture those intentions. The domains used for the evaluation included:

- Quality;
- Access;
- Community Benefit;
- Facilities Maintenance;
- Cost; and
- Financial Performance.

Upon the Authority's request, PYA agreed to append the initial evaluation domains to include, as able, the Hospital's performance in emerging areas of importance to the Authority, including:

- Diversity, Equity, and Inclusion (Belonging); and
- COVID-19 Response Management.

For each of the eight (8) agreed-upon evaluation domains, PYA worked with the Authority to identify a critical question to be addressed through the evaluation. The critical questions this report attempts to answer include:

- **Quality** – Does the Hospital provide quality care to the community it serves?
- **Access** – Has the Hospital maintained and/or improved access to care in the community (e.g., locations, services)?
- **Community Benefit** – Has the Hospital met its obligations regarding the delivery of care to the indigent?
- **Facilities Maintenance** – Is the Hospital appropriately maintaining the Authority's assets?
- **Cost** – Does the Hospital provide services at an appropriate cost?
- **Financial Performance** – Has the financial management been of a caliber to service the debt, and to provide relative assurance the organization will continue to operate in the foreseeable future?
- **Diversity, Equity, and Inclusion (Belonging)** – Does the Hospital advance health equity and belonging to create a more just and equitable organization?
- **COVID-19 Response** Management – How effectively has the Hospital managed the COVID-19 pandemic?

Within each domain, PYA identified reputable, industry-standard data sources that enable relative comparisons between the Hospital's performance and that of its peers. PYA leveraged existing definitions and frameworks for each domain to ensure the objectivity of the evaluation. For example, the Institute of Medicine's ("IOM") definition of quality along six dimensions (safe, effective, patient-centered, timely, efficient, and equitable) was utilized as our Quality domain framework. In other areas where industry-accepted definitions are in place, those were utilized.

While this approach did not always allow for a "perfect fit" of industry definitions into the eight (8) evaluation domains (e.g., IOM includes "equitable" in quality, whereas PYA included it in the Diversity, Health Equity, and Inclusion domain) we re-categorized definitions and metrics to ensure inclusion and completeness. Lastly, PYA also requested, and received, internal performance data from the Hospital that enabled the evaluation of trends where comparative data were unavailable, or where the Hospital

uses other sources of data (i.e., Audited Financial Statements) to internally track and report on measures.

In total, the metrics that comprise each evaluation domain include:

Assessment Domain	Evaluation Measures
Quality	• Total Hospital-Acquired Condition ("HAC") Score Percentile • 30-Day All Cause Hospital-Wide Readmission Rate • Deaths Among Patients with Serious Treatable Complications After Surgery • HCAHPS Star Rating • Average Time Patients Spent in the Emergency Department ("ED") Before Leaving from the Visit • Centers for Medicare & Medicaid Services ("CMS") Hospital Compare Overall Rating
Access	• PPMH Access Points in Dougherty County • PPMH Clinical Services Additions with the Past 5 Years
Community Benefit	• Indigent/Charity Care Deductions as a Percent of: Gross Revenue Less Bad Debt/Medicare/Medicaid Deductions • Financial Assistance and Other Community Benefits as a Percentage of Total Expenses
Facilities Maintenance	• Average Age of Plant • Annual Capital Expenditures to Depreciation Ratio
Cost	• Case Mix-Adjusted Cost per Adjusted Discharge • CMI-adjusted Average Length of Stay • Medicare Spending per Beneficiary
Financial Performance	• Earnings Before Interest, Depreciation, Taxes, and Amortization ("EBIDTA") Margin • Days Cash on Hand • Debt to Capitalization Ratio
Diversity, Equity, and Inclusion (Belonging)	• PPMH performance against Just Health Collective's Health & Belonging Maturity Model • PPMH's Board and Leadership Diversity Relative to Community Demographics
COVID-19 Response Management	• Hospital County 7-Day Total COVID Cases • Hospital County 7-Day Percent Positivity • Hospital County 7-Day Testing Volume • Hospital County 7-Day New Hospital Admissions • Hospital County % of Total Population Vaccinated • Hospital States % of Total Population Fully Vaccinated • Local Peer Group Hospital Vaccinations as % of County Vaccinations

The Hospital's performance for the criteria listed above was measured either against similarly situated facilities, or against the Hospital's own performance trends, as follows:

- Public and internally generated, trended Hospital performance information; and

- Peer group comparisons (comprised of local (GA), regional, and national health systems that serve markets similarly comprised to Albany and Dougherty County).

Peer groups were defined utilizing community and hospital characteristics (e.g., population, hospital beds, race/ethnicity, socioeconomics, insurance coverage, financial health, other) approved by the Authority as connoting similarity to Albany and Dougherty County. Complete methodologies and definitions of peer groups are provided in *Appendix A*.

With the exception of the criteria associated with the COVID-19 Response domain, the evaluation and analyses contained herein, where able, are focused on the period 2015-2019, to ensure: a) relative levels of performance improvement/degradation could be measured, and b) the impact of COVID-19 on Hospital performance would be mitigated. In some instances, largely dictated by data availability, differing comparison periods are utilized.

PYA further conducted several interviews and reviewed these qualitative perceptions of key Hospital and community stakeholders to assess whether the facts identified through the data metrics and comparisons to peer groups match up to the reality of the care experience. A list of the individuals interviewed can be found in *Appendix B*.

Key Takeaways

Quality: After assessing PPMH relative to the agreed-upon quality criteria, we believe the Hospital is committed to providing quality care as stated in its mission, vision, values, strategic plans, and scorecards, and is delivering comparable or better quality than its peers in many areas. The importance of quality and quality improvement is recognized across PPMH leadership, including, and most importantly, in those areas where improvement is required. PPMH has achieved marked improvement in quality over the years within those areas where the Hospital has invested its focus and resources.

Access: PPMH provides a broad and deep set of primary care and comprehensive specialty services for a community of Albany's size. Over the last several years, the Hospital has continued to add new programs and services. The physical locations/access points are centralized within the Albany city limits, where the majority of the Dougherty County population reside, such that access to those outside the city limits may be limited to virtual visits or the mobile health centers if travel to the current physical access points is prohibitive. Overall, it is apparent that PPMH is making investments to improve the access to care within the community.

Community Benefit: The Hospital has met its lease obligations to the Hospital Authority regarding the delivery of care to the indigent, by exceeding the 3% target metric for indigent charity care as a percentage of gross revenue in each year from 2015 to 2019. While PPMH's percentage of charity care to gross revenue remained lower than its peers since 2016, the Hospital's total charity care spending at $71 million is nearly the same as it was in 2015 ($77 million) when PPMH's charity care percentage exceeding other peer groups. The Hospital states in its 2020 Audited Financial Statements that it spends approximately $94 million annually in various community benefits and intends to invest in community programs over the next few years aligned with needs identified in its community needs assessment (e.g., Diabetes Prevention, Behavioral Health and Addiction, Improving Birth Outcomes, and Cancer Prevention). Measures that specifically factor in this community benefit spending show the Hospital equaling most peer groups' levels of spending in all years except 2018.

Facilities Maintenance: The majority of PPMH's capital investments since 2015 have been for equipment purchases, with very little investment into the facilities. Smaller building improvement investments have been made recently to expand services such as the vascular lab, hybrid operating room, and to procure the mobile health centers. PYA also noted a significant investment in the Hospital's electronic medical record system in 2015. Compared to its peers, the Hospital is investing less in its fixed assets. It may be the case that PPMH made most of the necessary building acquisitions and investments in the years prior to 2015.

Cost: The cost of the services provided by PPMH are, on average, higher than local, regional, and national peers. The unfavorable cost comparisons may be due, in part, to the Hospital's length of stay performance, which is higher than peer groups. PYA also notes that PPMH's unfavorable cost performance may also be impacted by the Hospital's provision of more costly comprehensive subspecialty services, such as cardiovascular, stroke, and cancer care, as compared to its peers. Data, unfortunately, are insufficient to enable adjustment for such factors. We noted, also, that the Hospital's spending on Medicare patients appears to be more consistent with its peer group. Finally, we note that PPMH makes a number of investments in programs that benefit the local community, which may also elevate its costs above some of its peers.

Financial Performance: As expressed by Moody's, the Hospital's financial health is very strong. While Earnings Before Interest, Depreciation, and Amortization ("EBITDA") Margin, a measure of hospital cash flow, fluctuated during the evaluation period, the Hospital's EBITDA margin performance is comparable, if not better, than its peers. As noted in the Cost Domain section of this report, it is likely that the Hospital's high operating expenses required to deliver comprehensive services to the community is the primary factor contributing to a suppression of the EBITDA margin over the past five years. The Hospital has sufficient liquidity to weather downturns and performs favorably here compared to its peers. One area of concern is the Hospital's high Debt-to-Capitalization ratio, a measure of the utilization of debt to fund its assets, showing the Hospital has relied on long-term debt as a source of total available capital.

Diversity, Health Equity, and Inclusion (Belonging): PPHS is making forward movement and exhibiting early success in creating a more just and equitable health system. Yet, as the Hospital fully recognizes, further work is required to advance health equity as an integral component of the overall strategy, vision, and transformation process.

COVID-19 Response Management: At a county level, Dougherty County is favorable in number of COVID-19 cases, testing volume, and new hospital admissions compared to the local, regional, and national peer groups. Although the county is falling below all peer groups in percentage of population vaccinated, PPMH has been a significant contributor to the community for testing and the treatment of patients with COVID, as well as, administering COVID-19 vaccines. As with hospitals nationally, PPMH has been agile in responding to the pandemic and has accomplished and celebrated several significant milestones over the past year.

Additional detail and supporting information regarding the above summarized findings are included in the body of the report.

Report Limitations

Report limitations every reader should be of aware include:

- Reliance on publicly-available data to enable peer group comparisons – it is recognized that publicly-available data sources are often based on voluntary participation by hospitals and health systems.
- Rankings – some hospitals choose to prioritize achieving high performance according to specific well known ranking programs, such as US News Rankings or Leapfrog Hospital Safety Grades. These ranking systems are built on several defined criteria; most appropriately targeting common quality measures, though some measures require hospitals to make significant resource investments to achieve high scores. Though directionally accurate, programs that look to demonstrate high quality through other means may not measure up in these grading systems as well as their peers.
- Recency – metrics such as those related to Covid-19 are limited to one year of data, with variances in types of data available by states or counties based on few standardized approaches and available resources.
- Differences in definitions – some data sources that report measures define certain metrics one way, while other reports capture a similar measure slightly differently, whether it's adjusting for case mix index, measuring just Medicare patients, or including all or some patients in a length of stay measure.
- 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 different from each other. While the Medicare Cost Reports may be asking for certain categories of data, the inputs may be derived differently.
- Time periods vary based on the metric and its data source, with some reporting individual years, while others aggregate the years provided.
- To meet the reporting expectations of the lease, financial information presented to the Authority by PPMH have historically been provided from annual Audited Financial Statements; thus, these may not reflect the same numbers presented in the metrics provided from other sources in this report which interpret the data differently.

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This remainder of this report constitutes the entirety of PYA's findings associated with the Hospital's performance against the eight (8) evaluation domains described above.

Quality

Quality

Authority Question

Does the Hospital provide quality care to the community it serves?

Context

The term "quality" in health care can be measured in many ways and frequently means different things to different people. Likewise, public and private "arbiters" of quality – the Agency for Healthcare Research and Quality ("AHRQ"), the Centers for Medicare and Medicaid Services ("CMS"), the Institute of Medicine ("IOM"), the Institute for Healthcare Improvement ("IHI"), Leapfrog, the Lown Institute, many others – ascribe to numerous, differing approaches to defining, sourcing and measuring quality.

For purposes of this report, quality refers to the extent to which the healthcare services are provided to individuals and patient populations to improve health outcomes. To measure quality, PYA utilized one of the most influential and generally-accepted quality evaluation frameworks: the IOM, which defines the quality as a function of six (6) dimensions: safe, effective, patient-centered, timely, efficient, and equitable.[3] While the dimensions "efficient" and "equitable" will be addressed in other sections, the other four (4) dimensions are evaluated utilizing generally-accepted and comparable data elements from several sources, including:

Quality Dimension	Data Measures
Safe, Effective	Total Hospital-Acquired Condition ("HAC") Score Percentile
	30-Day All Cause Hospital-Wide Readmission Rate
	Deaths Among Patients with Serious Treatable Complications After Surgery
Patient-Centered	HCAHPS Star Rating
Timely	Average Time Patients Spent in the Emergency Department ("ED") Before Leaving from the Visit
Addresses Multiple Dimensions	CMS Hospital Compare Overall Rating

Safe, Effective

Total Hospital Acquired Condition ("HAC") Score Percentile
Data Source: Definitive Healthcare

The HAC Reduction Program is a Medicare pay-for-performance program that supports the CMS effort to link Medicare payments to healthcare quality in the inpatient hospital setting. Hospitals that rank in the worst-performing 25 percentile of all Total HAC Scores are subject to Medicare payment reductions.[4]

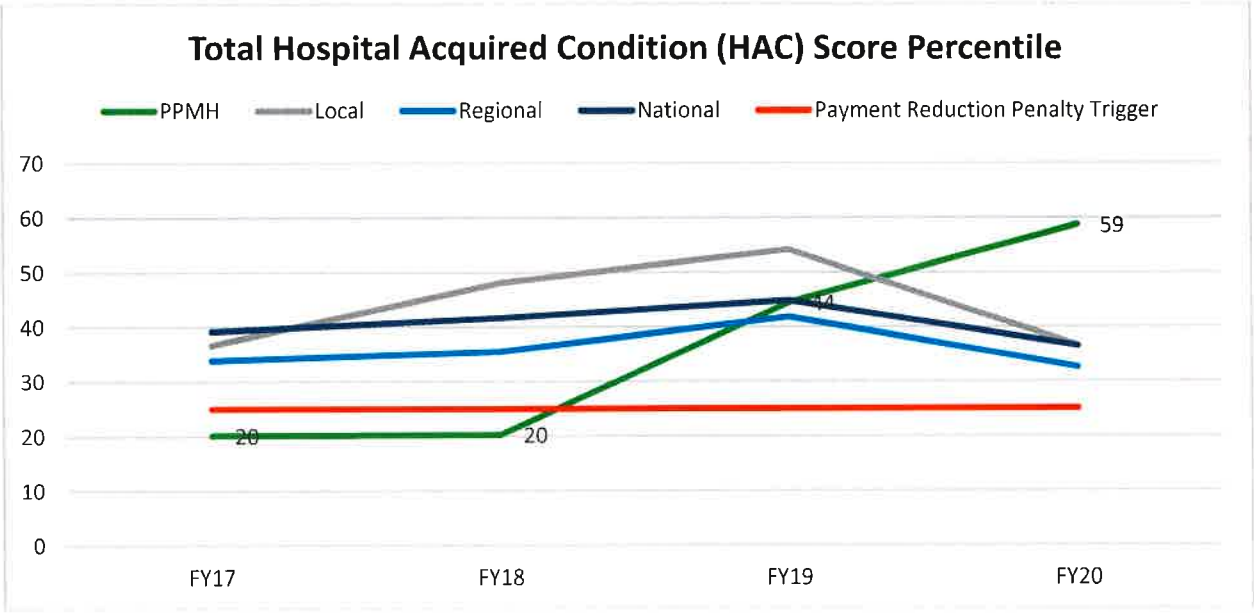
The Total HAC Score is based on data for quality measures, including:

[3] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.
[4] CMS. Hospital-Acquired Condition Reduction Program Fiscal Year 2020 Fact Sheet; July 2019. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/HAC-Reduction-Program-Fact-Sheet.pdf>, accessed on April 28, 2021.

- CMS Recalibrated Patient Safety Indicator ("PSI") 90 and Centers for Disease Control
- Prevention ("CDC") National Healthcare Safety Network ("NHSN") healthcare-associated infection ("HAI") measures which include:
    - Central Line-Associated Bloodstream Infection ("CLABSI")
    - Catheter-Associated Urinary Tract Infection ("CAUTI")
    - Surgical Site Infection ("SSI") – colon and hysterectomy
    - Methicillin-resistant Staphylococcus aureus ("MRSA") bacteremia
    - Clostridium difficile Infection ("CDI")

As displayed in *Figure 1* below, PPMH ranked below the 25th percentile in FY17 and FY18, which triggered a payment reduction penalty. In recent years (FY19 and FY20), however, PPMH achieved marked improvement, exceeding the regional and national peer groups at the 44th and 59th percentiles in FY19 and FY20, respectively.

Figure 1



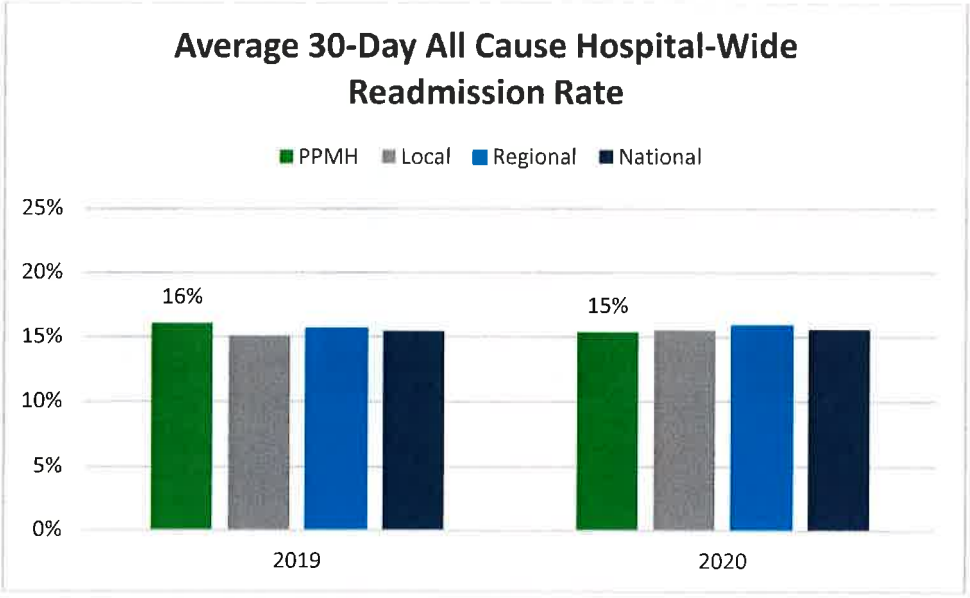
30-Day All Cause Hospital-Wide Readmission Rate (Medicare Fee-For-Service Only)
Data Source: Definitive Healthcare

Some readmissions are unavoidable but may result from lapses in care quality, inadequate communication/coordination, or lack of effective care transition and discharge planning. A standard, widely used safety benchmark from CMS is the 30-day All-Cause Hospital Readmission Rate. This 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 an acute care hospital within 30 days of discharge.[5]

[5] 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 28, 2021.

As shown in *Figure 2* below, in 2019 and 2020, PPMH's readmission rate declined from 16% to 15%. In 2020, PPMH is in line, if not slightly below the local, regional, and national peer group readmission rates.

Figure 2



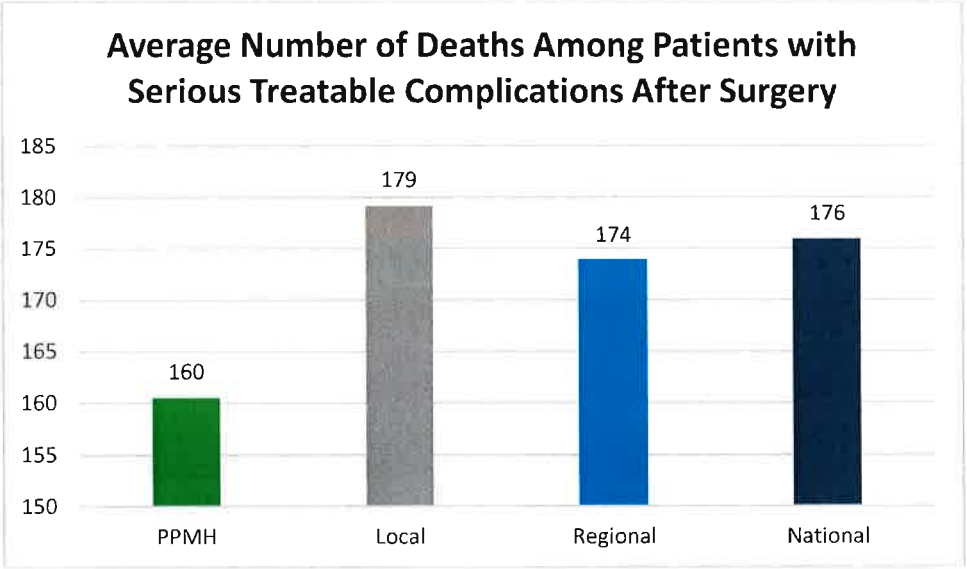
Deaths Among Patients with Serious Treatable Complications After Surgery
Data Source: Hospital Compare

Deaths among patients with serious treatable complications after surgery refers to number of deaths per 1,000 surgical patients who died after developing serious complications that could have been treated. Complications, whether serious or not, during or after surgery 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.[6]

As shown in *Figure 3* below, from July 1, 2017 to June 30, 2019, PPMH had 160 deaths per 1,000 patients with serious treatable complications after surgery, materially outperforming the local, regional, and national peer group rates.

[6] Complications & deaths, Centers for Medicare & Medicaid Services (CMS), <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths/>, accessed on April 28, 2021.

Figure 3



Patient-Centered

HCAHPS Star Rating
Data source: Definitive Healthcare (peer groups) and Hospital Compare Archives (PPMH historic)

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

The HCAHPS Survey is 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 4 times a year. HCAHPS results are based on 4 quarters of data on a rolling basis.

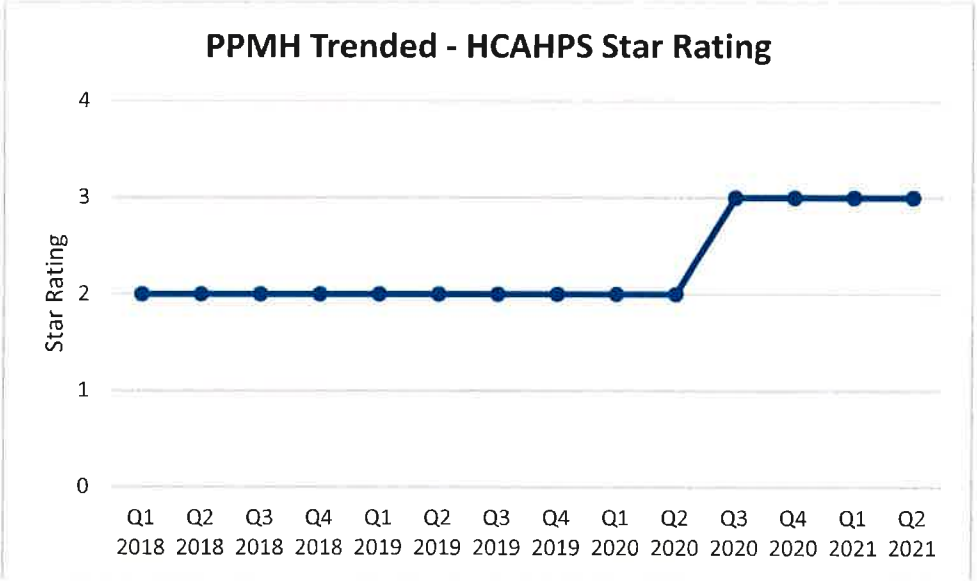
The HCAHPS Survey is 29 questions in length and assess critical aspects of the hospital experience including: nurse communication, doctor communication, responsiveness of hospital staff, communication about medicines, discharge information, care transition, cleanliness of hospital environment, quietness of hospital environment, and willingness to recommend hospital.[7]

Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes updated HCAHPS results four times a year on its Hospital Compare website.

For two and a half years (Q1 2018 to Q2 2020), PPMH consistently received a 2-star rating as trended below in *Figure 4*. However, despite the distraction of the COVID-19 pandemic and local crisis surrounding this challenge, in Q3 2020, PPMH received a 3-star HCAHPS rating and has retained that rating the past four quarters.

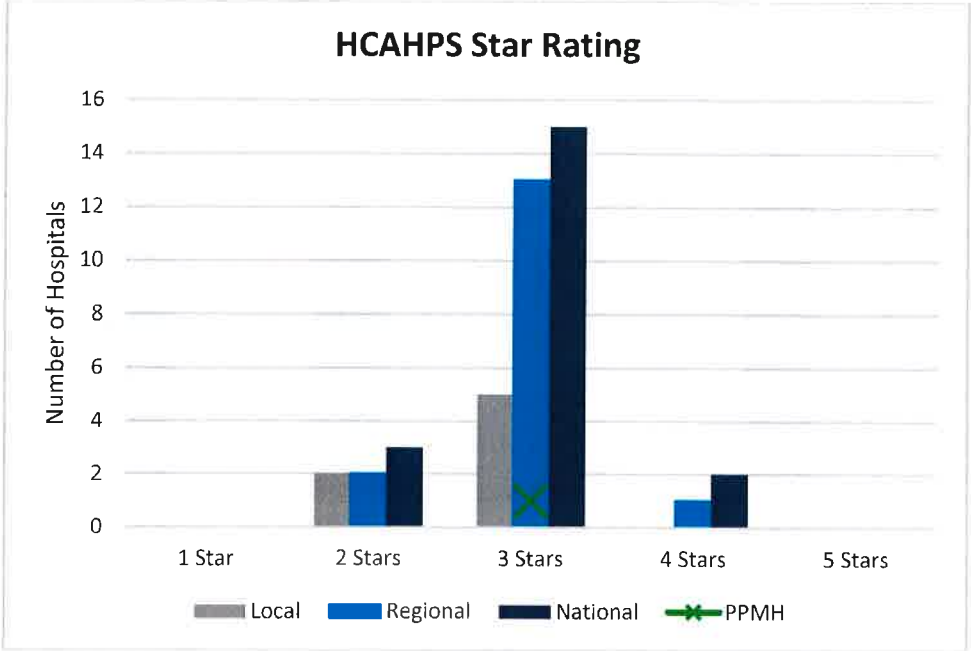
[7] Survey of patients' experiences (HCAHPS), Centers for Medicare & Medicaid Services (CMS), <https://data.cms.gov/provider-data/topics/hospitals/hcahps>, accessed on April 28, 2021

Figure 4



When measured against its peers on HCAHPS ratings, the Hospital also performs well as shown in *Figure 5* below.[8] As compared to the Hospital's 3-star rating, the weighted averages for the local, regional and national peer groups, respectively, was 2.7, 2.9 and 3.0, reflecting the perception among surveyed patients their experience being treated by the Hospital was equivalent to, if not slightly better regarded, than its peers.

Figure 5



[8] Peer comparison HCAHPS rating based data pulled through Q1 2021.

Timely

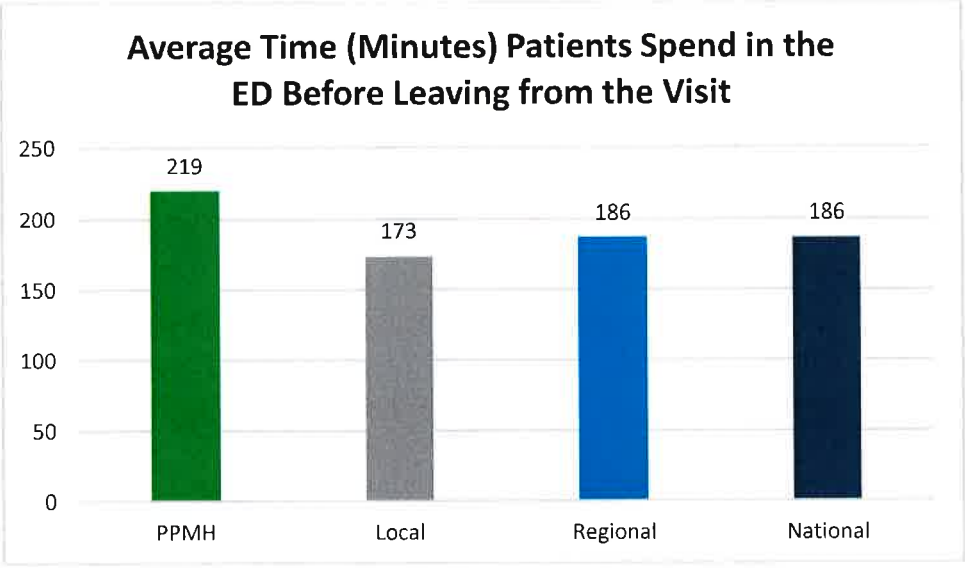
Average (median) Time Patients Spend in the ED Before Leaving from the Visit
Data source: Hospital Compare

CMS tracks several measures regarding timely care. Often, the "front door" of the hospital is the Emergency Department ("ED"). PYA findings during stakeholder interviews found that the ED is indeed perceived to be the front door for many PPMH patients. As a result of those observations, this metric was selected for the timely care measure criteria. As defined 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 a patient is sent home after evaluation or treatment may be a sign that the ED is understaffed or overcrowded. While higher levels of patient acuity may be a factor for increased time spent in the ED, more time could result in delays in treatment, increased suffering for those who wait, and unpleasant treatment environments.

This measure reports the average (median) time in minutes that patients spent in the emergency department – 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.[9]

As displayed in *Figure 6* below, in 2019, PPMH averaged 219 minutes in the ED. This is higher than the local, regional, and national peer groups' averages, and implies risks to quality and patient satisfaction driven by timely delivery of services. As previously mentioned, this measure does not adjust for patient acuity.

Figure 6



[9] 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 29, 2021.

Overall

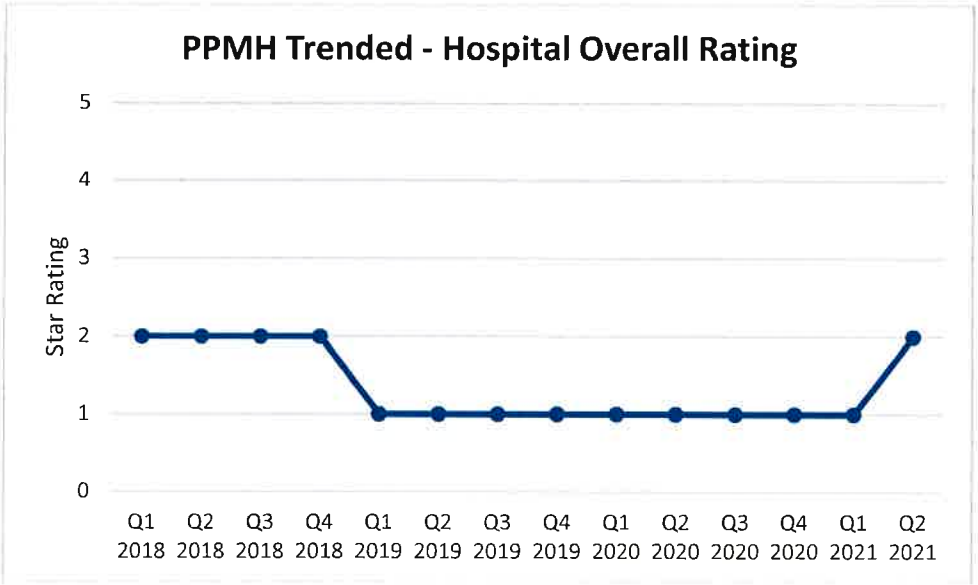
Centers for Medicare and Medicaid Services ("CMS") Hospital Compare Overall Rating
Data source: Definitive Healthcare (peer groups) and Hospital Compare Archives (PPMH historic)

To measure and enable comparisons of quality across institutions, CMS reports an Overall Hospital Quality Star Rating ("Star Rating"). Hospitals report data to CMS through the Hospital Inpatient Quality Reporting ("IQR") Program and the Hospital Outpatient Quality Reporting ("OQR") Program. The Star Rating summarizes a variety of measures across 7 areas of quality into a single star rating for each hospital. Similar to the IOM, the 7 areas include: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.[10] PYA acknowledges the limitations of these types of "overall" metrics that summarize the dimensions of quality into a single star or letter or number grade, as noted earlier. However, due to the growing popularity of these measures for trying to communicate quality, we felt it was important to include the CMS measure.

Of those 7 areas, PPMH currently ranks below the national average in 5 of the areas including mortality, readmission, patient experience, effectiveness of care, and timeliness of care. The Hospital's ranking is the same as the national average in efficient use of medical imaging. The Hospital is above the national average is one of the areas, safety of care.

Based on January 2021 results (2020 data), PPMH received a 1-star rating. PPMH has received a 1-star rating for the 9 quarters and received a 2-star rating in data released on April 29, 2021, as shown in *Figure 7* below.

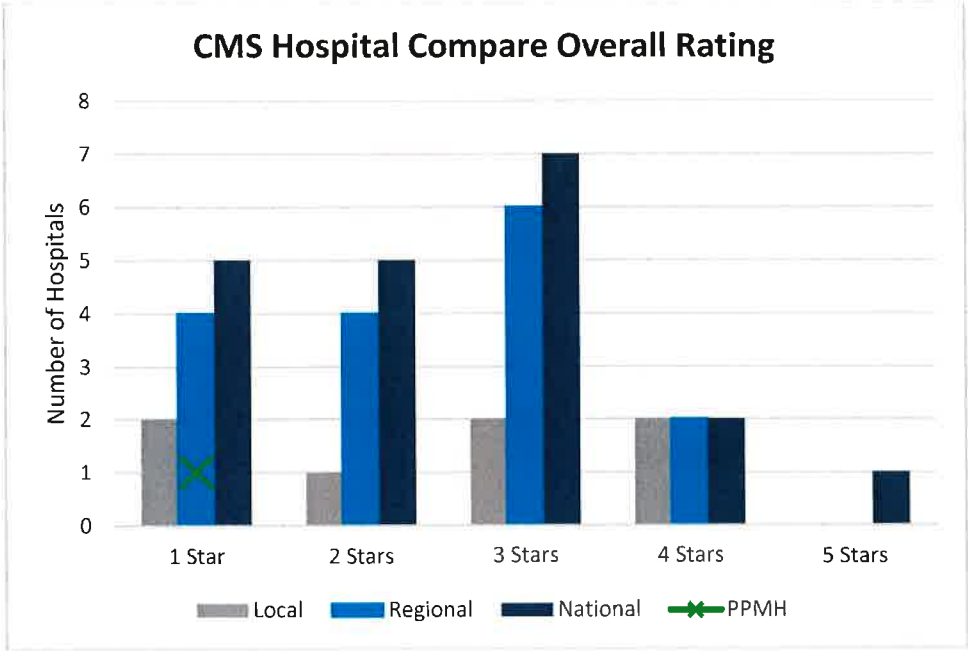
Figure 7



[10] Overall Hospital Quality Star Rating, Centers for Medicare & Medicaid Services (CMS), https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating, accessed on April 29, 2021.

Based on January 2021 results (2020 data), half of the hospitals in the regional and national peer groups received a 1- or 2-star rating as shown in *Figure 8* below. Only 1 hospital in the national peer group received a 5-star rating. The weighted average for the local peer group was 2.6, regional peer group was 2.4 and national was 2.5. PPMH's Hospital Compare overall rating is below all peer groups.

Figure 8[11]

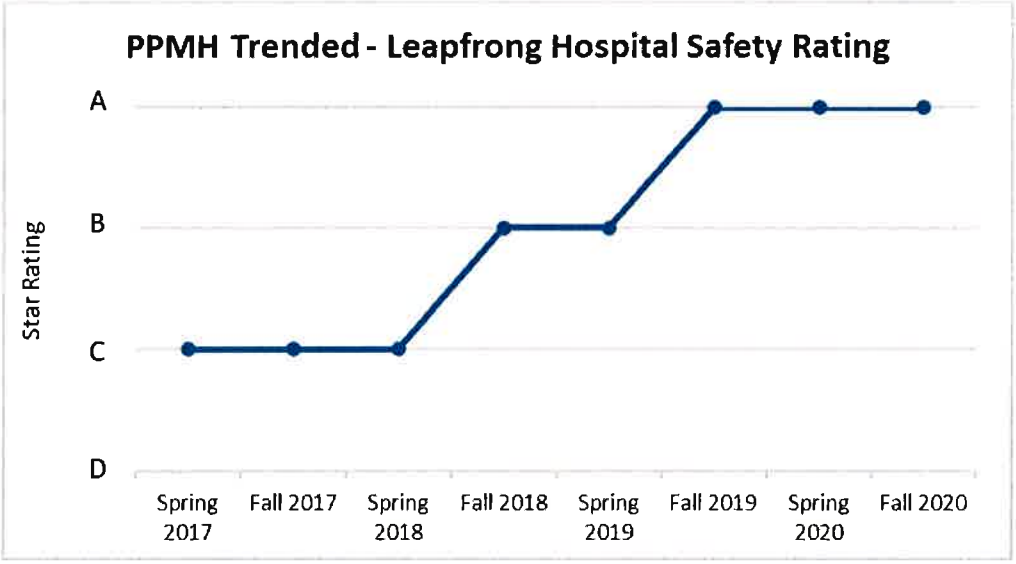


Other Observations

- PYA is aware that PPMH has made it a priority in recent years to focus on quality improvements as defined by Leapfrog Hospital Safety Grades. A Patient Safety Campaign was launched by the Hospital in 2007. Their efforts have moved PPMH from a C safety grade program in Spring 2018 to an A grade program by Fall of 2019, which PPMH has retained today as shown in *Figure 9* below.

[11] Based on January 2021 results (2020 data)

Figure 9



- In 2016, the Hospital adopted the Preventable Harm Index and Lead Continuous Performance Improvement Methodologies. Harm events have since declined by 58% from FY16 to FY20 as a result, based on internal PPMH dashboards.
- As seen in the Hospital's mission, vision, and values statements, delivering quality care is part of the organization's culture. As the mission statement notes, "We empower every member of the Phoebe Family to safeguard the health of our communities".
- Quality and Safety are among the five strategic pillars in Phoebe Focus, the new strategy, philosophy, plan, and approach guiding PPMH.
- Patient Safety and Quality are included in PPMH's strategic scorecard. The Hospital is tracking various measures including patient safety index reduction, mortality reduction, Leapfrog Hospital Safety Grade and CMS Star Rating, and patient safety survey.
- PPMH is actively tracking patient experience on a system scorecard and has defined targets related to each HCAHPS category. As of February 2021, Phoebe Main is below target in 6 of the 10 HCAHPS categories. Phoebe North is below target in 9 or the 10 HCAHPS categories. The HCAHPS categories are listed in the evaluation section above.
- PPMH has instituted a *High Reliability Organization* plan. High reliability organizations work to create a safe environment in which potential problems are anticipated, detected early, and virtually always responded to early enough to prevent catastrophic consequences.
- PPMH invested in the *Clean Hands/Safe Hands* program in FY21 to improve hand hygiene compliance and continue to develop a culture of hospital-acquired infection prevention.
- The PPMH website provides transparent detail on current quality initiatives, surgical infection metrics, awards, and recognitions, and provides education on hospital quality standards.
- A select sample of awards and accreditations received in 2019 or 2020 include:
    - DNV-GL Hip & Knee Replacement Center of Excellence
    - DNV-GL Certified Primary Stroke Center
    - Commission on Cancer Accredited Program
    - NAPBC Breast Cancer Center of Excellence
    - State Designated Regional Perinatal Center

- National Hospital of the Year and Southern Regional Hospital of the Year by Mended Hearts
- American Heart Association/American Stroke Association: Get with the Guidelines© - Resuscitation Silver Plus Award
- American Heart Association/American Stroke Association: Target: Stroke Honor Roll Elite Award
- American Heart Association/American Stroke Association: Gold Plus Achievement for Get with the Guidelines© – Stroke
- Accredited as Comprehensive Center under Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program

Takeaways

After assessing PPMH relative to the agreed-upon quality criteria, we believe the organization is committed to providing quality care as stated in its mission, vision, values, strategic plans, and scorecards, and is delivering comparable or better quality than its peers in many areas. The importance of quality and quality improvement is recognized across PPMH leadership, including, and most importantly, in those areas where improvement is required. PPMH has achieved marked improvement in quality over the years within those areas where the Hospital has invested its focus and resources.

Access

Access

Authority Question

Has the Hospital maintained and/or improved access to care in the community (e.g. access point locations and services)?

Context

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 (e.g., health insurance) falls outside the control of the hospital, providing convenient, consistent and reliable 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 health care system.

To answer the above question, the following measures were analyzed:

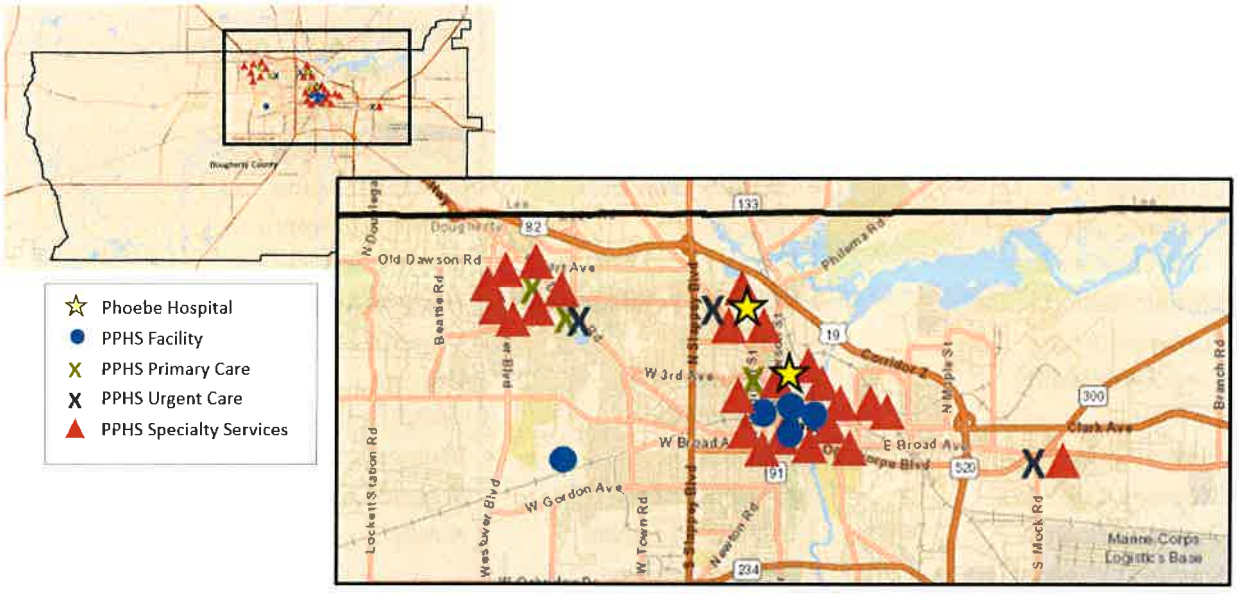
Access Dimension	Data Measures
Geographic Reach	PPHS Access Points in Dougherty County
Scope of Services and Programs	PPMH Clinical Services Additions within the Past 5 Years

Assessment

PPMH Access Points in Dougherty County
Data source: PPMH management team

In addition to physical locations within Dougherty County, the Hospital has locations in Americus, Ashburn, Buena Vista, Camilla, Cordele, Cuthbert, Ellaville, Leesburg, and Sylvester, Georgia. *Figure 10* maps the locations within Dougherty County. Locations are approximate and may overlap due to facilities/services being located in close proximity.

Figure 10



The Hospital has three primary care locations within Albany. One of the locations, Primary Care at Northwest, includes urgent care services. There is one additional urgent care in East Albany and a community care clinic on the North campus. On the main Hospital campus resides a Specialty Pharmacy, a Cancer Center Boutique, and a Rehab unit. A list of several service locations can be found in *Appendix C*.

In accessing the demographics across Dougherty County, it appears most of the Hospital's physical locations are in areas of significant minority population.

In addition to these physical access points, the Hospital offers a number of specialty clinical services in the community. Those services include the following.[12]

Comprehensive Services		
Adult Obesity	Emergency Medicine	Occupational Therapy
Alzheimer's Care	Gastric Bypass	Oncology
Ambulatory Infusion	Gastroenterology	Orthopaedic & Sports Medicine
Aneurysms (Aortic)	General Surgery	Pain Management
Angioplasty	Gynecology	Palliative Care
Arrhythmia	Hand Conditions	Pastoral Care
Audiology	Hearing (Audiology)	Pediatrics
Bariatrics (Weight Loss Surgery)	Heart & Vascular	Perinatal Care
Behavioral Health	Heart Attack Care	Physical & Occupational Therapy
Brain and Nerve Disorders	Heart Services	Plastic & Reconstructive Surgery
Breast Health	Hemorrhoids	Primary Care
Cancer Care	Home Health	Prostate Cancer

[12] Comprehensive services, https://www.phoebehealth.com/services/services-a-z, accessed on May 13, 2021.

Comprehensive Services		
Cancer Support Groups	Hospice	Radiology
Cancer Treatment Options	Imaging	Rehabilitation
Cardiac Catheterization	Joint Camp	Rheumatology
Cardiac Electrophysiology	Knee Conditions	Sleep Disorders
Cardiac Rehabilitation	Laboratory	Speech Therapy
Cardiology	Lactation Services	Sports Medicine
Cardiovascular Surgery	Lung Watch	Stroke Treatment
Children's Services	Mammograms	Surgical Services
Chronic Pain	Maternal Fetal Medicine	Thoracic Surgery
Community Care	Maternity	Urgent Care
Corporate Health	Mental Health	Urology
CT Scan	Neonatal Care	Weight Loss Surgery
Dermatology	Neurology	Women's & Children's
Diabetes Care	Neurosciences	Wound Care
Digestive Health	Nutrition Services	X-rays
Electrophysiology	Obesity Surgery	

Of the services listed above, highly complex specialty service lines such as cardiovascular, oncology, bariatrics and stroke have been a significant focus of growth and investment at PPMH over the years.

The Hospital also offers virtual visits delivered by all primary care clinics and via recently procured mobile health units and offers corporate health programs as well. As stated in the 2020 Community Benefit Report, the Hospital's corporate health program helps businesses and institutions lower their costs through health screenings, educational programs, and onsite prevention strategies. The program is comprised of:

- 925+ corporate partners
- 1,010 workers' comp clinic visits
- 1,500 avg patient visits per month
- 145 avg number of on-site visits per month
- 20 telehealth visits per month

Clinical Services Additions with the Past 5 Years
Data source: PPMH management team

The Hospital has added several new programs and services since 2016. Below is a list by year provided by management.

2016	2017
• Began offering TAVR ("Transcatheter Aortic Valve Replacement") • Opened Community Care Clinic • Replaced two linear accelerators in Radiation Oncology • Implemented High Intensity ICU model	• Opened Flaggstone, a $8 million medical student housing complex • Established Nurse Residency program

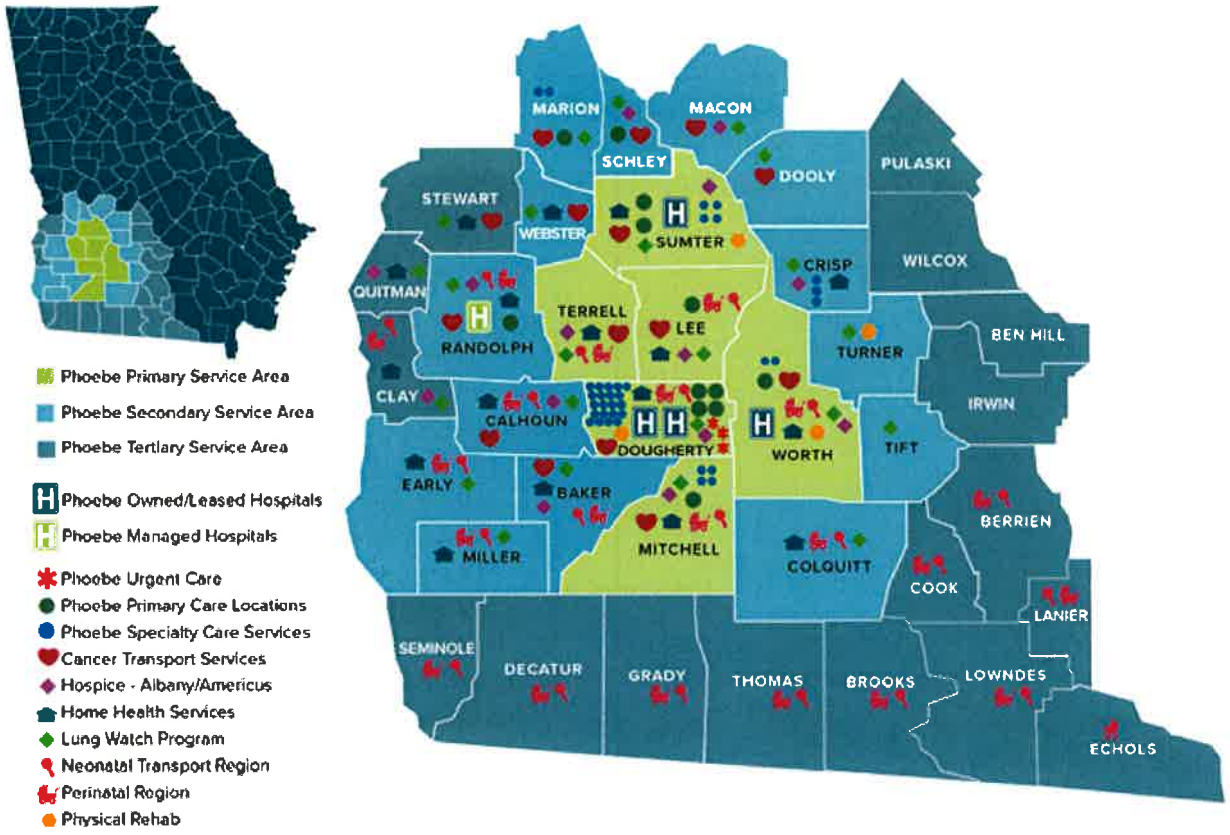
2018	2019
• Launched OB Hospitalist program to advance Women & Children's department • Acquired second robotic surgical system	• Established Care Command Center • Pursued Level II Trauma designation, including the hiring of a Trauma surgeon • Cardiovascular Services – Developed structural heart program, a multidisciplinary team that performs minimally invasive treatments to repair heart valves and other common heart defects – Expanded access to electrophysiologist ("EP") and cardiology services with 4 new cardiologists – Began offering WATCHMAN procedure, a procedure designed to reduce the risk of strokes • Oncology Services – Initiated high-risk breast screening – Added interventional radiology as 4th pillar of cancer care – Enhanced multi-disciplinary team with additions of urologist, reconstructive surgeon, and dermatologist • Diagnostic Imaging Services – Invested in new low-dose 256-slice CT – Invested in additional wide-bore MRI –
2020	**2021 & Other**
• Constructed helipad on main campus • Opened Light House, a residential facility for cancer patients being treated at Phoebe Cancer Center • Constructed Hybrid Operating Room • Converted all inpatient rooms to private (e.g., one patient per room) • Opened 22-bed observation unit • Opened Simulation Lab and Innovation Center for training and education • Constructed new vascular lab	• Invested in two mobile healthcare units • Partnered with Atrium for pediatric services Other • Renovated Mother/Baby, Oncology, and Pediatric units • Established Intensivist model in the Intensive Care Units • Added Clinical Pharmacist in the Emergency Department

Other Observations

A majority of the Hospital's locations and services are in north and west Albany, where a majority of the Dougherty County population resides. All Hospital locations and services are within a four-mile radius of the main Hospital campus.

As provided by the Authority's website and as shown in *Figure 11* below, PPHS provides not only services in Albany and Dougherty County, but throughout the region.[13]

Figure 11



In the Hospital's 2020 Community Health Needs Assessment ("CHNA"), health ranked as the number one overall need identified by participants in the community health survey. Other needs identified included: education, employment, income, and housing. The five major health or health related issues were: prevention services, knowledge of health resources, payment assistance, early child nutrition, and healthy eating habits. In addition, access to healthcare for the uninsured and availability of providers was a main theme identified in the CHNA interview process.

Takeaways

PPMH provides a broad and deep set of primary care and comprehensive specialty services for a community of Albany's size. Over the last several years, the Hospital has continued to add new programs and services. The physical locations/access points are centralized within the Albany city limits, where the majority of the Dougherty County population reside, such that access to those outside the city limits may be limited to virtual visits or the mobile health centers if travel to the current physical access points is prohibitive. Overall, it is apparent that PPMH is making investments to improve the access to care within the community.

[13] Growth and Assets, <http://www.haadc.org/HospitalAuthority_GrowthAssets.html>, accessed on April 28, 2021.

Community Benefit

Community Benefit

Authority Question

Has the Hospital met its obligations regarding the delivery of care to the indigent?

Context

The Lease specifically defines the Hospital's obligations regarding the delivery of care to the indigent. The Hospital's performance against this metric is included below. Additionally, the Lease defines several expectations from the Hospital to report contributions made that benefit the community, including an annual Community Benefit Report and triennial community needs assessment.

To ensure a full accounting of the Hospital's contributions to the Albany and Dougherty County communities' benefit, the following measures were assessed:

Access Dimension	Data Measures
Financial Assistance	Indigent/Charity Care Charges as a Percentage of Gross Revenues Less Bad Debt/Medicare/Medicaid Deductions
Community Benefit	Financial Assistance and Community Benefit Spending as a Percentage of Total Expenses

Assessment

Indigent/Charity Care Charges as a Percentage of Gross Revenues Less Bad Debt/Medicare/Medicaid Deductions
Data Source: Medicare Cost Reports

According to the lease agreement,

"PPMH shall annually allocate funds for the purpose of providing charity care. The funds allocated will be no less than 3% of the gross revenues of the Hospital after provisions for bad debt and Medicaid and Medicare adjustments have been deducted."

Charity care represents that portion of health care services that are provided but where payment is not expected. Charity care charges in Georgia are reported for services to patients with demonstrated inability to pay for some or all of the service and whose family income is greater than 125% of the Federal Poverty Guidelines, and which were written off to a formal charity account in the agency's accounting records. In Georgia, indigent care is reported for any unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines care and should exclude unpaid charges for patients who were eligible for Medicare, Medicaid, Third Party, or patients provided other free care.[14]

[14] Division of Health Planning General Financial Definitions, <http://georgiahealthdata.info/Division%20of%20Health%20Planning%20Financial%20Definitions.PDF>, accessed April 28, 2021.

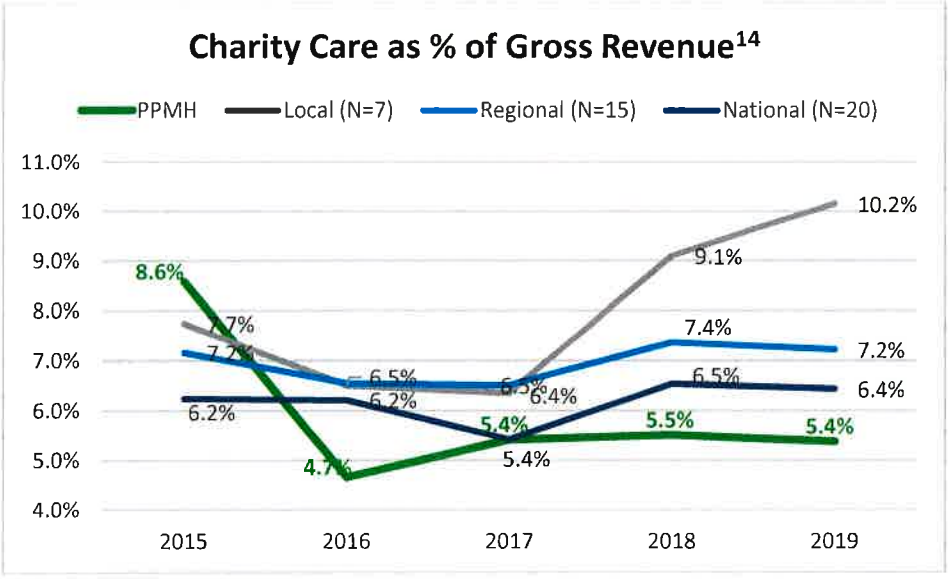
To allow comparison of PPMH against its peers, we calculate each hospitals' indigent/charity care deductions (charges) as a percentage of its gross revenues. The calculation as defined in the Lease is:

Charity Care Charges/ (Gross Revenue - Medicare and Medicaid Contractual Allowances - Total Bad Debt).[15]

Whether a state expanded Medicaid eligibility under the ACA can have a big effect on how much charity care its hospitals provide. Medicaid reimburses at below commercial rates, so hospitals tend to lose money on Medicaid patients.[16] Therefore, we would expect the local and regional peers to have the highest levels of charity care, as nearly all the southern states chose not to expand Medicaid.

As noted previously, the Hospital is obligated under the Lease to exceed 3% of indigent/charity care to gross revenues. As *Figure 12* below shows, the Hospital has met its obligations from 2015 to 2019, with greater than 4.7% of gross revenues coming from charity care. However, the Hospital has a lower indigent/charity care percentage than its local, regional, and national peers in all years except 2015. Over the past four years, the Hospital's charity care percentage has been relatively constant after a large decline from 2015 levels, when charity care comprised 8.6% of total charges after bad debt and Medicare/Medicaid deductions. Further review indicated that the Hospital reduced its charity contributions from $77 million in 2015 to $43 million in 2016. Charity care increased in the next several years to $71 million by 2019. However, because total Hospital charges experienced a significant increase in 2018 and 2019, the metric for the percentage of charity to total gross revenues remained at around 5.4%. In 2019, the percentage of gross revenues contributed to charity care by other local peers, was 10.2%, followed by 7.2% from regional peers and 6.4% from national peers.

Figure 12



[15] Gross revenues exclude bad debt and Medicaid and Medicare deductions to align with the lease agreement definition.

[16] Charity care spending flat among top hospitals, Tara Bannow, Modern Healthcare, January 06, 2018, <https://www.modernhealthcare.com/article/20180106/NEWS/180109941/charity-care-spending-flat-among-top-hospitals>, accessed on April 28, 2021.

As mentioned earlier in this report, the charge structures of hospitals comprising the peer group may vary significantly from one another, including PPMH. These differences may contribute significant disparities in the presentation and comparison of the charity care metrics presented above.

Additionally, PYA is aware that the Hospital has historically presented its charity care and other financial performance to the Authority using its Audited Financial Statements. *Figure 13* below indicates that, using PPMH's Audited Financial Statements, PPMH's charity care percentage using the same calculation as expected per the Lease has been fairly constant over the past five years ranging from 7.7% to 8.9% between 2016 and 2020. However, the audited financial statement measures show a different result than the Medicare Cost Report data source used in *Figure 12*. This appears to be due to a difference in accounting for bad debt (provisions for bad debt applied to the audited financial statements while actual write offs to bad debt were used in the Cost Reports) and potentially some variances in the Medicare Managed Care revenues, which may not have been entirely captured in the Medicare line item in the Cost Reports.

Figure 13

Charity Care Charges as a Percent of Gross Revenues
(less bad debt and Medicare/Medicaid Allowances)

Phoebe Putney Memorial Hospital
(Dollars in Thousands)

	2016	2017	2018	2019	2020
Charity Charges	$ 59,000	$ 60,000	$ 56,000	$ 75,000	$ 68,000
Total Gross Charges	$ 1,455,599	$ 1,569,154	$ 1,662,990	$ 1,936,721	$ 1,935,685
Provision for Bad Debt	$ 91,706	$ 100,078	$ 105,681	$ 121,669	$ 114,232
Medicare Deductions	$ 486,000	$ 553,000	$ 637,000	$ 732,000	$ 714,000
Medicaid Deductions	$ 182,000	$ 200,000	$ 195,000	$ 244,000	$ 264,000
Charity Care % of Gross Charges less Provision for Bad Debt/Medicaid/Medicare Deductions	8.5%	8.4%	7.7%	8.9%	8.1%

Source: PPMH Audited Financial Statements

Financial Assistance and Community Benefit Spending as a Percentage of Total Expenses
Data Source: IRS 990 Forms

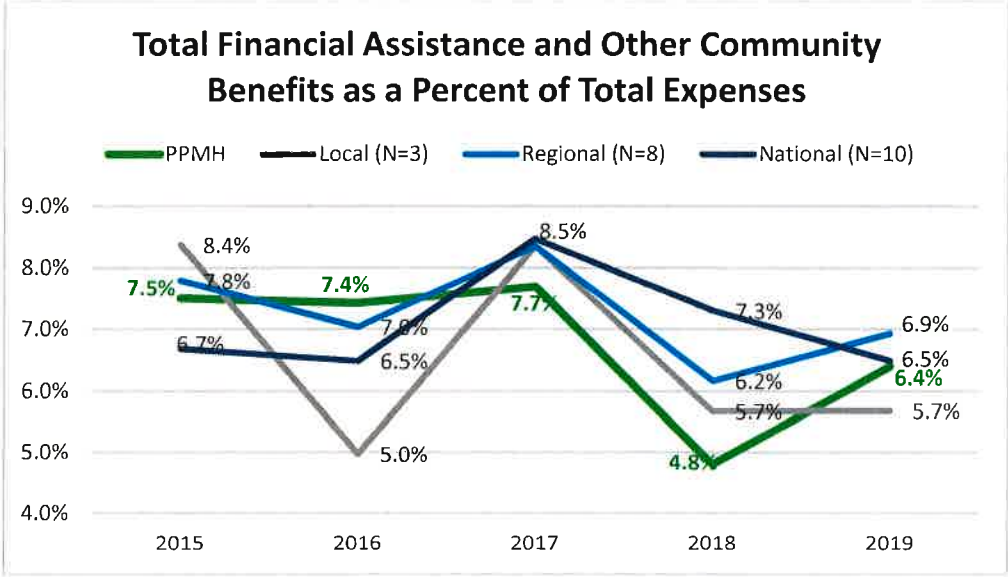
PYA is aware that organizations also invest in their communities not just through the amount of charity care they provide, but also through developing programs and services focused on providing benefit to the community where needed. Therefore, to allow room for these investment approaches, as well as to allow comparison of the Hospital against peers that may have different revenue and expense profiles, PYA also calculated the ratio of financial assistance and community benefit expenses to total hospital expenses. Financial assistance and community benefit spending is reported on IRS Tax Form 990s and includes:

- Direct patient care services such as charity care, unreimbursed Medicaid or other programs, and subsidized services; and
- Community-focused activities such as community health improvement services and community benefit, health professions education, research, and cash and in-kind contributions.

The Hospital spent between 6.4% and 7.7% of total expenses on financial assistance and other community benefits in all years except 2018, when spending dropped to just 4.8%, as shown in *Figure*

14. The Hospital exceeded the spending of the local peer group in all years except 2017-2018. Hospital rates were similar to or slightly higher than regional and national peer groups in 2015 and 2016 and then shifted to being lower than these peers in 2017-2019.

Figure 14

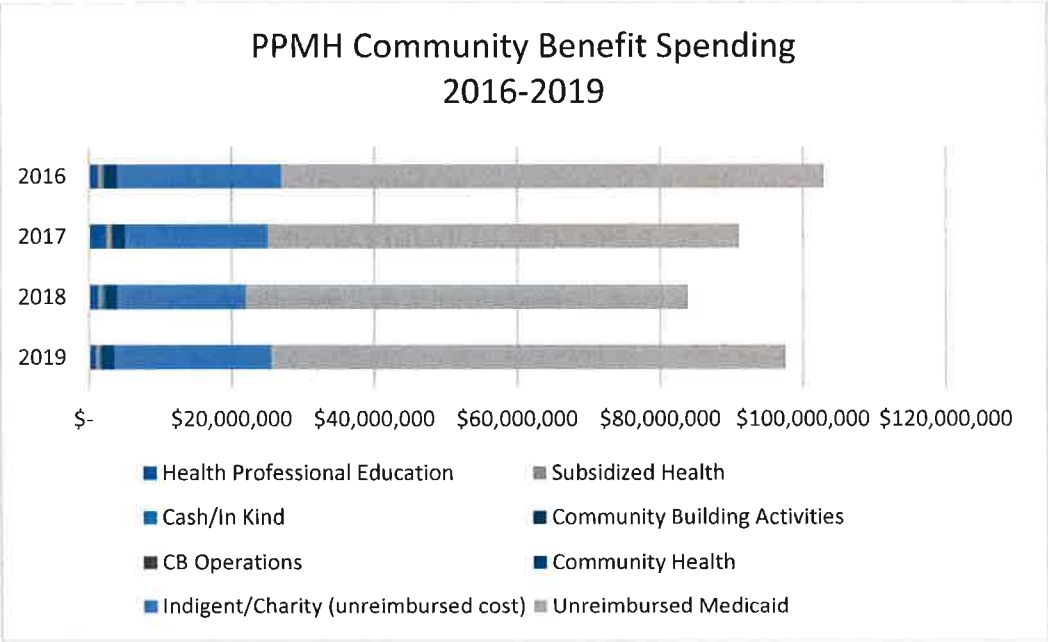


Other Observations

- The Hospital has a written Financial Assistance Program ("FAP") policy for persons who have healthcare needs and are uninsured or under-insured, ineligible for government programs, and otherwise unable to pay for medically necessary care based on their individual financial situation. Based on financial need, either reduced payments or free care may be available.
- The Hospital indicates in its 2020 community benefit report that its total economic impact is $1.16 billion based on 3,817 jobs created, $285 million in wages and benefits, and $21 million in community benefit.
- According to its audited financial statements, the Hospital contributed on average $94 million annually in community benefit related investments in the categories shown in *Figure 15* below. Unreimbursed Medicaid comprised the majority of the spending in each year.[17]

[17] Source: PPMH Audited Financial Statements. Excludes spending on unreimbursed Medicare costs.

Figure 15



- In its 2020 Community Benefit Report, the Hospital notes the following specific contributions it has made to positively impact the community. Similar community activities are noted in prior year reports as well.
    - 476 hospital volunteers contributed 48,490 hours and donated $209,000 to the Phoebe Foundation through volunteer services
    - The Community Care Clinic has provided urgent care services to 65,769 cases from March 2016-July 2002
    - The mobile health units that were purchased in 2021 have begun with a focus on Covid testing and vaccine outreach. These units will deliver other services such as clinical assessments and physicals, hearing exams, access to specialists and lab services, Covid and other testing, vaccinations, drug screenings, and health and wellness education.
    - Three community gardens established through partnerships with Flint River Fresh in Albany and Sumter and The Village Community Gardens in Sylvester
    - $330,000 in community health education to more than 12,500 individuals
    - $376,000 invested in the School Nurse Program to cover 13,000 Dougherty County students
    - $1.5 million invested in health professional education
    - $445,500 provided in financial and in-kind support to area nonprofit organizations
    - Nearly $269,000 in financial support provided to Network of Trust in-school, interactive outreach program
    - 50 teens enrolled in Teen Parent Program
    - 5,711 students completed Opioid Prevention Project
    - Nearly 4,500 prescriptions filled for indigent or uninsured patients totaling $154,000
- Other benefits provided by PPMH that are not considered part of a government-reported community benefit calculation but still are relevant to supporting a community include:
    - Corporate health program provided to over 925 corporate partners to include numerous healthcare services such as 1,000 workers compensation clinic visits and an average of

1,500 patient visits per month for physical exams, immunizations, drug screenings, CPR/first aid training, wellness coaching, on-site mobile health services including preventive health screenings and more.
    - Partnering and support for area colleges' healthcare programs including 24 family medicine residents, 48 pharmacy students, 750 total medical student clinical rotations from 39 schools, 42 nurse externs and 59 nurse residency program graduates
- The Phoebe Foundation notes in the 2020 community benefit report that it has raised nearly $3 million in total funds to support needs such as $2.2 million for hospital initiatives, 556 patients helped through patient assistance funds, and $33,000 provided in employee assistance and disaster aid.
- The Hospital also conducts a Community Health Needs assessment that drives its investment priorities. Moving forward to the next three years (2021-2023), the Hospital indicates that it is focused on:
    - Improving birth outcomes and reproductive responsibility to reduce low and very-low birthweight infants;
    - Preventing and managing diabetes to reduce diabetes-related deaths;
    - Cancer prevention and treatment to reduce cancer-related deaths; and
    - Behavioral health and addictive disease advocacy to reduce suicide-related deaths.
    - Creating all private rooms
    - New Emergency & Trauma Center
    - Expanded Ambulatory Care Network
    - New NICU and Enhances Women's and Children's Services
    - Expanded Clinical Services at Phoebe North; and
    - Updated Operating Room
- Several specific investments in fixed assets benefitting the community that have been made or are underway, include:
    - $1 million investment in two Phoebe Mobile Health Centers, initiated in Spring 2021
    - $2.0 million Urgent Care Clinic and Community Care Clinic expansion
    - Community Wellness Center
    - $2.6 million Light House facility for cancer patients and their caregivers
    - Additional physician practice locations, such as Phoebe Primary Care of Buena Vista and Phoebe Dermatology

Takeaways

The Hospital has met its lease obligations to the Hospital Authority regarding the delivery of care to the indigent, by exceeding the 3% target metric for indigent charity care as a percentage of gross revenue in each year from 2015 to 2019. While PPMH's percentage of charity care to gross revenue remained lower than its peers since 2016, the Hospital's total charity care spending at $71 million is nearly the same as it was in 2015 ($77 million) when PPMH's charity care percentage exceeding other peer groups. The Hospital states in its 2020 Audited Financial Statements that it spends approximately $94 million annually in various community benefits and intends to invest in community programs over the next few years aligned with needs identified in its community needs assessment (e.g., Diabetes Prevention, Behavioral Health and Addiction, Improving Birth Outcomes, and Cancer Prevention). Measures that specifically factor in this community benefit spending show the Hospital equaling most peer groups' levels of spending in all years except 2018.

Facilities Maintenance

Facilities Maintenance

Authority Question

Is the Hospital appropriately maintaining the Authority's assets?

Context

Among the more straightforwardly articulated terms in the Lease, it is the Hospital's responsibility to "keep and maintain the existing facilities and all improvements...in a good state of repair and preservation." In this section, the Hospital's maintenance of the fixed assets transferred to it by the Authority is measured. Assets include the existing facilities and all improvements, including all electrical, plumbing, HVAC systems, and equipment.

To measure the Hospital's commitment to investing to maintain and improve the Authority's assets, the following, industry-standard measures of investment in hospital assets were employed:

Access Dimension	Data Measures
Fixed Asset Investments	Average Age of Plant
	Annual Capital Expenditures to Depreciation Ratio

Assessment

Average Age of Plant
Data Source: Medicare Cost Reports

The Average Age of Plant ratio provides a measure of the average age of a hospital's fixed assets, calculated in years. The lower the number, the "younger" (or newer) the asset, and thus the lesser implied investment required to keep such assets (such as hospital buildings and large equipment) in good, working order. Conversely, higher results indicate older assets that may require outsized capital investment to maintain, if not replace.

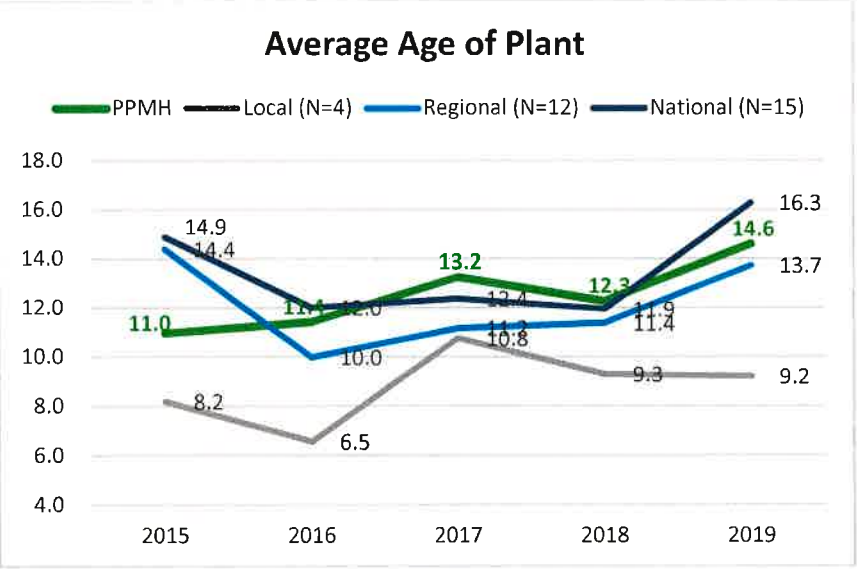
The Average Age of Plant calculation is:

Accumulated Depreciation / Depreciation Expense.

As *Figure 16* below shows, the Hospital facilities are older than most benchmarks.[18] The Hospital had an average age of plant of 14.6 years in 2019. Since 2017, the Hospital's average age of plant has been higher than its local, regional, and national peers, except for 2019 when the average age of plant for national peers exceeded PPMH. Of note, per interviews with PPMH, PYA understands that the Hospital changed accounting methods in 2019 and standardized all fixed asset ages across the System, which reclassified some ages of their fixed assets. According to Moody's Investor Services, the US median average age of plant for other A1 rated organizations, similar to PPMH, was 11.7 years in 2019.[19]

[18] Peer facilities with either no data or average age of plant years that are based on the value at acquisition by the health system, rather than actual age, are excluded from chart.
[19] Source: Moody's Investor Services 2020 US Medians for NFP and Public Healthcare Report published September 9, 2020.

Figure 16



Annual Capital Expenditures to Depreciation Ratio
Data Source: Medicare Cost Reports

Capital expenditures, or total acquisitions, represent funds used by a company to acquire, upgrade, and maintain physical assets such as property, plants, buildings, technology, or equipment. This ratio shows if an organization is sufficiently spending on fixed assets to maintain their operation. It also indicates the growth phase of the business. The average business across all industries has a ratio of about 1.0. A firm that is growing often has a higher ratio, which shows the organization is investing significantly in its long-term assets. An organization that is no longer buying significant long-term assets usually has a lower ratio.

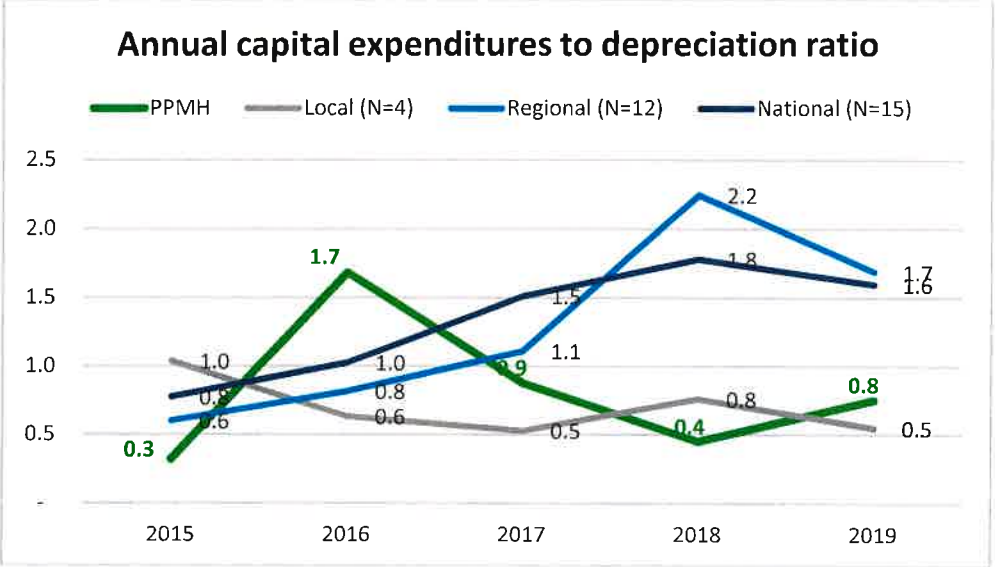
The Capital Expenditures to Depreciation Expense ratio calculation is:

Total Acquisitions / Capital Depreciation Expense.

As *Figure 17* below illustrates, the Hospital's total acquisitions trend is relatively flat, at less than 1.0 in all years except 2016, when it increased to 1.7. This trend likely indicates that most of the acquisitions are for lower cost investments or maintenance, and not business expansion. Compared to local, regional, and national peer groups, with ratios ranging from 0.5 to 2.2, the Hospital's investment in fixed assets appears to have been consistently on the lower end of the peer group range over the past five years. The Moody's US median average capital spending ratio for other A1 rated organizations was 1.2 in 2019.[20]

[20] Source: Moody's Investor Services 2020 US Medians for NFP and Public Healthcare Report published September 9, 2020.

Figure 17



Other Observations

- The Phoebe Putney Health System in total includes four acute care hospital facilities, two of these, Phoebe Putney Memorial Hospital and Phoebe Putney North, are under the Lease with the Albany-Dougherty County Hospital Authority. According to 2019 property records, the Hospital has purchased 30 acres of land and over 695,000 in building square feet. Combined with Hospital Authority properties, healthcare-related facilities total $302 million in purchases and $131 million in building improvements for 108 acres and 1.7 million total square feet.

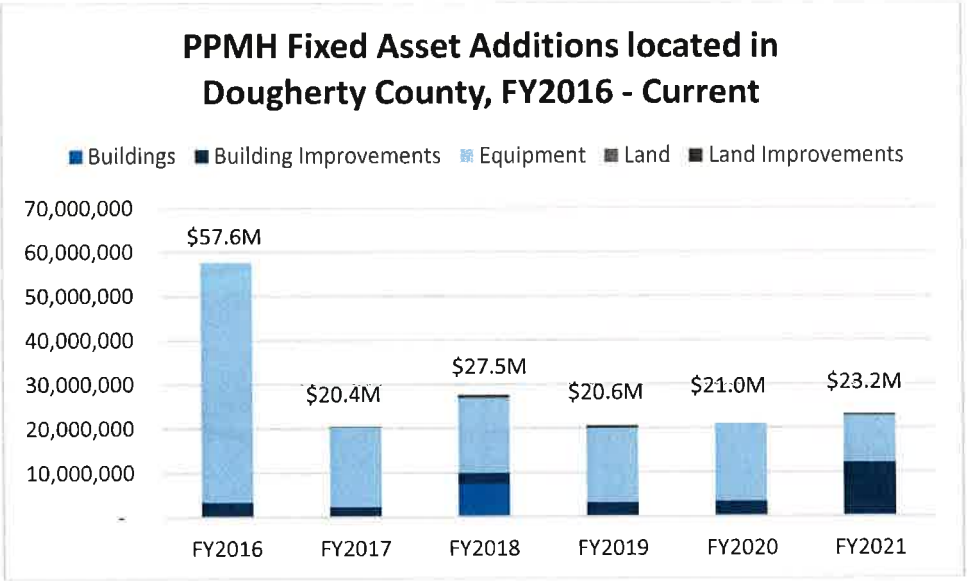
- Since 2016, the Hospital has invested over $170 million in capital in Dougherty County including over $134 million in equipment, $26 million in building improvements and over $7 million in buildings, as shown in *Figure 18* below.[21] As *Figure 19* illustrates, annual spend has been between $20 to $27 million in each year after a $57 million investment primarily from a system wide Meditech electronic medical record ("EMR") system project completed in late 2015 and accounted for in 2016 income statements.[22]

Figure 18

	FY2016 - Current	
Buildings	$	7,559,678
Building Improvements	$	26,965,504
Equipment	$	134,218,865
Land	$	311,468
Land Improvements	$	1,323,101
TOTAL PPMH	**$**	**170,378,617**

[21] Data provided by Phoebe Putney Health System.
[22] Data provided by Phoebe Putney Health System. Note, in 2018, $4.3 million spent on building, equipment, and land improvements in Mitchell County were subtracting from the totals in the chart.

Figure 19



- The Hospital published in its 2020 community benefit report $250 million in initiatives underway that include investment in building new facilities, elevating services, and expanding delivery of care over the next five years to include:
    - All private rooms
    - New Emergency & Trauma Center
    - Expanded Ambulatory Care Network
    - New NICU and Enhances Women's and Children's Services
    - Expanded Clinical Services at Phoebe North; and
    - Updated Operating Room
- Several specific investments fixed assets have been made or are underway, including:
    - $1 million investment in two Phoebe Mobile Health Centers, initiated in Spring 2021
    - $5.3 million Phoebe Simulation and Innovation Center
    - $4 million new vascular lab
    - $3.7 million hybrid operating room
    - $2.5 million Orthopedics outpatient expansion
    - $2.0 million Urgent Care Clinic and Community Care Clinic expansion
    - Community Wellness Center
    - $2.6 million Light House facility for cancer patients and their caregivers
    - Meditech EMR system-wide upgrade
    - Established additional physician practice locations, such as Phoebe Primary Care of Buena Vista and Phoebe Dermatology

Takeaways

The majority of PPMH's capital investments since 2015 have been for equipment purchases, with very little investment into the facilities. Smaller building improvement investments have been made recently to expand services such as the vascular lab, hybrid operating room, and to procure the mobile health centers. PYA also noted a significant investment in the Hospital's electronic medical record system in 2015. Compared to its peers, the Hospital is investing less in its fixed assets. It may be the case that

PPMH made most of the necessary building acquisitions and investments in the years prior to 2015. However, with an average age of PPMH's facilities slightly higher than local and regional peers in 2019, PPMH should evaluate its capital planning and priorities to properly maintain the Authority's facilities.

Cost

Cost

Authority Question

Does the Hospital provide services at an appropriate cost?

Context

Related to cost under the Lease, the Authority expects that the Hospital will provide an annual report addressing performance on lowering the cost of health care in the community. In this assessment, it is important to reflect that the definition and perspective of cost of care varies by the party that is incurring the expense. Defining and comparing the cost that is the responsibility of the patient receiving the care is not easily available. This amount is impacted by the relationship that a patient may have to an insurer and the insurer's relationship to the healthcare facilities where care is provided. 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.

To complete this assessment, the following data measures related to cost of care were analyzed for the Hospital and its peers:

Access Dimension	Data Measures
Cost of Care	Case-Mix Adjusted Cost per Discharge
	Medicare Spending per Beneficiary
	Case-Mix Adjusted Average Length of Stay

Assessment

Case-Mix ("CMI") Adjusted Cost per Discharge
Data Source: Medicare Cost Reports

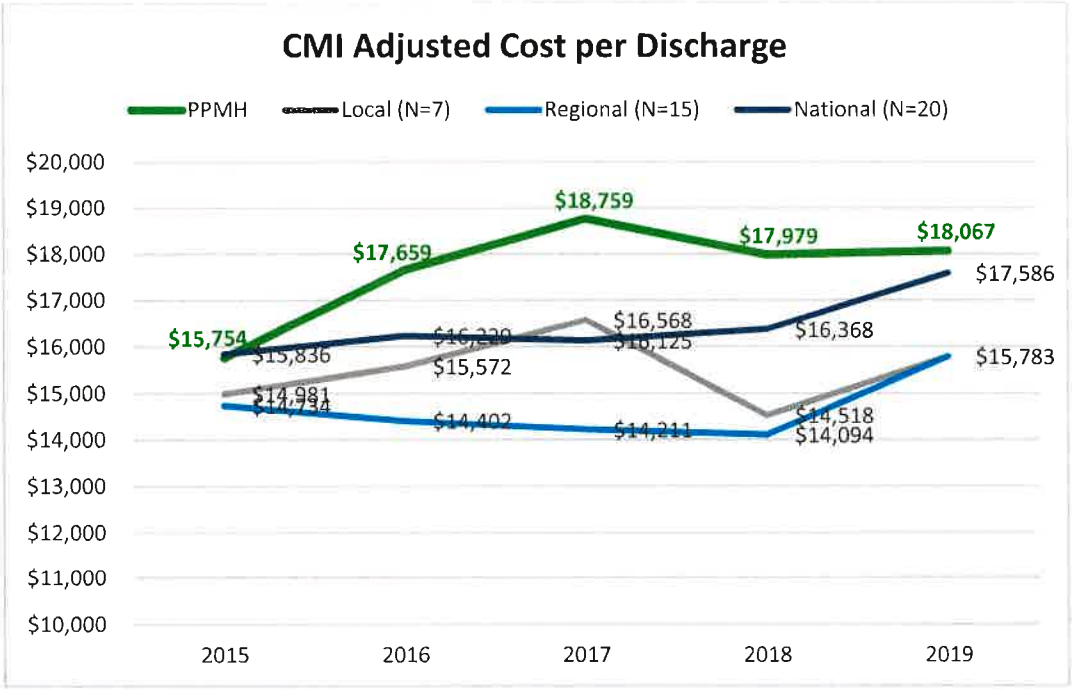
Case mix adjusted cost per discharge is calculated as:

*Total Operating Expenses / ((Hospital Discharges * Net Patient Service Revenue) / Total Inpatient Patient Revenues) / CMI / Wage Index).*

Applying a CMI 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 Hospital peers more equal.

As *Figure 20* below shows, the Hospital's CMI-adjusted cost per discharge has grown from $15,754 in 2015 to $18,067 in 2019 but been somewhat constant over the past three years. Except for 2015, the Hospital's costs were higher than local, regional, and national peers in all years. In 2019, PPMH costs per adjusted discharge were $2,200 higher than local and regional peers and just under $500 higher than national peers.

Figure 20



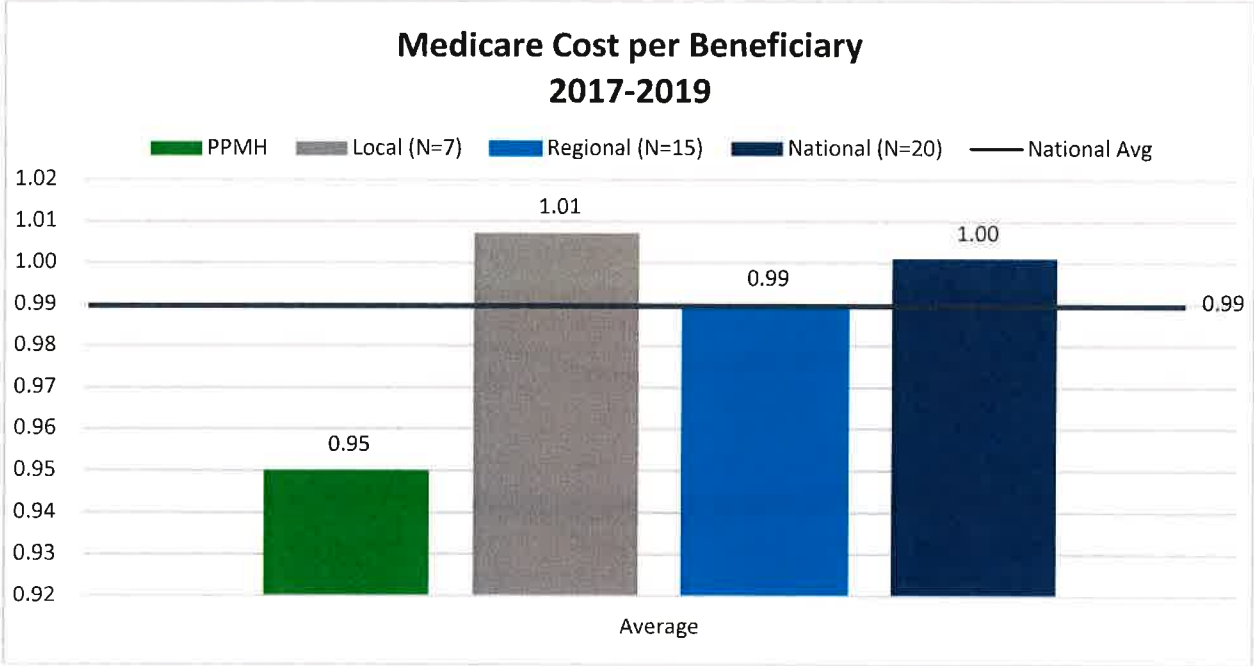
Medicare Spending per Beneficiary
Data Source: Hospital Compare

The Medicare Spending Per Beneficiary (MSPB or "Medicare hospital spending per patient") measures whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific inpatient hospital compared to how much Medicare spends on an episode of care across all inpatient hospitals nationally. 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 measure score is a ratio calculated by dividing the amount Medicare spent per patient for an episode of care initiated at the Hospital 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 is 0.99 between 2017-2019. As shown in *Figure 21*, the Hospital had a rate of 0.95 over the same period, indicating it spends less per patient for an episode of care than across all inpatient hospitals nationally. The Hospital's rate is also lower than local, regional, and national peer groups. Local and national peers average MSPB is higher than the national average at 1.01 and 1.00, respectively while regional peers are equal to the national average.

Figure 21



Adjusted Average Length of Stay
Data Source: Definitive Healthcare, as reported in the Medicare Cost Reports

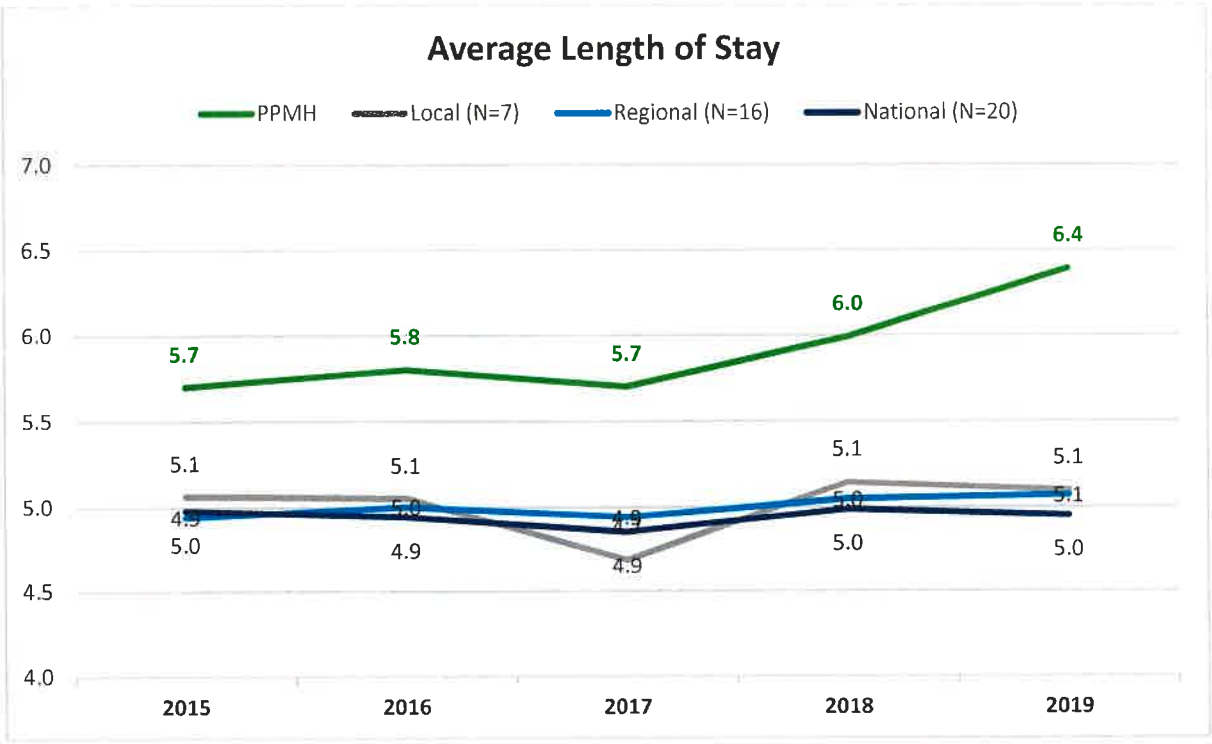
Average length of stay is calculated as:

(Total patient days / total discharges)

Average Length of Stay is a measure of the total patient days (number of days a patient stays in the hospital) divided by the number of discharges (total number of inpatients at a hospital in a given year). Reducing length of stay improves financial and operational outcomes by decreasing the costs of care for a patient. It can also improve patient health outcomes by minimizing the risk of hospital-acquired conditions. Average length of stay duration can be impacted by factors within the hospital's control such as quality of care delivered and overall operating effectiveness, and factors outside of the hospital's control such as the patient acuity, social determinants of health, and continuity of care outside of the hospital.

As *Figure 22* below shows, the Hospital's average length of stay in 2019 of 6.1 days was over a day longer than the average of each of the peer groups, which each had a 5.0 to 5.1-day average length of stay that same year. PYA understands that PPMH serves a number of NICU patients, which may drive up length of stay volumes; peer groups may or may not have similar NICU days. PPMH's average length of stay increased from a length of stay of 5.7 days in 2017.

Figure 22



Other Observations

- As presented in the Access section of this Report, PPMH provides comprehensive access to primary and subspecialty healthcare services, such as cardiology and cancer, at a level potentially higher than other communities its size, which may contribute to the overall costs for care delivery.
- As noted in the Community Benefit section of this Report, PPMH invests in many programs that benefit the community that add to its cost structure.

Takeaways

The cost of the services provided by PPMH are, on average, higher than local, regional, and national peers. The unfavorable cost comparisons may be due, in part, to the Hospital's length of stay performance, which is higher than peer groups. PYA also notes that PPMH's unfavorable cost performance may also be impacted by the Hospital's provision of more costly comprehensive subspecialty services, such as cardiovascular, stroke, and cancer care, as compared to its peers. Data, unfortunately, are insufficient to enable adjustment for such factors. We noted, also, that the Hospital's spending on Medicare patients appears to be more consistent with its peer group. Finally, we note that PPMH makes a number of investments in programs that benefit the local community, which may also elevate its costs above some of its peers.

Financial Performance

Financial Performance

Authority Question

Has the financial management been of a caliber to service the debt, and to provide relative assurance the organization will continue to operate in the foreseeable future?

Context

Like any other business or industry, a hospital's financial performance is a key indicator of overall health and sustainability. This is especially important for tax-exempt hospitals, like the Hospital, because if an organization does not reach certain levels of financial performance or generate enough revenue, it will not be able to support operations and fulfill its charitable mission.

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 revenue to invest in growth; liquidity measures an organization's ability to weather any unexpected economic or other downturns (e.g., COVID-19) 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.

Although the Lease requires annual audited financial statements be submitted to the Authority, it does not define specific financial metrics the Hospital is obligated to report outside of charity care contributions (as provided in the Community section of this report). Therefore, the following industry-standard data measures were assessed to measure the Hospital's financial performance:

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

Assessment

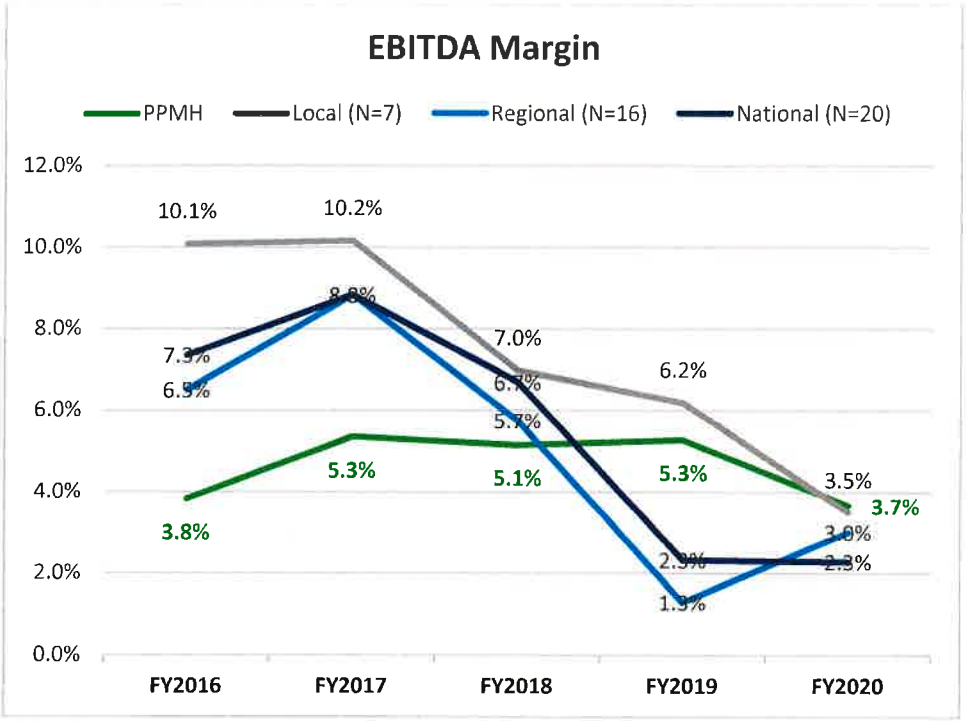
EBITDA ("earnings before interest, taxes, depreciation, and amortization") Margin
Data Source: Definitive Healthcare, as reported in the Medicare Cost Reports

EBITDA Margin, which measures a company's earnings before interest, tax, depreciation, and amortization as a percentage of the company's 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 how much cash profit a company made in a given year.

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 23* below, according to data submitted in the Medicare Cost Reports and as reported by Definitive Healthcare, the Hospital maintained a consistent EBITDA margin from FY2017 to FY2019. From FY2019 to FY2020, the hospital experienced a slight decline, decreasing from 5.3% to 3.7%. Even with a 3.7% EBITDA Margin in 2019, the Hospital was slightly above the local, regional, and national peer groups.

Figure 23



The results generated out of Definitive Healthcare were also compared to the hospital's audited financial statements, as shown in *Figure 24* below. Operating EBITDA Margin calculated below, is based on rating agency standards. Accordingly, the Operating EBITDA Margin calculated below does not reconcile to Definitive Healthcare's EBITDA Margin calculation.

Figure 24

Phoebe Putney Memorial Hospital
(Dollars in Thousands)

	FY2016	FY2017	FY2018	FY2019	FY2020
Net Patient Revenue	$ 498,901	$ 499,965	$ 509,989	$ 558,131	$ 574,997
Total Operating Revenue	$ 516,562	$ 518,568	$ 530,780	$ 580,139	$ 606,605
Total Operating Expenses	$ 526,296	$ 517,137	$ 528,853	$ 568,742	$ 595,952
Depreciation and Amortization	$ 39,368	$ 36,380	$ 26,246	$ 22,920	$ 26,328
Interest	$ 6,932	$ 7,116	$ 7,829	$ 9,130	$ 8,104
Operating EBITDA[1]	$ 36,566	$ 44,927	$ 36,002	$ 43,447	$ 45,085
Operating EBITDA Margin[2]	7.1%	8.7%	6.8%	7.5%	7.4%

[1]Operating EBITDA = Total Operating Revenue - Total Operating Expenses) + Interest + Depreciation and Amortization

[2] *Operating EBITDA Margin = EBITDA / Total Operating Revenue*

Source: PPMH Audited Financial Statements

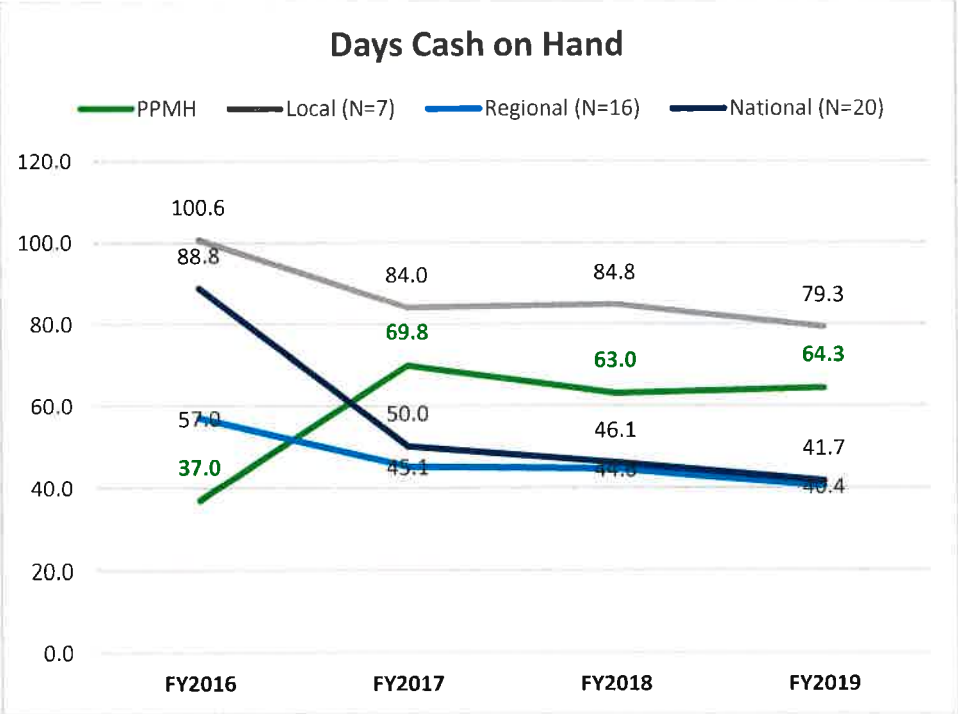
Days Cash on Hand
Data Source: Definitive Healthcare, as reported in the Medicare Cost Reports

Days Cash on Hand ("DCOH") is a measure of how long an organization could meet its obligations and continue operations if cash receipts were discontinued. Higher values indicate high liquidity. DCOH is calculated by:

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

As shown in *Figure 25* below, since FY2017, PPMH is performing above the regional and national peer groups in DCOH. Due to COVID-19 relief funding which skews the reported Day Cash on Hand, FY2020 was excluded. According to Moody's Investor Services, A1 rated hospitals had a median Days Cash on Hand of 254.1 in 2019.

Figure 25



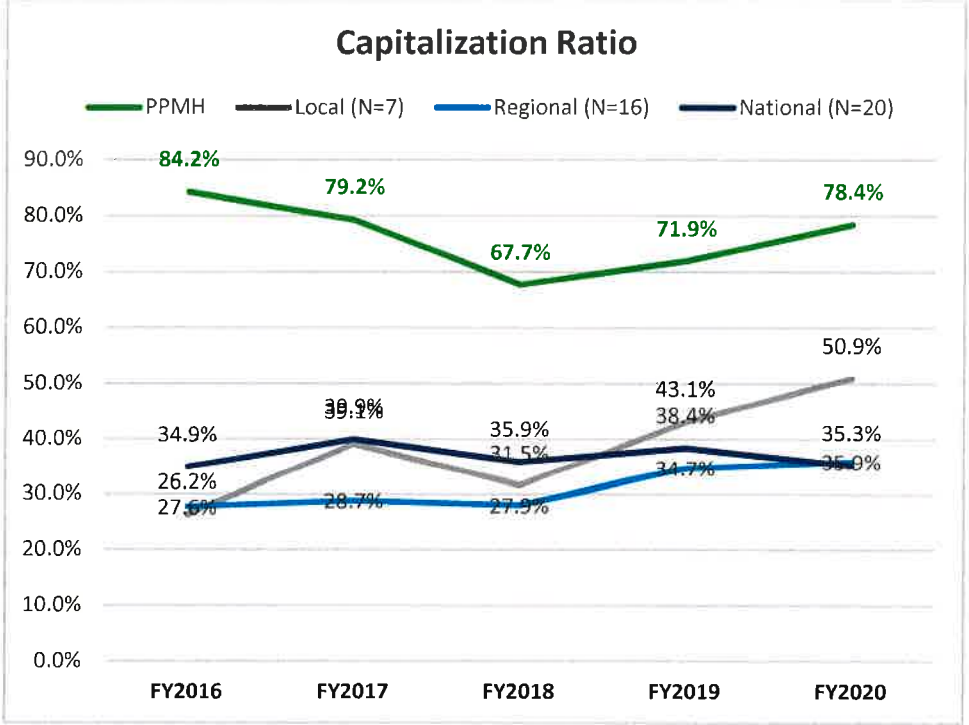
Debt to Capitalization Ratio
Data Source: Definitive Healthcare, as reported in the Medicare Cost Reports

The Debt to Capitalization ratio measures the degree to which a company is financing its operation through debt versus wholly-owned assets. Lower values are preferable, whereas higher values imply a greater reliance on debt financing and may indicate a reduced ability to take on additional debt.

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 of peer groups, PYA has utilized Definitive Healthcare's calculation of Debt to Capitalization Ratio.

As shown in *Figure 26* below, according to data submitted in the Medicare Cost Reports and as reported by Definitive Healthcare, the Hospital has had a higher capitalization ratio compared to all peer groups over the past five years. The Hospital's ratio took a slight dip in FY2018 but has overall remained steady at over 67% the past 5 years.

Figure 26



The results generated out of Definitive Healthcare were also compared to the hospital's audited financial statements, as shown in *Figure 27* below. The Capitalization Ratio calculated below, is based on rating agency standards. Accordingly, the Capitalization Ratio calculated below does not reconcile to Definitive Healthcare's Capitalization Ratio calculation, which includes other liabilities such as Medicare advanced payments and accrued pension costs.

Figure 27

Phoebe Putney Memorial Hospital
(Dollars in Thousands)

	FY2016	FY2017	FY2018	FY2019	FY2020
Total Long-Term Debt	$ 291,417	$ 283,584	$ 277,053	$ 270,261	$ 269,794
Total Short-Term Debt	$ -	$ -	$ -	$ -	$ 68
Net Assets	$ 91,430	$ 121,695	$ 184,498	$ 161,744	$ 137,100
Capitalization Ratio[1]	76.1%	70.0%	60.0%	62.6%	66.3%

[1]Capitilization Ratio = (Long-Term Debt + Short-Term Debt) / (Long-Term Debt + Short-Term Debt + Net Assets)
Source: PPMH Audited Financial Statements

Other Observations

The ultimate, composite standard of financial health among U.S. hospitals and health systems is their bond rating, which is assigned upon evaluation by one of the three major "rating agencies" (Fitch, Moody's, Standard & Poor's). The Hospital is rated by Moody's.

As of June 2020, Moody's affirmed the Hospital's investment grade, A1 rating and revised the health system financial outlook to stable from negative. In Moody's most recent report, they provided the following rationale for the upgraded outlook:

> *The stable outlook reflects expectations that PPHS will show financial stability as COVID-19 cases continue to decline, Sole Community Provider funding continues, liquidity will remain at above average levels, the expectation of no additional debt and a reduction in capital spending in 2020.*

Additional detail regarding Moody's report can be found in Appendix D.

In an effort of transparency, the Hospital makes available on their website the past six years of audited financial reports as well as the Internal Revenue Service Form 900 (a tax-exempt organization requirement).

Takeaways

As expressed by Moody's, the Hospital's financial health is very strong. While EBITDA (Earnings Before Interest, Depreciation, and Amortization) Margin, a measure of hospital cash flow, fluctuated during the evaluation period, the Hospital's EBITDA margin performance is comparable, if not better, than its peers. As noted in the Cost Domain section of this report, it is likely that the Hospital's high operating expenses required to deliver comprehensive services to the community is the primary factor contributing to a suppression of the EBITDA margin over the past five years. The Hospital has sufficient liquidity to weather downturns and performs favorably here compared to its peers. One area of concern is the Hospital's high Debt-to-Capitalization ratio, a measure of the utilization of debt to fund its assets, showing the Hospital has relied on long-term debt as a source of total available capital.

Diversity, Equity, and Inclusion (Belonging)

Diversity, Health Equity, and Inclusion (Belonging)

Authority Question

Does the Hospital advance health equity and belonging to create a more just and equitable organization?

Context for Inclusion

Communities are more diverse than ever, along virtually any dimension, including race, ethnicity, language, sexual orientation, gender, gender identity, national origin, disability, income, veteran status and more. This reality was amplified, and rose to the surface of U.S. healthcare's conscious, by the social unrest that took place across the country in 2020. As a result, it has become clear that any healthcare organization that seeks to truly address the needs of its communities must adapt to a more diverse stakeholder population, particularly for improved outcomes in health and healthcare.

By 2060, according to Census Bureau projections, the United States population will be "majority minority," meaning most of the population will be made up of members of minority demographics.[23] Additionally, women continue to take on more prominent roles in every segment of our society including in healthcare where 80% of healthcare decisions for families are made by women.[24] And the concerns of long-ignored and marginalized groups, such as the lesbian, gay, transgender, queer or questioning (LGBTQ) community are being recognized and addressed by healthcare disruptors.

For healthcare organizations, embracing growing diversity is critical. Health systems are shifting toward reimbursements based on population-based health outcomes. A critical factor in those outcomes are the social determinants of health that include non-medical factors such as education, employment, transportation, and food insecurity impacting the places we live, work, grow and play. These determinants vary based on race, ethnicity, and other diversity demographics and are historically based in systemic racism. According to the CDC, "When policies, programs, and systems that support health are equitable, poor health outcomes can be reduced, health disparities can be prevented, and the whole of society benefits" (2020).[25]

COVID-19 unearthed and brought to public consciousness the far-reaching impact of social determinants of health and the inequities that plague communities of color and other marginalized groups. As heard through interviews with the Hospital as well as the community, Albany, Georgia's risk of exposure, severe illness, hospitalizations, and death disproportionately impacted Black and other communities of color.

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[23] Demographic Turning Points for the United States: Population Projections for 2020 to 2060, https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf, accessed on April 29, 2021.
[24] Women responsible for most health decisions in the home, Kristyna Wentz-Graff, May 11, 2017, https://news.ohsu.edu/2017/05/11/women-responsible-for-most-health-decisions-in-the-home, accessed on April 29, 2021.
[25] COVID-19 Racial and Ethnic Health Disparities, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html, accessed on April 29, 2021.

Many healthcare organizations cite diversity, inclusion and health equity as a top priority since the COVID-19 pandemic and social unrest resulting from the murders of George Floyd, Breonna Taylor, and Ahmaud Arbery in 2020. Many organizations, in and outside of healthcare, have struggled to make meaningful impact inside of their cultures and as they interact with diverse demographic populations. Despite a realization that health equity and belonging matter, little has been done to address how health systems and their leadership must evolve to meet these challenges. Health systems' ability to recruit, retain, and develop talent is increasingly dependent on the extent to which they create an inclusive culture and a sense of belonging for their front-line workers, middle managers, clinicians, and executives.

Diversity affects the bottom line for organizations of all types, as well. A study conducted by McKinsey found that companies with above-average diversity on their management teams reported higher revenues than their lower diversity counterparts.[26] Despite that, the representation of diversity within healthcare leadership nationally has not significantly improved, with representation of minorities and women remaining low.

Engaging with these diverse groups and delivering high quality health outcomes requires new behaviors, values, and attitudes — new ways of leading. Adapting an equity lens to leadership practices and policies allows organizations to design more effective processes, deliver more value, and engage more deeply in building trust and improving outcomes within marginalized communities. Health equity and belonging strategies should be integrated as the foundation for population health management, human capital, quality, safety, and healthcare delivery strategy to build an equitable and healthy society.

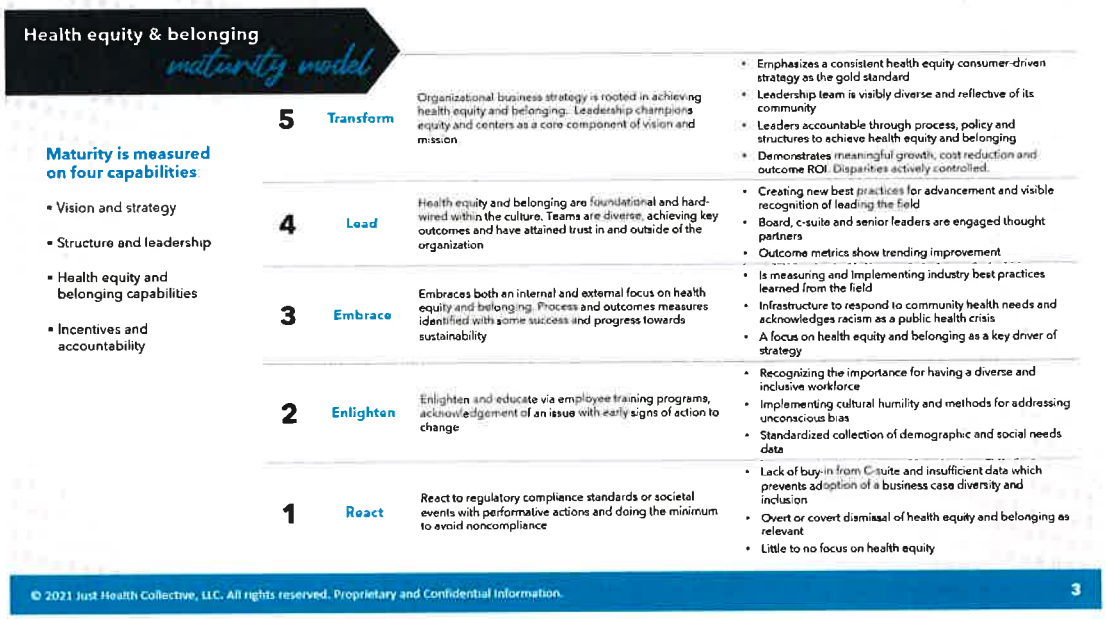
In this assessment, health equity and belonging were evaluated based on the following question: ***Does the Hospital advance health equity and belonging to create a more just and equitable organization?*** The simple answer to this question is yes, the Hospital is making forward movement and exhibiting early success in creating a more just and equitable health system. Yet, further work is required to advance health equity as an integral component of the overall strategy, vision, and transformation process.

Data Measure

The Just Health Collective **Belonging and Health Equity Maturity Model™** will be used as an overall measure of progress to evaluate health system performance:

- Vision and strategy
- Structure and leadership
- Health equity and belonging capabilities
- Incentives and accountability

[26] "Delivering through Diversity", Authors: Hunt, Price, Dixon-Fyle, McKinsey & Company, January 2018.



Hospital Performance

Data Sources: In-depth interviews, research, and document review

Vision and strategy – ***Does the organization have a documented vision and strategy for how it plans to achieve health equity and belonging across the enterprise***?

The Hospital began its journey to improve diversity, equity, and inclusion ("DEI") across the health system in 2020. The Hospital has quickly accelerated its work on DEI but has not explicitly documented a plan for advancing health equity, which should at minimum include: (1) a plan to standardize the collection of race, ethnicity, language ("REAL") and sexual orientation and

gender identity data for every patient across the health system; (2) a plan to measure and address identified racial, ethnic or cultural disparities among groups.

The Hospital's current strategy is focused exclusively on workforce and building a culture of inclusion and outlines the following five goals:

1. Improve organizational awareness and understanding of diversity and inclusion principles and practices
2. Enhance employee acceptance and engagement
3. Permeate Phoebe culture with D&I activities: live our values through intentional actions
4. Become a leading DEI partner/ambassador in our community
5. Hardwire DEI into our talent management process

Scott Steiner, president and CEO of Phoebe Putney Health System, noted early in his tenure that Phoebe has, "an incredibly vibrant and diverse workforce that is representative of the communities we serve. In some areas of our organization – like on our management team – that diversity has been less evident, and we are committed to looking at ways to making meaningful change."

Prior to launch of the Phoebe Diversity Council, the organization conducted focus groups made up of minority leaders across the health system – distilling their input into key action items. The first recommendation was the establishment of a diversity council and system-wide diversity and unconscious bias training. The Hospital adopted those recommendations leading to the current structure and work.

Racial and Gender Composition

Data Source: PPMH management, Phoebe website, ESRI, and Governance Institute

As a starting point for measuring the Hospital's improvement over time, the 2021 workforce diversity baseline is shown in *Figure 28* below.

Figure 28

	Race			Gender	
	White	African American	Other	Male	Female
Health System Governing Board[1] (n=14)	78.6%	21.4%	*unknown*	78.6%	21.4%
Executive and Medical Leadership[2] (n=26)	61.5%	19.2%	*19.2%*	73.1%	26.9%
Employees[1] (n=2,653)	49.5%	45.4%	5.1%	83.3%	16.5%
Dougherty County[2] (n=93,616)	24.2%	71.4%	4.3%	46.9%	53.1%
PPMH Primary Service Area[2,3]	40.9%	54.2%	5.0%	48.3%	51.7%

[1] *Provided by Phoebe Management as of 3/25/2021*

[2] *Racial and gender designations noted above based on generalized assumptions only from website reviews and are not intended to be an 100% accurate reflection of an individual's race or gender as one might personally identify.*

[2] *ESRI; 2020 Demographic and Income Profile Report*

[3] PPMH Primary Service Area includes: Dougherty, Lee, Mitchell, Sumter, Terrell, and Worth Counties

According to the Governance Institute's 2019 Biennial Survey of hospital and health system boards, the average health system Board size in 2019 was 17 members. *Figure 29* below shows that for a health system with between 500-999 beds (PPHS has a total of 777 staffed beds between all four hospitals), the average number of females represented on the board was 4.3

individuals and the average number of ethnic minorities was 3.2 individuals. Assuming the average Board size of 17 people, that equates to 25% female and 19% ethnic minorities. These are in line with the current composition of Phoebe Health System's Governing Board as shown above. The Governance Institute notes that there has not been any significant movement in these areas since 2007.[27] The PPMH Board composition when compared to Dougherty County or PPMH's Primary Service Area is underrepresented in both females and minorities.

Figure 29

Table 9. Female & Ethnic Minority Representation on the Board by Organization Size (2019 vs. 2017)

	Females (average)		Ethnic Minorities (average)	
	2019	2017	2019	2017
< 100 beds	3.1	2.9	0.7	2.9
100–299 beds	3.7	3.6	1.3	3.6
300–499 beds	4.5	4.7	1.9	4.7
500–999 beds	4.3	4.0	3.2	4.0
1000–1999 beds	4.1	4.3	2.6	4.3
2000+ beds	3.6	2.8	2.0	2.8

The Hospital's mission, vision and values were updated in 2019. However, they do not explicitly mention DEI or health equity, though this may be implied.

MISSION:
We empower every member of the Phoebe Family to safeguard the health of our communities - embracing a culture that delivers great patient experiences, innovative treatments, and access to superior care.

VISION:
To make every life we touch, better.

OUR VALUES:

- Safety is fundamental. Zero harm is priority #1.
- Community is our focus. We are a part of the places we serve. These are our families, our friends, and our neighbors – together, we rise.
- Compassion is our core. For us, it's not a catch phrase – it's who we are.
- Service is our calling. This is not just a job; this is our life's work – it's what we love and what we are meant to do.
- Commitment is our promise to always get better. We don't settle for "that's how it has always been done." We learn from our past and build a better tomorrow.

[27] The Governance Institute's 2019 Biennial Survey of Hospitals and Healthcare Systems

Best practice examples on DEI inclusion in mission, vision or values statements[28]:

- Novant Health – One of five elements of Vision Statement: Diversity and inclusion- *We recognize that every person is different, each shaped by unique life experiences. This enables us to better understand each other and our customers.*
- Atrium Health – Mission: *To improve health, elevate hope and advance healing – for all.*
- University of Illinois (UI) Health – Mission: *In collaboration with our academic partners, our mission is to advance healthcare to improve the health of our patients and communities, promote health equity and develop the next generations of healthcare leaders.*

Key takeaway: The Hospital's mission, vision, and values of were recently updated. However, DEI was not explicitly called out. One might infer, based on the new language, that health equity and belonging are implied, but there is clear need for alignment in the narrative. Narrative will ultimately allow employees, leaders, and the community to understand the Hospital's commitment to health equity and belonging as an intrinsic value rooted in their core belief and aspiration statements. Additionally, PPMH should strive to increase its Board Member representation to better reflect its community in gender and diversity.

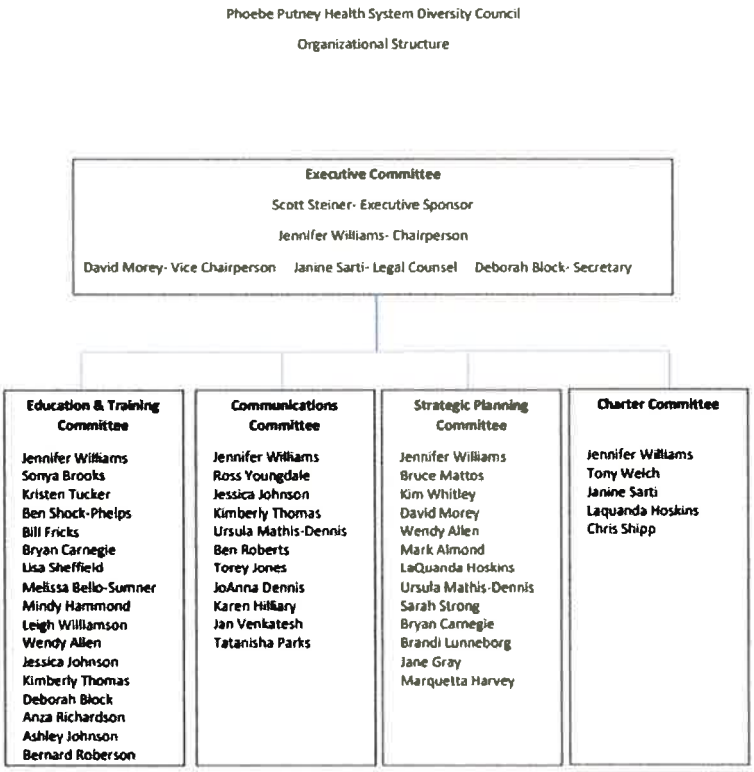
Structure and leadership – *Does the organization have a structure in place to execute against its vision and strategy for health equity and belonging*?
Data Sources: PPHS diversity council organizational structure, in-depth interviews, and document review

In May 2020, Jennifer Williams, Ph.D., was hired as an organizational development coach. In April 2021, she was promoted to corporate director of diversity, inclusion, and engagement over the Hospital. Dr. Williams' scope of responsibility is to drive the system-wide development, implementation, and integration of best practices, resources, and policy to increase and improve diversity, equity, inclusion and employee engagement. Her work, to date, has been centered on advancing workplace culture and representation as evidenced by the Hospital's diversity and inclusion sustainability plan and dashboard.

Dr. Williams does not have dedicated staff full-time equivalents ("FTEs") to advance the work of DEI across the system but relies on collaboration from the 40-member Phoebe Diversity Council ("PDC") as shown in *Figure 30* below. The PDC includes employees from across the organization who represent various races, ethnicities, ages, sexual orientations, religion, and years of work experience. The PDC is united around a common goal to ensure the Hospital provides a diverse, equitable and inclusive environment for employees, patients, board members, visitors, and volunteers.

[28] https://www.novanthealth.org/home/about-us/mission-vision--values.aspx, accessed on May 16, 2021.
https://atriumhealth.org/about-us/mission-vision, accessed on May 16, 2021.
https://hospital.uillinois.edu/about-ui-health/mission-vision-and-values, accessed on May 16, 2021.

Figure 30



Ursula Mathis-Dennis, Oncology Quality Director in the Phoebe Cancer Center, is a member of the PDC and stated that, "It is rewarding to see the organization acknowledge shortcomings and commit to change. I can honestly say there is a shift in the atmosphere and culture at Phoebe, and I am grateful to be a part of that change…"

Key takeaway:
PPHS has hired an executive to advance the belonging work. However, at this time there are not additional staff to support this leader who have subject matter expertise in diversity, equity and inclusion work; this may limit efficiency and ability to execute as their goals and aspirations become more nuanced and sophisticated. Currently, the PPHS Diversity Council is focused on internal advancement of diversity and inclusion. However, as the group matures there should be an intentional focus on developing and integrating internal equity and health equity strategies.

Health equity and belonging capabilities – *Does the organization have tactical actions, tools, and resources to implement its strategy to achieve health equity and belonging across the enterprise*?
Data Sources: In-depth interviews and document review

The Hospital has implemented an impressive list of actions in short order to advance their DEI plan, but has not explicitly outlined actions and capabilities to advance health equity. The system's DEI director has spent much of her career in public policy and administration, with little exposure to the inner workings of a healthcare organization. Most typically, one will see DEI leaders in healthcare have responsibility for both DEI *and* health equity initiatives, but it does

vary by organization. To achieve the best to advance health equity, the DEI leader should be paired with a clinical leader to form a dyad which integrates and aligns DEI and health equity.

Figure 31

Technical capability demonstrated	Yes	No	Inconsistent
Foundational diversity, equity, and inclusion training	x		
Unconscious bias training	x		
Micro-aggressions training		x	
Health equity training		x	
Anti-racism training		x	
Cultural competency	x		
Evaluation of organizational policies from an equity lens		x	
Systematic collection of REAL, SOGI and social needs data			x
Continuous quality improvement of clinical disparities			x
DEI dashboard and measurement plan (plan but not dashboard)			x
DEI workgroup or council in place	x		
External DEI activities and organizational commitment	x		
Health equity dashboard and measurement plan		x	
Health equity workgroup our council in place		x	
External health equity activities and organization commitment			x
Systematic collection referral to social service agencies when a social need is identified			x
Board oversight and engagement of DEI initiatives	x		
Board oversight and engagement of health equity initiatives			x
Patient experience data systematically filtered by REAL and SOGI		x	
Community partnerships to improve health equity established			x
Advocacy for policies that support improvement of health equity	x		
Leadership development programs with intentional focus on women and minority development		x	
Succession planning process to identify future women and minority talent		x	
Quality and safety data consistently stratifies data by REAL and SOGI			x
Executive compensation tied to health equity and belonging measures		x	
Physician compensation tied to health disparities performance data		x	
Employee performance reviews measure individual contributions to health equity and belonging		x	
Population health programs systematically address social needs			x
Supplier diversity program in place		x	
Diversity statement included in vendor RFPs and contracts	x		
Language access and accessibility services in place			x
Recruiting process and training focuses on unconscious bias		x	
Measurement of candidate attrition through entire recruiting process		x	
Completes organizational DEI assessment (e.g., National Diversity Council Diversity Index)	x		
Completes Human Rights Campaign Healthcare Equality Index (i.e., LGBTQ equality survey)[29]		x	
Completes health equity assessment (Equity of care awards process for IFHDE)[30]		x	

[29] Healthcare Equality Index, <https://www.hrc.org/resources/healthcare-equality-index>, accessed April 30, 2021.
[30] Equity of care Awards, https://ifdhe.aha.org/2021-equity-care-award-applications-open, accessed April 30, 2021.

Technical capability demonstrated	Yes	No	Inconsistent
Awards, recognitions, and honors for health equity and belonging work		x	
System in place for anonymous health equity and belonging complaint reporting		x	
Exit interview questions focused on belonging and health equity		x	
Audit of performance reviews for bias		x	
Employee resource groups exist within the organization			
Employee engagement survey includes questions related to health equity and belonging	x		
All functional units (departments) have a clear health equity and belonging goal tied to organizational strategic plan		x	

The Hospital has positive indicators of planning and implementation of tactical actions related to diversity, equity, and inclusion. For instance, it has trained staff, established the PDC, established metrics for performance and hosted focus groups and listening sessions across the system. To date, more than 230 Hospital leaders have completed diversity and unconscious bias training, and the PDC plans to roll out similar training to employees throughout the enterprise in 2021.

Currently, the Hospital's strength lies in foundational DEI tactics to root the organization in understanding of the rationale, purpose and impact that should be anticipated in this type of transformation. As it moves forward, the Hospital will want to ensure that activities are expanded into and owned by various business leaders to facilitate the inclusion of DEI actions within their organizational responsibility. This would include activities like ensuring diversity in candidate panels, executing inclusive meetings, etc. As time progresses, it will be critical for the diversity and inclusion leader to have support staff roles to address daily work while she works to engage and execute strategy across the enterprise.

In 2020, the Hospital joined the Georgia Diversity Council ("GADC"), an extension of the National Diversity Council. The mission of the GADC is to foster an understanding and appreciation of diversity and inclusion as a dynamic strategy for business success and community well-being through various initiatives. Phoebe's investment represents a key action to support the organization's commitment to DEI. Additionally, Mr. Steiner serves on the GADC Board of Directors and Dr. Williams serves on the GADC Advisory Council.

Key takeaway: Overall the Hospital is on track for where we would expect, given that the DEI leader has been in place for a short period of time and implementation of the DEI sustainability plan only began in January. The Hospital, like most, is new to the journey and so one would not expect to see accountability and incentive measures beyond those identified in the diversity and inclusion sustainability plan. A dashboard inclusive of HR metrics, employee engagement and patient experience data would help PPHS as they continue forward. PPHS should also consider developing a health equity tactical plan, like the diversity and inclusion sustainability plan, that would coordinate and advance health equity tactics across the system. As the organization comes to greater awareness of the goals and expectations, the leadership team should be prepared to adjust performance goals and compensation to reflect health equity and belonging as a strategic priority.

Incentive and accountability – ***Does the organization have measurable goals, metrics and data that is used to incentivize accomplishment of strategy and to hold leaders accountable for change***?

Data Sources: In-depth interviews and document review

To advance measurable change in health equity and belonging, it is critical for organizations to implement various incentives and accountability structures. These structures might exist in policy, compensation, technology, and stakeholder visibility. Organizations that are more advanced in their journey will often have some percentage of executive compensation tied to achieving health equity and belonging goals. This shows up not only for the functional leader (e.g., chief diversity officer, chief health equity officer, etc.) but for all executives who should have a stake in advancing these objectives.

The Hospital board chair is engaged and clearly understands the work occurring in diversity, equity, and inclusion. One advantage for the Hospital is that the board chair has had experience in developing a system wide diversity and inclusion plan; and, therefore, understands the practical components necessary to move the organization forward.

Given where the Hospital is in its transformation journey, one would expect to see primarily process metrics versus outcomes metrics being put in place, as there has not been enough time within which to achieve measurable performance outcomes. Based on review of the Hospital's diversity and inclusion sustainability plan, it has reached approximately 75% completion for a plan that runs from quarter three 2020 through quarter three 2021. This is excellent movement for an organization that has only been at work on diversity, equity, and inclusion for one year.

Key takeaway: Given the Hospital is new to the journey, it would be unreasonable to expect to see accountability and incentive measures beyond those identified in the diversity and inclusion sustainability plan. The board, leadership and council have awareness of current strategy and goals. As the organization comes to greater awareness of the goals and expectations, the leadership team should be prepared to adjust performance goals and compensation to reflect health equity and belonging as a strategic priority.

COVID-19 Response Management

COVID-19 Response Management

Authority Question

How effectively has the Hospital managed the COVID-19 pandemic?

Context

COVID-19 has disrupted and altered the way health care is delivered in the United States and across the world. Over the past year, hospitals have had to be flexible and rapidly change operational and strategic priorities, typically something hospitals are not known for. A hospital's response to the COVID-19 pandemic is difficult, at this point, to measure across peers, given the paucity of available public data. The most reliable and routinely updated data was gathered from the Centers for Disease Control and Prevention ("CDC") at the county and state level, as well as the Georgia Department of Health. Arguably, the most important measures of this domain is community perception.

The Hospital is not the sole responsible party for pandemic management, even though it may have been thrust into that role given circumstances. It should be noted that this domain requires an overall community effort that the hospital is a part of and that, as the data suggests, infers the Hospital has done a very strong job to help the community manage what was a near existential crisis in early/mid-2020.

It should also be noted the data available for this domain is updated in real time, some without extensive vetting for accuracy.

To quantify the Hospital's response to the pandemic, the following measures were analyzed:

1. Hospital County 7-Day Total COVID Cases
2. Hospital County 7-Day Percent Positivity
3. Hospital County 7-Day Testing Volume
4. Hospital County 7-Day New Hospital Admissions
5. Hospital County % of Total Population Vaccinated
6. Hospital States % of Total Population Fully Vaccinated
7. Local Peer Group Hospital Vaccinations as % of County Vaccinations

Assessment

As noted above, the CDC has been the reputable source for COVID-19 statistics reported at a national, state, and county level. Their public tool, COVID Data Tracker, allows for exploration of standardized data across the country.[31] As displayed in *Figure 32* below, from March 26, 2021 to April 1, 2021, Dougherty County is below (lower number is more favorable) the local, regional, and national peer group in three of the 7-day reported measures: Total Cases, Testing Volume, and New Hospital Admissions. The 7-Day percent positivity in falling within the median of the peer groups. As of April 6, 2021, Dougherty County had 4% of the population vaccinated. This rate is significantly below all peer groups.

[31] CDC. COVID Data Tracker – County View. https://covid.cdc.gov/covid-data-tracker/#county-view

Figure 32

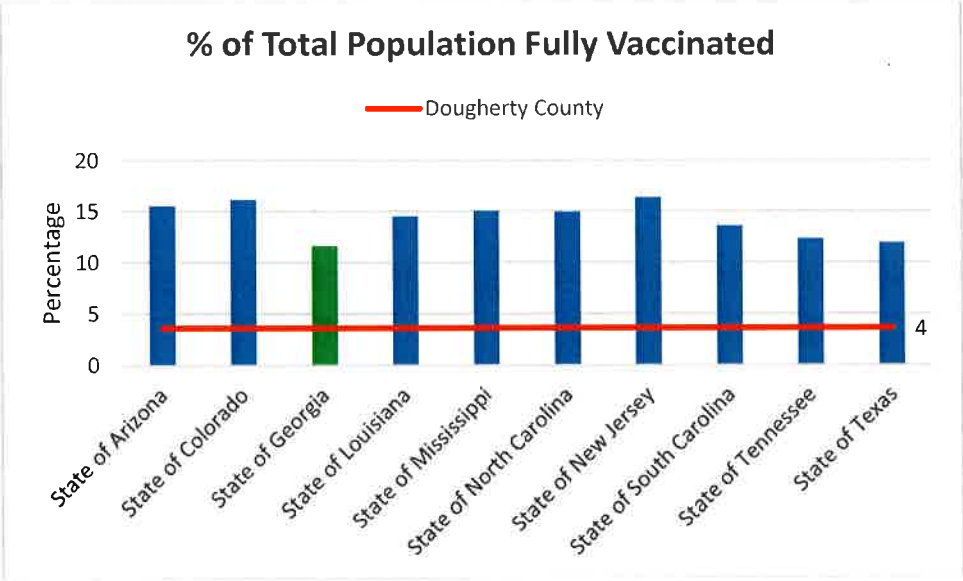
Data Measure	Dougherty County	Local Average	Regional Average	National Average
Hospital County 7-Day Total Cases[1]	66	88	86	104
Hospital County 7-Day Percent Positivity[1]	5.2%	5.6%	5.1%	4.7%
Hospital County 7-Day Testing Volume[1]	539	682	1,389	1,853
Hospital County 7-Day New Hospital Admissions[1]	10	21	21	23
Hospital County % of Total Population Vaccinated[2]	4%	8%	13%	13%

[1] *CDC COVID Data Tracker County View; March 26, 2021 - April 01 2021*

[2] *CDC COVID Data Tracker County View; As of April 6, 2021*

Of the states represented in the national peer group, Georgia had the lowest percentage of the total state population fully vaccinated at 12% (as of March 26, 2021), as shown in *Figure 33* below.[32]

Figure 33



The Georgia Department of Health also tracks vaccination administered at a county level as well as by site. As of March 31, 2021, the Hospital administered 52% of all Dougherty County COVID-19 vaccinations. This includes the doses administered at the following Dougherty County sites: Phoebe Family – Albany, Phoebe Family Care Center, Phoebe Physician Group, PPMH, and PPMH – Employee Health. As shown in *Figure 34* below, compared to the local peer group hospitals, the Hospital-administered the most doses at almost 29,000.

[32] U.S. Department of Health & Human Services. COVID-19 State Profile Report (SPR). https://healthdata.gov/

Figure 34

Hospital Name	County	County Doses Administered	Hospital Doses Administered	Hospital % of County Doses Administered
Phoebe Putney Health System	Dougherty	56,094	28,973	52%
Archbold Memorial Hospital	Thomas	29,124	20,870	72%
Houston Medical Center	Houston	49,211	14,909	30%
Piedmont Athens Regional Medical Center	Clarke	69,065	12	0%
Piedmont Columbus Regional - Midtown	Muscogee	48,399	13,654	28%
South Georgia Medical Center	Lowndes	40,239	20,802	52%
The Medical Center Navicent Health	Bibb	80,658	25,317	31%
WellStar West Georgia Medical Center	Troup	14,933	4,414	30%

Source: Georgia Department of Public Health. Georgia Immunization Registry (GRITS); As of March 31, 2021

Other Observations

The Hospital maintains a COVID-19 dashboard to track system census, COVID-19 patient hospitalizations, and vaccinations administered. Below are key takeaways of the March 12, 2021 dashboard provided by Hospital management.

- The system acute care census peaked throughout March and April 2020 and January 2021.
- Out of the 37,069 total vaccinations administered, 79% were given to the 65+ aged population, 13% were to employees and medical staff, and 8% were given to community healthcare workers.
- Of the 65+ aged population who received the vaccine, 53% were white, 40% were African American, 3% were another race, and 4% had a race that was unknown.

Since April 27, 2021, PPHS has administered a total of 50,012 total vaccinations. Within 46 days (between March 12, 2021 and April 27, 2021), the system administered an additional 13,000 COVID-19 vaccines.

Over the past year, the Hospital also accomplished several notable milestones in managing the COVID-19 pandemic, including but not limited to:

- March 2020 – Established Command Center; Opened COVID-19 Hotline
- April 2020 – Launched Telehealth Visits
- May 2020 – Launched COVID-19 Antibody Testing
- July 2020 – Started Contact Tracing Training with State
- August 2020 – Purchased 2 Mobile Wellness Clinics
- October 2020 – Launched COVID-19 Rapid Testing
- November 2020 – ER Renovations & New Observation Unit Opened
- December 2020 – Administered 1st COVID-19 Vaccine
- January 2021 – Opened Community Vaccination Sites
- February 2021 – Produced vaccine educational toolkits for churches and community partners
- March 2021 – Mobile Wellness Clinics arrived in Albany – will assist with vaccine efforts in surrounding rural communities

Additionally, the Hospital's response to COVID-19 is shown in the magnitude of the following statistics within the first 100 days of the pandemic:

- 13,871 people tested
- 2,728 positive cases
- 914 admissions
- 70,000+ hours of staff overtime
- 1,783 employees assisted in sanitizing, temperature checks and mask detail
- 123,700+ pieces of personal protection equipment ("PPE") donated
- 24,0000+ meals prepared
- $3,496,244 cash donations and pledges for COVID-19 relief fund

Takeaways

At a county level, Dougherty County is favorable in number of COVID-19 cases, testing volume, and new hospital admission compared to the local, regional, and national peer groups. Although the county is below all peer groups in percentage of population vaccinated, the Hospital has been a significant contributor in the community in testing and treating patients with COVID-19, as well as, administering COVID-19 vaccines. As have hospitals nationally, the Hospital has demonstrated skill and agility in responding to the pandemic and has accomplished and celebrated several significant, well-deserved milestones over the past year.

Appendix A – Peer Groups

Peer Group Criteria

Criteria	Local	Regional	National
Hospital Type	Short Term Acute Care Hospital		
State	GA	AL, FL, GA, MS, NC, SC, TN	
Staffed Beds	200 - 900		All
CBSA Population	All	100,000 – 249,999	All
Ownership	Hospital Authority	All	All
2020 Median Household Income	<150% of Dougherty County ($39,695)		All
2020 Minority Population	>50% of Dougherty County (76.86%)		All
2018 Households Below the Poverty Level (%)	>50% of Dougherty County (26.68%)		All
Hospital Medicaid Percentage	>50% of Phoebe Putney Memorial Hospital (13%)		All

Local Peer Group

Hospital Name	County	City	State
Archbold Memorial Hospital	Thomas	Thomasville	GA
Houston Medical Center	Houston	Warner Robins	GA
Piedmont Athens Regional Medical Center	Clarke	Athens	GA
Piedmont Columbus Regional - Midtown	Muscogee	Columbus	GA
South Georgia Medical Center	Lowndes	Valdosta	GA
The Medical Center Navicent Health	Bibb	Macon	GA
WellStar West Georgia Medical Center	Troup	La Grange	GA

Regional Peer Group

Hospital Name	County	City	State
Coliseum Medical Centers	Bibb	Macon	GA
Hamilton Medical Center	Whitfield	Dalton	GA
Houston Medical Center	Houston	Warner Robins	GA
Piedmont Athens Regional Medical Center	Clarke	Athens	GA
South Georgia Medical Center	Lowndes	Valdosta	GA
The Medical Center Navicent Health	Bibb	Macon	GA
WellStar West Georgia Medical Center	Troup	La Grange	GA
Forrest General Hospital	Forrest	Hattiesburg	MS
Nash UNC Health Care - Nash General Hospital	Nash	Rocky Mount	NC
UNC Health Southeastern	Robeson	Lumberton	NC
Vidant Medical Center	Pitt	Greenville	NC
Wayne UNC Health Care	Wayne	Goldsboro	NC
McLeod Regional Medical Center	Florence	Florence	SC
MUSC Health Florence Medical Center	Florence	Florence	SC
Prisma Health Tuomey Hospital	Sumter	Sumter	SC
Jackson-Madison County General Hospital	Madison	Jackson	TN

National Peer Group

Hospital Name	County	City	State
Yuma Regional Medical Center	Yuma	Yuma	AZ
Parkview Medical Center	Pueblo	Pueblo	CO
Hamilton Medical Center	Whitfield	Dalton	GA
Houston Medical Center	Houston	Warner Robins	GA
Piedmont Athens Regional Medical Center	Clarke	Athens	GA
South Georgia Medical Center	Lowndes	Valdosta	GA
The Medical Center Navicent Health	Bibb	Macon	GA
WellStar West Georgia Medical Center	Troup	La Grange	GA
CHRISTUS St Frances Cabrini Hospital	Rapides	Alexandria	LA
St Francis Medical Center	Ouachita	Monroe	LA
Forrest General Hospital	Forrest	Hattiesburg	MS
Nash UNC Health Care - Nash General Hospital	Nash	Rocky Mount	NC
UNC Health Southeastern	Robeson	Lumberton	NC
Vidant Medical Center	Pitt	Greenville	NC
Wayne UNC Health Care	Wayne	Goldsboro	NC
Inspira Medical Center Vineland	Cumberland	Vineland	NJ
McLeod Regional Medical Center	Florence	Florence	SC
Prisma Health Tuomey Hospital	Sumter	Sumter	SC
Jackson-Madison County General Hospital	Madison	Jackson	TN
CHRISTUS Mother Frances Hospital - Tyler	Smith	Tyler	TX

Appendix B – Interviewees

PPMH Individuals	Community Individuals
• **Scott Steiner** – CEO Health System • **Brian Church** – CFO/CAO Health System • **Dr. Dianna Grant** – CMO Health System • **Dawn Benson** – General Counsel Health System • **Joe Austin** – CEO Main Hospital • **Jeff Flowers** – COO Main Hospital • **Darrel Sabbs** – Community Benefits Coordinator • **Jen Williams** – Organizational Development Coach • **Dr. Jim Hotz** – Internal Medicine Physician • **John Culbreath** – PPMH Board Chair • **Marvin Laster** – PPMH Board Vice Chair	• **Shelley Spires** – CEO Albany Area Primary Health Care, Inc. • **Clinton Johnson** – Dougherty County Commissioner • **Sherrell Byrd** – Chair, SOWEGA Rising • **Luke Flat** – AB&T President & CEO • **Dorothy Hubbard** – Former Mayor / Current Hospital Authority Board Member • **Daniel Simmons** – Pastor, Mt. Zion Baptist Church • **Marion Ross Fedrick** – President, Albany State University

Appendix C – Access Point Locations

PPHS Facilities	Address	City	State
Phoebe Putney Memorial Hospital	417 W. 3rd Avenue	Albany	GA
Phoebe Specialty Pharmacy	417 W. 3rd Avenue	Albany	GA
Phoebe Cancer Center Boutique	427 W. 3rd Avenue	Albany	GA
Phoebe Putney Memorial Hospital-Rehab	427 W. 3rd Avenue	Albany	GA
Phoebe Putney Memorial Hospital North	2000 Palmyra Road	Albany	GA
Phoebe Home Health of Albany	320 Foundation Lane	Albany	GA

PPHS Primary Care	Address	City	State
Phoebe Primary Care at Northwest	2336 Dawson Road, Suite 1500	Albany	GA
Phoebe Primary Care at Meredyth	2709 Meredyth Drive, Suite 340	Albany	GA
Phoebe Primary Care of Albany	901 N. Madison Street	Albany	GA

PPHS Urgent Care	Address	City	State
Phoebe Community Care Clinic	417 14th Avenue	Albany	GA
Phoebe Urgent Care Center at Northwest	2336 Dawson Road	Albany	GA
Phoebe Urgent Care Center of East Albany	2410 Sylvester Road	Albany	GA
PPHS Specialty Services	**Address**	**City**	**State**
Phoebe Urology of Albany	1950 Palmyra Road	Albany	GA
Phoebe Hospice	2000 Palmyra Road	Albany	GA
Phoebe Pulmonology	2002 Palmyra Road, Suite 101	Albany	GA
Phoebe Corporate Health	2410 Sylvester Road	Albany	GA
Phoebe Neurosurgery	2622 Meredyth Drive	Albany	GA
Phoebe Neurology	2709 Meredyth Drive, Suite 230	Albany	GA
Phoebe Dermatology	2709 Meredyth Drive, Suite 340	Albany	GA
Phoebe Plastics & Reconstructive Surgery	2709 Meredyth Drive, Suite 340	Albany	GA
Phoebe Orthopaedics of Albany	2709 Meredyth Drive, Suite 450	Albany	GA
Phoebe Rheumatology	2709 Meredyth Drive, Suite 550	Albany	GA
Phoebe Gastroenterology	2740 Ray Knight Way	Albany	GA
Phoebe Radiology	417 W. 3rd Avenue	Albany	GA
Phoebe Surgical Oncology	425 W. 3rd Avenue, Suite 410	Albany	GA
Phoebe Cardiovascular Surgery	425 W. 3rd Avenue, Suite 510	Albany	GA
Phoebe Cardiology Of Albany	425 W. 3rd Avenue, Suite 600	Albany	GA
Phoebe Electrophysiology	425 W. 3rd Avenue, Suite 700	Albany	GA
Phoebe Hematology Oncology	425 W. 3rd. Avenue	Albany	GA
Phoebe Heart Valve Clinic	425 W. 3rd. Avenue, Suite 510	Albany	GA
Phoebe Maternal-Fetal Medicine	425 W. 3rd. Avenue, Suite 550	Albany	GA
Phoebe General Surgery of Albany	425 W. 3rd. Avenue, Suite 410	Albany	GA
Phoebe Cancer Center	427 W. 3rd Avenue	Albany	GA
Phoebe Vascular Surgery	427 W. 3rd Avenue, Suite 210	Albany	GA
Phoebe Behavioral Health	500 W. 3rd Avenue, Suite 100	Albany	GA
Phoebe Wound Care & Hyperbaric Medicine	803 N. Jefferson Street	Albany	GA

Appendix D – Select Evaluation Measure Definitions

Key Definitions

Diversity — The differences, similarities and intersections that make us unique individuals. This includes race and ethnicity, language, national origin, sexual orientation, gender identity, veteran status, religion, abilities, educational background, socio-economic status, social preferences, political affiliations, work experience and other characteristics.

Equity – Beyond equality, equity is about giving people what they need to be full contributing members of society. Equality is giving people the same resource and equity is giving people what they need based on circumstance. In healthcare systems, this can mean placing COVID-19 vaccine distribution sites in zip codes with a higher concentration of minorities and older individuals to ensure equitable distribution, prevention of severe illness, and death.

Inclusion – Sustaining a work environment in which all individuals are treated fairly and respectfully and can contribute fully to their organization's success. In healthcare systems, inclusion is not just which staff members are invited to serve on a committee or task force, but how well their voices and contributions are incorporated into decision-making and planning processes.

Belonging – The intersection of diversity, equity, and inclusion. Belonging leads people to feel valued, respected, and safe to know that they can show up as their whole selves in any place or circumstance without fear of ostracism, retribution, or harm.

Health disparity – differences in illness, injury, disability, morbidity, and mortality rates across population groups

Heath inequity – the unjust and avoidable differences in people's health across the population and between specific population groups

Social determinants of health – the places and circumstances in which we live, work, play, grow and age that impact our health.

Moody's Investor Services Outlook Detail – The revision of the outlook to stable reflects the material CARES Act funding and state support Phoebe Putney Health System (PPHS) has and will receive given the COVID-19 outbreak in this region and the material improvement PPHS demonstrated prior to the outbreak. The A1 reflects expectations that PPHS should be able to return to the financial momentum demonstrated through mid-2020 prior to coronavirus, given physician recruitments, volume growth, expense reductions and Medicare designation as a Sole Community Hospital, the latter of which will provide a material increase in revenues. Given the outbreak in Albany and Dougherty County, fiscal 2020 performance will show a departure from the momentum although CARES Act funding should allow PPHS to report financial metrics for 2020 that are on par with 2019. Despite above average exposure to equity investments, the A1 will also reflect maintenance of a strong absolute and relative liquidity position, even prior to the receipt of Medicare accelerated funds, and expectations of no additional debt. Offsets will include a modest revenue base for the rating level and an aging population in the rural southwestern part of the state. High exposure to Medicaid, which is a social risk under Moody's ESG taxonomy because of heightened exposure to government policy changes, will also continue to be a credit challenge. Longer-term competition will arise if a proposed new 60-bed facility opens in adjacent Lee County.