No.	Guidance section	Bucket	Sub categories	Metric	Why it matters	Years (FY 2025 submitted, FY 2023-2024 are submitted and approved, 2022 and prior are actuals)	Data source	Metrics to review in conjuction with metric	Data details	Benchmarks/comparators	Notes about benchmark/comparators
1	Section 1	Target	Affordability	Net patient revenue growth	Net patient revenue can be used as an indicator of a healthcare organization's financial strength as it represents the aggregate money generated from patient services collected across payers. Can assess the role of price and utilization in driving overall growth trends. May be indicative of rising prices for health care services.	FY2025-FY2024 Approved	Adaptive	Payer mix, adjusted discharge growth, commercial price growth, commercial cost, operating margin	Confirmed in Adaptive as "Net Patient Care Revenue"	3.5%-4.3% over the FY24 system-wide approved budget	
2	Section 1	Target	Affordability	Commercial price growth	Hospital spending is 40-45% of commercial total spending in the state-growth in this trend will have a substantial impact on affordability of health care. VT has higher commercial cost compared to nation. GMCB's regulatory charge is to contain the growth of spending with HBR process.	FY2025-FY2024 Approved	Adaptive	Commercial cost	Adaptive has data on submitted and approved commercial as rate	State CPI, Wage growth	
3	Section 1	Target	Financial sustainability	Operating margin	Operating margin shows the relationship between expenses vs. revenues for patient services and is used for managing hospital operations. It represents earnings on hospital patient services, excluding non-patient realted income and costs.	Greater than 0	Adaptive	Operating expense growth, case mix index, payer mix, total margin	Confirmed in Adaptive as "Operating Margin %"	>0%	
4	Section 2	Revenue trends	Key metric	Charge growth	Charge growth details how hospitals are changing their charges from year to year. The Board has previously established upper limits on hospital charge growth.	FY2025-FY2022	Adaptive	NPR growth, commercial NPR growth, operating expense growth	Adaptive "Submitted Rate" or "Approved Rate per Latest Order" and then the change in that over time.	State CPI	
5	Section 2	Revenue trends	Key metric	Medicaid NPR growth	Medicaid NPR will provide an indicator that combines the price and volume increases in the Medicaid/public sector.	FY2025-FY2022	Adaptive	NPR growth, operating expense growth	Adaptive "Medicaid Net Patient Revenue" and then looking at growth over time	Medicaid rates approved in SFY budgets	
6	Section 2	Revenue trends	Key metric	Medicare Advantage NPR growth	Medicare NPR will provide an indicator that combines the price and volume increases in the Medicare/public sector.	FY2025-FY2022	Adaptive	NPR growth, operating expense growth	Adaptive "Medicare - Advantage Net Patient Revenue" and then looking at growth over time	Medicare Market Basket data	
7	Section 2	Revenue trends	Key metric	Medicare - Traditional NPR growth	Medicare NPR will provide an indiciator that combines the price and volume increases in the Medicare/public sector.	FY2025-FY2022	Adaptive	NPR growth, operating expense growth	Adaptive "Medicare - Traditional Net Patient Revenue" and then looking at growth over time	Medicare Market Basket data	
8	Section 2	Revenue trends	Key metric	Commerical NPR growth	Commercial NPR will provide an indicator that combines the price and volume increases in the commercial sector.	FY2025-FY2022	Adaptive	NPR growth, operating expense growth	Adaptive "Commercial Net Patient Revenue" and then looking at growth over time.	Medicare, Medicaid NPR growth	
9	Section 2	Revenue trends	Key metric	Net patient revenue per adjusted discharge	Metric that shows hospital revenue in relation to utilization and allows for comparison of key revenue metric of across hospitals with different volumes	FY2025-FY2022	Adaptive	Case mix index, operating expense per adjusted discharge	**Currently not in Adaptive**. Adaptive has net revenue per adjusted admission, not net revenue per adjusted discharge. **We would need to calculate per adjusted discharge** in order for this data to be comparable to NASHP dataset.	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT), metrics reported by hospital
10	Section 2	Revenue trends	Access	Visit lag	An access indicator of how long it takes patients to be scheduled for visits. Gives insight into the wait times for services	2024-May	Adaptive	Adjusted admissions per FTE, case mix index, payer mix, other access measures	Information previously provided via narrative. **Will be added to Adaptive for FY25**	State peer group	AAMC publishes median visit lag for new patients which is a sample of Amercican Medical Colleges - not representative of all hospitals
11	Section 2	Revenue trends	Access	Referral lag	An access indicator of how long it takes patients to be scheduled for visits. Gives insight into the wait times for follow up care	2024-May	Adaptive	Adjusted admissions per FTE, case mix index, payer mix, other access measures	Information previously provided via narrative. **Will be added to Adaptive for FY25**	State peer group	No national benchmark found, will use state peer group
12	Section 2	Revenue trends	Access	Wait Times for Specialty Care	An access indicator of wait times for new patients at hospital-owned specialty care practices.	Current - 2022	Independent Study	Adjusted admissions per FTE, case mix index, payer mix, other access measures		State peer group	Potential comparator is AMN/Merritt Hawkins Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates- includes 15 major metropolitan areas (none are in Vermont)
13	Section 2	Revenue trends	Access	Average (median) time patients spent in the emergency department before leaving from the visit	This measure calculates the median time from emergency department arrival to departure for patients discharged from the emergency department (ED). It gives insight solely into ED wait times.	FY2022-FY2017	CMS Care Compare	Other access measures	Median time from emergency department arrival to emergency department departure for discharged patients - excludes psychiatric/mental health and transferred patients Updated Quarterly (January, April, July, October) Measure identifier: OP-18b The measure has been publicly reported since 2013 as part of the ED Throughput measure set of the CMS Hospital Outpatient Quality Reporting (OQR) Program [Federal ID Number: CBE 0496]	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital CMS Care Compare compares against other hospitals with similar volumes: Volume legend (patients annually): Low: 0 - 19,999 Medium: 20,000 - 39,999 High: 40,000 - 59,999 Very High: 60,000+
14	Section 2	Revenue trends	Access	Transfer Impedance	This is an estimate of annual spending due to each hospital's inability to transfer ER patients to more appropriate care settings. It gives insight into transfer issues, boarding issues, and potential shortages of post-acute care providers.	FY2025-FY2022	Adaptive	Adjusted admissions per FTE, case mix index, payer mix, other access measures	The estimated annual expenditures associated with providing care that cannot be reimbursed due to the inability to transfer patients to post-acute or other more appropriate care settings. Examples include stays that exceed length of stay requirements for reimbursement or other care that would not generally be provided in a hospital setting. The 2024 Budget Guidance requested that hospitals include an estimate of how many boarding episodes occurred in your ED for that period, the associated total patient days and charges, and the proportion of each associated with a primary diagnosis related to mental health	State peer group	No national benchmark found, will use state peer group
15	Section 2	Revenue trends	Access	Interhospital transfers	An indicator of whether the individual is able to receive the care needed at the hospital or if another hospital is better suited to provide care. Meaningful when looking at the reasons for transfer and which facilities are receiving most transfers.	FY2022-FY2017	VHCURES	Adjusted admissions per FTE, case mix index, payer mix, other access measures	Could be calculated as discharges as percentage transfers from ED or discharges as transfers as % of IP + ED. Investigating transfers as part of Act 167- could align measure with this work VHCURES can link the record within same day and look at the codes but would take more time and resources. VHUDDS is unreliable due to coding issues.	State peer group	No national benchmark found, will use state peer group
16	Section 2	Revenue trends	Access	Proportion of medical claim dollars staying home HSA	Indicator of whether individuals are able to access care at their home HSA or are seeking care at a different HSA	FY 2022-FY2020	VHCURES	Adjusted admissions per FTE, case mix index, payer mix, other access measures	Option is to do this only for hospital services, or use volume counts.	State peer group	No national benchmark found, will use state peer group
17	Section 2	Revenue trends	Access	Prevention Quality Indicator (PQI) 90 rate for HSA	PQIs can identify gaps in primary care access or outpatient services in a community and highlight potential health care quality problem areas that might need further investigation.	FY 2022-FY2020	VHCURES	Adjusted admissions per FTE, case mix index, payer mix, other access measures	AHRQ measure. Adjusted rates by age/gender Overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection	Peer group	AHRQ has national benchmark available- Prevention Quality Indicators (PQI) Benchmark Data Tables, v2022
18	Section 2	Revenue trends	Clinical Productivity	Occupancy rate per staffed bed	Occupancy rates give insight into actual utilization of an inpatient health facility for a given time period.	FY 2024	Adaptive	Staffed beds, average length of stay, NPR growth, adjusted discharge growth, visit lag	**Currently not in Adaptive**. Information previously provided via narrative: https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY23%20Hospital%20Budget%20Guidance-%20FINAL.pdf.	State peer group	No national benchmark found, will use state peer group
19	Section 2	Revenue trends	Clinical Productivity	Average length of stay	A high average length of stay may indicate that patients are staying in the hospital for an unnecessary amount of days. Such an indicator could suggest delays in discharge due to unecessary waiting, poor organization of care, delays in decision-making, or difficulties related to discharge planning.	FY 2024	Adaptive	Staffed beds, occupancy rate per staffed bed, NPR growth, adjusted discharge growth, visit lag	Confirmed in Adaptive as "Average Length of Stay"	Peer group	
20	Section 2	Revenue trends	Clinical Productivity	Average daily census	The average daily census (ADC) is the average number of inpatient stays for a day in a hospital over a designated period of time. Monitoring ADC is crucial for managing patient flow and allocating resources. The ADC can provide important performance information for hospitals, which can be used to improve treatment and maximize operational efficiency. For example, ADC can help hospitals see which departments are overburdened or which times of years are the busiest. The ADC also helps hospitals see which departments	FY2022-FY2017	Adaptive	Other utilization measures such as wait times and other clinical productivity measures such as average length of stay and occupancy rate per staffed bed	In Adaptive Statistics Metric sheet. The total number of inpatient stays for a hospital over a year. Calculation: Total IP Routine Days/365	Peer group	Measure can be calculated from HCRIS data, Inpatient Days/365
21	Section 2	Revenue trends	Clinical Productivity	Adjusted Admissions Per FTE	An aggregate figure reflecting the number of days of inpatient care, plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in terms of level of effort.	FY 2024	Adaptive	Staffed beds, occupancy rate per staffed bed, NPR growth, adjusted discharge growth, visit lag	Confirmed in Adaptive as "Adjusted Admissions per FTE"	State peer group	No national benchmark found, will use state peer group
22	Section 2	Revenue trends	Clinical Productivity	FTE per 1,000 adjusted discharge	Reflects how efficiently a hospital is distributing its resources by patient	FY 2024	Adaptive	Staffed beds, occupancy rate per staffed bed, NPR growth, adjusted discharge growth, visit lag	Option if GMCB would like to collect and start to report adjusted discharges instead of adjusted admissions	Peer group	Can calculate patient care FTE per 1,000 adjusted discharges with HCRIS data
23	Section 2	Revenue trends	Clinical Productivity	Work RVUs / Clinical FTEs	This is an estimate of productivity per clinical physician. It should give insights into the productivity of MD / DOs, and how much time they spend on non-clinical work.	FY 2024	Adaptive	Staffed beds, occupancy rate per staffed bed, NPR growth, adjusted discharge growth, visit lag	Relative value units (RVUs) are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment. RVUs do not directly define physician compensation in dollar amounts but define the value of a service or procedure relative to all services and procedures. Clinical FTEs include mid-level providers/practitioners , residents & fellows , physicians, and nurses	Peer group	Surveys seem to be the best data source for this benchmark. American Medical Group Association (AMGA) Medical Group Compensation and Productivity Survey had this data in past surveys, which is a proprietary product.

24	Section 2	Revenue trends	Clinical Productivity	Case mix index	It is a discrete measurement of the average clinical severity of patients admitted to each hospital. Helps hospitals determine appropriate staffing levels. The case mix index may also reflect why certain hospitals have higher costs if their patient populations have more complex conditions that require more costly care.	FY2022-FY2017	Adaptive	Commercial cost per discharge, operating expense per adjusted discharge, NPR per adjusted discharge	Confirmed in Adaptive as "Case Mix Index"	Peer group	Several options here for data for peer gropu: John Bartholomew/ Colorado, Medicare Provider Analysis and Review claims file for Medicare case mix index
25	Section 2	Revenue trends	Clinical Productivity	Case mix index by payer	It is a discrete measurement of the average clinical severity of patients admitted to each hospital. Helps hospitals determine appropriate staffing levels. The case mix index may also reflect why certain hospitals have higher costs if their patient populations have more complex conditions that require more costly care.	FY2022-FY2018	Adaptive	Commercial cost per discharge, operating expense per adjusted discharge, NPR per adjusted discharge	Currently on overall "Case Mix Index"	State peer group	No national benchmark found, will use state peer group
26	Section 2	Revenue trends	Commercial price	Revenue per adjusted discharge per payer	This indicator is a view of the hospital's revenue that is adjusted to account for oupatient care volume. It can be used as an indicator of hospital revenue and how that revenue varies by payer	FY2022-FY2017	Adaptive	Case mix index, operating expense per adjusted discharge, commercial cost per adjusted discharge	Adaptive has net revenue per adjusted admission, not net revenue per adjusted discharge. Adaptive does have NPR by payer. If we collect per adjusted discharge by payer we can calculate this (Commercial, Medicaid, Medicare- Traditional, Medicare- Advantage).	State peer group	No national benchmark found, will use state peer group
27	Section 2	Revenue trends	Commercial price	Estimated actual payment	Information about variation in allowed amounts across hospitals. This measure may be used as an assessment of how high commercial prices are and is expressed as a percent of Medicare price. Combined with commercial breakeven, the measure can also identify hospitals to focus on for improving affordability.	FY2022-FY2017	Medicare cost reports	Operating expense growth, charge growth, commercial price growth, commercial breakeven	Can look at this metric for health systems operating in Vermont Colorado/John Bartholomew methodology does not have separate inpatient/outpatient measures Alternatively, could use the RAND price which has commercial standardized price for inpatient and outpatient	Peer group	Data source relies on HCRIS data
28	Section 2	Revenue trends	Commercial price	Payer mix	Gives insight into a hospital's reimbursement structure and the percent of revenue that may come from each payer.	FY2022-FY2017	Medicare cost reports	Operating expense growth, case mix index, operating margin, total margin	Adaptive has Medicare, Medicaid, and Commercial/Self Pay as a percentage of Total Gross Revenue, a percentage of Net Revenue, and a percentage of Net Patient Care Revenue. Previously calculated with NPR/FPP	Peer group	Data source relies on HCRIS data
29	Section 2	Revenue trends	Commercial price	Commercial breakeven	Payment level or rate required from commercial payers (expressed as a percentage of Medicare rates) to allow the hospital to cover maximum expenses, with no profit, for hospital inpatient and outpatient services. This rate gives insight into how the hospital needs to set commercial prices to breakeven. This gives insight into hospital other income, Medicare payment rates, and reimbursement from other payers	FY2022-FY2017	Medicare cost reports	Commercial price growth, commercial standardized price	Could alternatively use NASHP commercial breakeven Can look at this metric for health systems operating in Vermont	Peer group	Data source relies on HCRIS data
30	Section 2	Operating efficiency	Key metric	Operating expense per adjusted discharge	Measurement of cost efficiency for hospitals and controls for utilization	FY2022-FY2017	Adaptive	Case mix index, revenue per adjusted discharge	Not currently a distinct field in Adaptive but can calculate from current Adaptive fields of operating expenses and adjusted discharges	Peer group	HCRIS data calculate operating cost per adjusted discharge
31	Section 2	Operating efficiency	Key metric	Operating expense growth	Assessment of the growth in operating expenses. Operating expense growth reflects both inflationary factors as well as utilization. When hospitals have high expense growth, further analysis can help determine which factors contribute to a higher trend.	FY2025-FY2022	Adaptive	Net patient revenue growth, operating margin	Confirmed in Adaptive as "Operating Expenses - Total" and then look at growth over time	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT) Could also compare to Medicare market basket growth
32	Section 2	Operating efficiency	Key metric	Adjusted discharge growth	Adjusted discharge growth reflects both inpatient and outpatient volume. As inpatient volumes declines and outpatient volumes increases, this measure can provide insight into the overall change in utilization.	FY2025-FY2022	Adaptive	Case mix index, net patient revenue growth, operating expense growth, commercial NPR growth	IP+OP adjusted discharge	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
33	Section 2	Operating efficiency	Key metric	Hospital Expense Distribution (Direct patient care vs. others)	Gives insight into how a hospital uses its assets and may expose potential inefficiencies.	FY2022-FY2017	Adaptive	Operating margin, NPR growth	To mirror NASHP benchmarks, the following Adaptive data fields may be leveraged for this analysis: Capital Cost % of Total Expense, Overhead Expense w/ fringe, as a % of Total Operating Exp, Cost per Adjusted Admission Inpatient revenue	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
34	Section 2	Operating efficiency	Key metric	CMI-adjusted average cost per Medicare discharge	MedPAC use this measure in conjunction with certain quality measures to estimate a hospital's rate of efficiency (low standardized cost with high quality outcomes corelates to a higher rate of efficiency).	FY2024-FY2017	Adaptive	Quality metrics	A hospital's CMI represents the average diagnosis-related group (DRG) relative weight for that hospital. It is calculated by summing the DRG weights for all Medicare discharges and dividing by the number of discharges.	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
35	Section 2	Operating efficiency	Labor	Overhead Expense w/ fringe, as a % of Total Operating Exp	This indicator can help assess how a hospital allocates its costs between patient care and overhead. May expose inefficiencies if the ratio is high.	FY2022-FY2017	Adaptive	Operating expense growth, operating margin	Adaptive has Fringe Non MD and Fringe MD so can likely calculate with existing fields	State peer group	No national benchmark found, will use state peer group
36	Section 2	Operating efficiency	Labor	Salary & Benefits per FTE- non-MD	This metric can help assess whether a hospital is paying its employees market-rate salaries or paying a higher price.	FY2022-FY2017	Adaptive	Previously reviewed with employment cost index	Confirmed in Adaptive as "Salary per FTE - Non-MD" Salary per FTE- non-MD field is also available	Peer group Bureau of Labor Statistics	
37	Section 2	Operating efficiency	Labor	FTE growth for direct patient care	FTE growth for direct patient care reflects how efficiently a hospital is distributing its resources by patient.	FY2022-FY2017	Adaptive	Contracted labor expense, operating expense growth	Hospitals report FTEs by staff class in Adaptive	Peer group Bureau of Labor Statistics	Could compare to full peer group using HCRIS data and also compare with BLS employment cost index
38	Section 2	Operating efficiency	Labor	Hospital labor expense	Can help assess how much a hospital is spending on labor.	FY2022-FY2017	Adaptive	FTE growth for direct patient care, operating expense growth, hospital labor expense	NASHP has information about hospital labor costs but we would propose adding this information to Adaptive. Hospitals currently report on contracted labor in HCRIS	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
39	Section 2	Operating efficiency	Labor	Contracted labor expense	Can help assess how much a hospital is spending on contracted labor. Contracted labor rates are generally higher than FTEs and can drive costs	FY2022-FY2017	Adaptive	FTE growth for direct patient care, operating expense growth, hospital labor expense	NASHP has information about contracted labor costs but we would propose adding this information to Adaptive. Hospitals currently report on contracted labor in HCRIS	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
40	Section 2	Operating efficiency	Labor	Staff Turnover and Vacancies	This measure lists the turnover and vacancy rates for hospital physicians, mid-level providers, and nurses. Low staff retention increases a hospital's reliance on travellers, increases its expenditures, and decreases the quality of its services.	FY2025	Adaptive				
41	Section 2	Operating efficiency	Pharmaceutical expenses	Pharmaceutical price growth	An indicator of costs related to pharmaceuticals to assess the cost trends of the base prices of pharmaceuticals independent of utilization	FY2022-FY2017	Adaptive	Pharmaceutical utilization growth, operating expense growth, operating margin	**Currently not in Adaptive.** FY24: Pharmaceutical expenses growth factor outlined in Questions in Section II of filings **Should this be added to Adaptive?**	Producer Price Index commodity index for prescription drugs	
42	Section 2	Operating efficiency	Pharmaceutical expenses	Pharmaceutical utilization growth - drug expense per adjusted discharge	Can help assess costs related to prescribing patterns and pharmaceutical utilization. This measure can also be used as an indicator if hospitals has higher concentration of services with pharmaceutical services.	FY2022-FY2017	Adaptive	Pharmaceutical price growth, operating expense growth, operating margin	Use adjusted discharge since we don't have patient day counts.	Peer group	Benchmark options include Syntellis Performance Solutions and potentially Kaufman Hall which has cited this metric in previous reports
43	Section 2	Operating efficiency	Medical supplies and materials	Medical supplies and materials growth	An indicator of costs related to medical supplies and medical supplies. This will assist in assessing what is driving cost trends.	FY2022-FY2017	Adaptive	Operating expense growth, operating margin		Producer Price Index	Both are proprietary products
44	Section 2	Financial health	Key metric	Operating margin	See row 4	FY2025-FY2022	Adaptive	See row 4	Confirmed in Adaptive as "Operating Margin %"	Fitch A median	GMCB has access to Fitch ratings
45	Section 2	Financial health	Profitability ratios	Total margin	When compared to operating margin, can show whether a hospital made up for losses through other means.	FY2022-FY2017	Adaptive	Operating expense growth, case mix index, payer mix, operating margin	Confirmed in Adaptive as "Total Margin %"	Fitch A median	GMCB has access to Fitch ratings
46	Section 2	Financial health	Profitability ratios	Operating EBIDA margin	Operating EBIDA margin allows for a comparison of one hospital's financial operating performance to others. Computationally it removes extraneous variation and thus establishes a foundation for comparison across and among hospitals. This measure differs from operating margin (row 4) as it reflects earnings before interest, taxes, depreciation, and amortization, and allows insight into profitibility before accounting for non-operating expenses.	FY2022-FY2017	Adaptive	Operating expense growth, case mix index, payer mix, operating margin, total margin	Confimed in Adaptive as "EBIDA %" EBIDA, or earning without adjustments for amortization, depreciation, and rental expenses, is a tool used to measure hospital financial operating performance.	Fitch A median	GMCB has access to Fitch ratings
47	Section 2	Financial health	Profitability ratios	Return on assets	A higher ROA means a company is more efficient and productive at managing its balance sheet to generate profits while a lower ROA indicates there is room for improvement.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Return on Assets"	Fitch A median	GMCB has access to Fitch ratings
48	Section 2	Financial health	Profitability ratios	Return on equity	The higher the ROE, the more efficient a company's management is at generating income and growth from its equity financing	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	**Currently not in Adaptive.**	Fitch A median	GMCB has access to Fitch ratings
49	Section 2	Financial health	Liquidity ratios	Current ratio	A current ratio that is in line with the industry average or slightly higher is generally considered acceptable. A current ratio that is lower than the industry average may indicate a higher risk of distress or default. Similarly, if a company has a very high current ratio compared with its peer group, it indicates that management may not be using its assets efficiently.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Current Ratio"	Fitch A median	GMCB has access to Fitch ratings

50	Section 2	Financial health	Liquidity ratios	Days cash on hand	Days cash on hand (DCOH) is an important measure of hospital liquidity. The hospital needs a certain amount to meet the requirements of lenders, rating agencies, and others. But if DCOH is too high, it may indicate that cash is not being deployed to areas of the business generating higher returns. It not only reflects liquidity based on past operating results, but it has great bearing on the potential of investment in future results	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, days in receivable	Confirmed in Adaptive as "Days Cash on Hand"	Fitch A median	GMCB has access to Fitch ratings
51	Section 2	Financial health	Debt ratios	Long term debt to total assets	A very high ratio is a potential danger sign for lenders and investors as it means the company may have to liquidate a large proportion of its assets to repay the long-term debt.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Long Term Debt to Total Assets"	State peer group	No national benchmark found, will use state peer group
52	Section 2	Financial health	Debt ratios	Long term debt to capitalization	This ratio can be used to determine a hospital's primary source of financing. Higher ratios indicate that a hospital is using debt as its primary source of financing and thus has a greater risk of insolvency.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Long Term Debt to Capitalization"	Fitch A median	GMCB has access to Fitch ratings
53	Section 2	Financial health	Debt ratios	Cash flow to total debt	This ratio is a type of coverage ratio and can be used to determine how long it would take a company to repay its debt if it devoted all of its cash flow to debt repayment. Cash flow is used rather than earnings because cash flow provides a better estimate of a company's ability to pay its obligations.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Cash Flow to Total Debt"	State peer group	No national benchmark found, will use state peer group
54	Section 2	Financial health	Debt ratios	Times interest earned	A solvency ratio indicating the ability to pay all interest on business debt obligations	FY2022-FY2017	Adaptive		**Currently not in Adaptive.**	State peer group	No national benchmark found, will use state peer group
55	Section 2	Financial health	Debt ratios	Liabilities as a percentage of total assets	This solvency ratio reflects how much of a hospital's assets are made of liabilities. A high ratio indicates potential solvency issues.	FY2022-FY2017	Adaptive		Calculated rate from Adaptive using "Total Assets" and "Total Liabilities"	State peer group	No national benchmark found, will use state peer group
56	Section 2	Financial health	Asset management ratios	Fixed asset turnover	This efficiency ratio compares net sales (income statement) to fixed assets (balance sheet) and measures a company's ability to generate net sales from its fixed-asset investments	FY2022-FY2017	Adaptive		**Currently not in Adaptive.**	State peer group	No national benchmark found, will use state peer group
57	Section 2	Financial health	Asset management ratios	Total asset turnover	Measures the efficiency with which a company uses its assets to produce sales	FY2022-FY2017	Adaptive		**Currently not in Adaptive.**	Peer group	In HCRIS, 2552-10 form
58	Section 2	Financial health	Asset management ratios	Days in patient account receivables	If AR days are high, it may indicate that a hospital has a problem with medical collection or billing processes.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand	**Currently not in Adaptive**. Information previously provided by some hospitals via narrative. **Should this be added to Adaptive?**	Fitch A median	GMCB has access to Fitch ratings
59	Section 2	Financial health	Asset management ratios	Average age of plant	Average age of plant can be used to gauge a hospital's short-term need for capital resources.	FY2022-FY2017	Adaptive	Total margin, operating margin, operating EBIDA margin, cash on hand, days in accounts receivable	Confirmed in Adaptive as "Age of Plant." Assuming this is the average. Adaptive also has "Age of Plant Building" and "Age of Plant Equipment"	Fitch A median	GMCB has access to Fitch ratings
60	Section 2	Other	Community benefit	Charity care payer mix	Insight into how much hospital spends on charity care/free care	FY2022-FY2017	Adaptive	Payer mix, NPR growth	Reported as percentage of hospital services provided to Charity Care program patients, as measured by Hospital Charges/ Gross patient revenue	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
61	Section 2	Other	Community benefit	Bad debt payer mix	Insight into how much hospital spends on uninsured and bad debt	FY2022-FY2017	Adaptive	Payer mix, NPR growth	Reported as percentage of hospital services provided to Bad Debt patients, as measured by Hospital Charges/Gross patient revenue	Peer group	HCRIS data allows use to look at the whole peer group sample (including hospitals outside VT)
62	Section 4	Quality	Safety	Influenza and covid vaccination coverage for healthcare personnel	These two annual measures identify the average percentage of healthcare personnel (HCP) who are considered up to date on their influenza and covid vaccines. [Federal ID Numbers: CBE 0431, CBE 3636]	FY2022-FY2017	CMS Care Compare	Other quality metrics	Percentage of healthcare workers given influenza vaccination and the percent of healthcare personnel who completed COVID-19 primary vaccination series. The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare workers contributing to successful influenza vaccination adherence divided by the total number of healthcare workers among who influenza vaccination is measured per the CDC's National Healthcare Safety Network (NHSN) protocol. CDC currently collects data that are voluntarily reported on COVID-19 (Severe Acute Respiratory Syndrome Coronavirus-2) vaccination coverage among healthcare personnel (HCP) through the National Healthcare Safety Network (NHSN). CDC intends to align NHSN COVID-19 vaccination coverage surveillance with the National Quality Forum (NQF)-endorsed quality measure for annual influenza vaccination coverage among Healthcare Personnel (NQF #0431), which is collected through the NHSN Healthcare Personnel Influenza Vaccination Module The influenza measure is updated annually (October) and the COVID-19 measure is updated quarterly (January, April, July, October) Measure identifiers: influenza (IMM-3) COVID-19 (HCP COVID-19)	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
63	Section 4	Quality	Safety	Patient and Adverse Events Composite	This composite measure summarizes patient safety across multiple indicators for the Medicare FFS population. Hospitals can use this measure to identify potential inhospital patient safety problems for targeted institution-level quality improvement efforts.	FY2022-FY2017	CMS Care Compare	Other quality metrics	Full measure specifications are listed at the following link: https://p4qm.org/measures/0531 [Federal ID Numbers: CBE 0531, PSI 90]	AHRQ	
64	Section 4	Quality	Safety	Healthcare-associated infection ratios	These mesaures identify CLABSI, CAUTI, C.Diff, and MRSA infection ratios in hospitals. [ID Numbers: HAI-1, HAI-2, HAI-5, HAI-6]	FY2022-FY2017	CMS Care Compare; VT Hospital Report Cards	Other quality metrics	Technical Name: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards Updated Quarterly (January, April, July, October) Measure Identifier: HAI-1 Technical Name: Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards Updated Quarterly (January, April, July, October) Measure Identifier: HAI-2 Technical Name: Methicillin-resistant Staphylococcus aureus (MRSA) Blood Laboratory-identified Events (Bloodstream infections) Updated Quarterly (January, April, July, October) Measure Identifier: HAI-5 Technical Name: Clostridioides difficile (C. diff) Laboratory-identified Events (Intestinal infections) Updated Quarterly (January, April, July, October) Measure Identifier: HAI-6 The Healthcare-Associated Infections (HAI) measures - national data. These measures are developed by Centers for Disease Control and Prevention (CDC) and collected through the National Healthcare Safety Network (NHSN). They provide information on infections that occur while the patient is in the hospital. These infections can be related to devices, such as central lines and urinary catheters, or spread from patient to patient after contact with an infected person or surface. Many healthcare associated infections can be prevented when the hospitals use CDC-recommended infection control stens.	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
65	Section 4	Quality	Effectiveness	CMS hospital quality star rating	Summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital.	FY2022-FY2017	CMS Care Compare	Case mix index, payer mix, access measures	CAHs do not have this score but this can be used as a single quality measure instead of three.	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
66	Section 4	Quality	Effectiveness	30-day, all-cause readmission rate	An indicator of quality of care. High readmissions cause a high burden to healthcare systems and patients. Readmissions may be linked with quality of care concerns, such as postoperative complications or other avoidable complications. Readmissions often vary widely.	FY2022-FY2017	VT Blueprint for Health Community Profiles	Payer mix, access measures	The 30-day unplanned hospital-wide readmission measure is an estimate of unplanned readmission to any acute care hospital within 30 days of discharge from a hospitalization for any cause. Readmissions are a part of the health care quality and utilization goals for the AHEAD model.	State peer group	
67	Section 4	Quality	Effectiveness	Rate of readmission for COPD patients	This measure focus on whether patients who were discharged from a hospital for COPD were hospitalized again within 30 days. Patients may return to the same hospital or to a different hospital. It should give us insight on the effectiveness of care for COPD.	FY2022-FY2017	CMS Care Compare	Other quality metrics	Technical Name: Chronic obstructive pulmonary disease (COPD) 30-day readmission rate Rate of readmission for chronic obstructive pulmonary disease (COPD) patients The 30-Day Risk-Standardized Readmission Measures are typically updated annually during the July Hospital Compare release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data Updated Annually (July) Measure identifier: READM-30-COPD	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital

68	Section 4	Quality	Effectiveness	Rate of readmission for heart failure patients	This measure focus on whether patients who were discharged from a hospital for heart failure were hospitalized again within 30 days. It should give us insight on the effectiveness of care for heart failure.	FY2022-FY2017	CMS Care Compare	Other quality metrics	Technical Name: Heart failure (HF) 30-day readmission rate Rate of readmission for heart failure patients The 30-Day Risk-Standardized Readmission Measures are typically updated annually during the July Hospital Compare release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data Updated Annually (July) Measure Identifier: READM-30-HF	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
69	Section 4	Quality	Effectiveness	Rate of readmission for pneumonia patients	This measure focus on whether patients who were discharged from a hospital for pneumonia were hospitalized again within 30 days. It should give us insight on the effectiveness of care for pneumonia.	FY2022-FY2017	CMS Care Compare	Other quality metrics	Technical Name: Pneumonia (PN) 30-day readmission rate Rate of readmission for pneumonia patients The 30-Day Risk-Standardized Readmission Measures are typically updated annually during the July Hospital Compare release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data Updated Annually (July) Measure Identifier: READM-30-PN	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
70	Section 4	Quality	Effectiveness	Serious Complications Measure	This measure shows serious complications that Medicare FFS patients experienced during a hospital stay or after certain inpatient surgical procedures. It should give us insight in the safety and effectiveness of hospital care.	FY2022-FY2017	CMS Care Compare	Other quality metrics	Technical Name: CMS Medicare PSI 90: Patient safety and adverse events composite A subset of the AHRQ Patient Safety Indicators and is a more relevant measure for the Medicare population because it utilizes ICD-10 data. The CMS PSI 90 measure summarizes patient safety across multiple indicators, monitors performance over time, and facilitates comparative reporting and quality improvement at the hospital level. The CMS PSI 90 composite measure intends to reflect the safety climate of a hospital by providing a marker of patient safety during the delivery of care. Updated Annually (July) Measure Identifier: PSI 90-SAFETY	Peer group	CMS Care Compare allows us to look at the peer group sample (including hospitals outside VT), metrics reported by hospital
71	Section 4	Quality	Patient-Centeredness	Nursing care hours per patient day	This measure captures the nursing care hours per patient day, meaning number of hours of nursing care provided on a hospital unit compared to the number of patients on that unit. It should give us insight into the nurse-patient ratio in hospital departments and highlight any that are severely understaffed.	FY2022-FY2017	VT Hospital Report Cards	Other quality metrics	Nurse staffing is measured by nursing care hours per patient day (the number of nursing care hours relative to the patient workload). Nursing Care Hours Per Patient Day refers to the number of hours of nursing care provided on a hospital unit, compared to the number of patients on that unit during a 24-hour period. This measure was developed by the American Nurses Association for the National Database of Nursing Quality Indicators. “Nursing care hours” are the number of hours worked by nursing staff that have direct patient care responsibilities for more than 50% of their shift. RN nursing care hours include hours worked by registered nurses (RNs). Total nursing care hours include hours worked by registered nurses (RNs), licensed practical and vocational nurses, licensed nurse’s aides, and mental health technicians. “Patient days” are the daily average of the number of patients on the unit, as counted at least once during each shift for 24 hours.	Peer group	The Leapfrog Group has a public nurse staffing and skill mix benchmarking report-nationwide percentile results Hospitals voluntarily participate in survey
72	Section 4	Quality	Patient-Centeredness	Percent of total nursing care hours provided by RNs	This measure captures the percentage of nursing care hours provided by registered nurses. It should give us insight into the nature and qualifications of hospital staff.	FY2022-FY2017	VT Hospital Report Cards	Other quality metrics	Nurse staffing is measured by nursing care hours per patient day (the number of nursing care hours relative to the patient workload). Nursing Care Hours Per Patient Day refers to the number of hours of nursing care provided on a hospital unit, compared to the number of patients on that unit during a 24-hour period. This measure was developed by the American Nurses Association for the National Database of Nursing Quality Indicators. “Nursing care hours” are the number of hours worked by nursing staff that have direct patient care responsibilities for more than 50% of their shift. RN nursing care hours include hours worked by registered nurses (RNs). Total nursing care hours include hours worked by registered nurses (RNs), licensed practical and vocational nurses, licensed nurse’s aides, and mental health technicians. “Patient days” are the daily average of the number of patients on the unit, as counted at least once during each shift for 24 hours.	State peer group	No national benchmark found, will use state peer group
73	Section 4	Quality	Patient-Centeredness	Four HCAHPS scores	Percentage of patients who reported that they "usually" or "always" received help as soon as they wanted Percentage of patients who "agreed" or "strongly agreed" they understood their care when they left the hospital Percentage of patients who gave their hospital a rating of 7 out of 10 or higher Percentage of patients who reported that they would recommend the hospital to friends and family	FY2022-FY2017	CMS Care Compare	Other quality metrics	The percetage of patients who reported that they "Always" received help as soon as they wanted is a part of the responsiveness of hospital staff (composite measure) in HCAHPS. The measure is updated quarterly (January, April, July, October). The measure identifier is H-COMP-3-A-P The percentage of patients who "Strongly Agree" they understood their care when they left the hospital is part of the care transition (composite measure) in HCAHPS. The measure is updated quarterly (January, April, July, October). The measure identifier is H-COMP-7-SA The percentage of patients who give their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) is part of the overall rating of hospital (global measure) in HCAHPS. The measure is updated quarterly (January, April, July, October). The measure identifier is H-HSP-RATING-9-10 The percentage of patients who reported YES, they would probably recommend the hospital is part of the willingness to recommend the hospital (global measure) in HCAHPS. The measure is updated quarterly (January, April, July, October). The measure identifier is H-RECMND-PY	Peer group	CMS Care Compare data
74	Section 4	Access	Other	Long ED Stays	This measure captures the average length of stay in the ER per CCSR diagnosis group. It also captures the percentage mental health stays over 24 hours and the percentage of other types of stays over 12 hours. It's designed to illuminate issues with transferring patients to post-acute care settings, either due to inefficiencies in the transfer process or to a shortage of post-acute care providers.	2021-2017	VUHDDS	Median Time Patients Spent in the Emergency Department Before Leaving from the Visit, Transfer Impedance, Occupancy Rate per Staffed Bed	The average length of stay for CCSR diagnosis group as well as the percentage of ED patients who stay longer than 12 hours or (for mental health patients) longer than 24 hours. The measure is modeled from other length-of-stay measures including those within the 2021 Vermont Hospitals Report.	Peer group	
75	Section 4	Access	Other	Preventable Hospital Stays	This measure uses the CMS definition of ambulatory-sensitive condition to estimate the number of hospital stays that could have been prevented with adequate ambulatory care. It reports the number of preventable hospital stays per 100,000 Medicare enrollees. It's designed to shed light on the shortage and / or insufficiency of ambulatory care providers. Measurement unit: county.	2023-2017	CMS Mapping Medicare Disparities Tool (County Health Rankings)	Primary Care Physicians Rate, Mental Health Providers Rate, All Community Data	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees per county. The measure uses the "Mapping Medicare Disparities Tool" definition of ambulatory-sensitive conditions. It is reported and sponsored by County Health Rankings and Roadmaps. Limitation: the metric only concerns Medicare enrollees and therefore excludes a sizable portion of the Vermont population.	Peer group	
76	Section 4	Access	Regional Health Resources	Primary Care Providers Rate	This measure lists the rates of primary care physicians (FTE) and primary care physician assistants (FTE) per HSA per 100,000 population. It illuminates potential shortages in primary care. Measurement unit: HSA	2018-2015	GMCB Report on Primary Care Access and VT Healthcare Provider Census	Preventable Hospital Stays, All Community Data	The rate of primary care providers (physicians and physician assistants) per 100,000 population per HSA. Limitations: The metric does not capture non-physician providers such as nurse practitioners. The data is also old (from 2018 and prior years).	All Vermont Counties	

77	Section 4	Access	Regional Health Resources	Mental Health Counselors Rate	The measure lists the rate of mental health counselors in a county per 100,000 population. It's designed to illuminate potential shortages in mental health care. According to County Health Rankings and Roadmpas, nearly 30% of the population lives in a county designated as a Mental Health Professional Shortage Area. Measurement unit: county.	2021-2017	VT Healthcare Provider Census	Preventable Hospital Stays, All Community Data	Lifted from census report: "This census of Licensed Clinical Mental Health Counselors is part of the Vermont Department of Health's healthcare provider data program, which is used to monitor and measure the supply of health care providers in Vermont over time. Vermont mental health counselors are relicensed every two years. Data for this report were obtained during the January 2021 relicensing period and represent a snapshot of the profession at that time. Mental health counselors diagnose and treat mental conditions, psychiatric disabilities, and emotional disorders; provide professional counseling services; and promote optimal mental health to individuals, couples, families, and groups. They are part of the allied mental health professional workforce in Vermont. To be licensed in Vermont, counselors must have completed a graduate degree with specific mental health counseling focus, have two years (at least 3000 hours) of supervised practice, and pass both the National Counselor Examination and the National Clinical Mental Health Counseling Examination."	All Vermont Counties
78	Section 4	Access	Regional Health Resources	Skilled Nursing Facility Beds Rate	This measure lists the number of beds in skilled nursing facilities (nursing homes) in a county per 100,000 population. It's designed to illuminate potential shortages in nursing home care. Measurement unit: county.	2023-2019	HRSA Area Health Resource Files	Median Age, Other Community Data	The total number of beds in Medicare-certified skilled nursing facilities. The data is reported and sponsored by the HRSA. Limitations: The metric merely captures the number of beds, not the number of beds that are staffed.	All Vermont Counties + Counties in State Peer Group
79	Section 4	Community Data	Demographics and Socieconomics	Score on the Social Vulnerability Index	This measure lists a county's score on the CDC/ATSDR social vulnerability index. It's designed to capture a county's susceptibility to health-related harm and disasters. Measurement unit: county.	2020, 2018, 2016	HRSA Area Deprivation Index	Other Community Data	The CDC/ATSDR Social Vulnerability Index uses sixteen U.S. census variables to identify areas susceptible to health-related disasters. The variables produce an overall score and also aggregate to four categories: - Socioeconomic status (below 150% poverty, unemployed, housing cost burden, no high school diploma, no health insurance) - Household characteristics (aged 65 or older, aged 17 or younger, civilian with a disability, single-parent households, English language proficiency) - Racial and ethnic minority status (Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino) -Housing type & transportation (multi-unit structures, mobile homes, crowding, no vehicle, group quarters)	All Vermont Counties + Counties in State Peer Group
80	Section 4	Community Data	Demographics and Socieconomics	Median Age	This measure captures the median age within a county. It's important because a population's age is a key determinant of its insurance coverage, health outcomes, and healthcare utilization. Measurement unit: county.	2023-2019	HRSA Area Health Resource Files, US Census	Other Community Data	This measure captures the median age within a county, using data from the US census.	All Vermont Counties + Counties in State Peer Group
81	Section 4	Community Data	Demographics and Socieconomics	Percent Non-White	This measure captures the percentage of a county that is nonwhite. It's important in contextualizing hospital efforts to improve the equity of their services. Measurement unit: county.	2023-2019	HRSA Area Health Resource Files, US Census	Other Community Data	This measure captures the percentage of a county that identifies as non-white, using data from the US census.	All Vermont Counties + Counties in State Peer Group
82	Section 4	Community Data	Demographics and Socieconomics	Per Capita Net Earnings	This measure captures the per capita net earnings per county. It's important because a population's income is a key determinant of its insurance coverage and health outcomes. Measurement unit: county.	2023-2019	Bureau of Economic Analysis (BEA)	Other Community Data	This measure captures the per capita net earnings per county, using data from the Bureau of Economic Analysis.	All Vermont Counties + Counties in State Peer Group
83	Section 4	Community Data	Physical Environment	Food Environment Index	This index produces a score for each county based on the percentage of residents who are low income and do not live close to a grocery store. It's important because a population's diet is a key determinant of its health outcomes. Measurement unit: county.	2023-2017	USDA Food Environment Atlas (County Health Rankings)	Other Community Data	The percentage of residents who are low income and do not live close to a grocery store. The measure is reported by the USDA Food Environment Atlas and sponsored by County Health Rankings and Roadmaps.	All Vermont Counties + Counties in State Peer Group
84	Section 4	Community Data	Physical Environment	Percent of Households with Severe Housing Problems	This measure reports the percentage of households with at least 1 of 4 problems: high housing costs, overcrowding, lack of kitchen facilities, and lack of plumbing facilities. Poor housing is an established determinant of health outcomes and a key obstacle for hospital staff retention. Measurement unit: county.	2023-2017	Comprehensive Housing Affordability Strategy (CHAS) Data (County Health Rankings)	Staff Turnover and Vacancies, Other Community Data	The percentage of households with at least 1 of 4 problems: high housing costs, overcrowding, lack of kitchen facilities, and lack of plumbing facilities. The measure is reported by Comprehensive Housing Affordability Strategy (CHAS) Data and sponsored by County Health Rankings and Roadmaps.	All Vermont Counties + Counties in State Peer Group
85	Section 4	Community Data	Healthcare Spending	Insurance Rates	This measure reports the percentage of an HSA population that is enrolled in commercial insurance vs. Medicare vs. Medicaid. It's important for understanding the payer mix at each hospital and its relation to the payer mix of the local population. Measurement unit: HSA	2021-2019	VT BluePrint for Health	Payer Mix	This measure reports the percentage of an HSA population that is enrolled in commercial insurance vs. Medicare vs. Medicaid.	All Vermont HSAs
86	Section 4	Community Data	Healthcare Spending	Total Expenditures PMPY (Inflation-Adjusted)	The measure reports the the the average total expenditures that insurance enrollees spent on their healthcare over the course of a year. Its useful for distinguishing healthcare spending by region. Measurement unit: HSA	2021-2019	VT BluePrint for Health, VHCURES	Per Capita Net Earnings, Other Community Data	The measure reports the the the average total expenditures that insurance enrollees spent on their healthcare over the course of a year. The data is lifted from VHCURES as has the relevant limitations.	All Vermont HSAs
87	Section 4	Community Data	Preventative Care	Adults with a Routine Doctor Visit in the Past Year	This survey measure captures the percent of a county adults that reported a routine medical visit in the past year. Its useful for understanding how general preventative care relates to spending on hospital care. Measurement unit: county.	2022-2017	The Behavioral Risk Factor Surveillance System (BRFSS) Data	Other Community Data	The percentage of Vermonters who reported a "routine doctor visit" in the past year. The data is reported and sponsored by the VDH as part of their BRFSS report. At the state level, it distinguishes rates by age, education, income, and other groups.	All Vermont Counties
88	Section 4	Community Data	Patient Migration	Patient Migration Data	This meausure reports the health expenditures within and outside Vermont HSAs. It's important for understanding where patients travel for medical care. Measurement unit: HSA	2022-2017	GMCB Patient Migration Report	Other Community Data	The Patient Migration report is an annual report based on the resident perspective, i.e. where the patient is going for care. It's on administrative claims for most of Vermont's insured population Note: within this data structure, patients can live in more than one area in the year and month. The structure allows these multiples over time because this most accurately represents the complete migration of populations. Also note: this report includes all provider types and all services within the HSA, not just those occurring at the hospitals. Limitations: –This version of the report focuses on medical claims only. Although previous versions incorporated pharmacy expenditures, further exploration of this data is needed to accurately depict utilization and cost. - Not all medical expenditures are captured on insurance claims. For example, capitated arrangements between insurers and providers, some case management payments, and pharmacy rebate payments are all examples of important areas of health care spending that are not included in claims. -The report includes fee-for-service (FFS) equivalent expenditures for Medicare beneficiaries attributed to an Accountable Care Organization (ACO) to replicate Medicare's own methodology for calculating total expenditures. Medicaid FFS equivalences are excluded because the prospective payments are not reconciled to claims-level expenditures. As a result, this analysis underestimates the total spending associated with Medicaid beneficiaries aligned to an ACO.	Peer group
89	Section 4	Community Data	Health Outcomes / Population Health	Life Expectancy	This measure lists life expectancy by county. It's important because life expectancy and other health outcomes help evaluate the efficacy of the health system. Measurement unit: county.	2023-2017	National Center for Health Statistics - Mortality Files (County Health Rankings)	Other Community Data	This measure lists life expectancy by county, using data from the National Center for Health Statistics.	All Vermont Counties + Counties in State Peer Group
90	Section 4	Community Data	Health Outcomes / Population Health	Age-Adjusted Death Rate	This measure lists age-adjusted death rates by county. It's important because death rates and other health outcomes help evaluate the efficacy of the health system. Measurement unit: county.	2023-2017	National Center for Health Statistics - Mortality Files (County Health Rankings)	Other Community Data	Age-adjusted death rates by county. The data is reported by the National Center for Health Statistics and sponsored by County Health Rankings and Roadmaps.	All Vermont Counties + Counties in State Peer Group
91	Section 4	Community Data	Health Outcomes / Population Health	Drug Overdose Mortality Rate	This measure lists drug overdose mortality rates by county. It's important because death rates and other health outcomes help evaluate the efficacy of the health system. Measurement unit: county.	2023-2017	National Center for Health Statistics - Mortality Files (County Health Rankings)	Other Community Data	Drug overdose mortality rates by county. The data is reported by the National Center for Health Statistics and sponsored by County Health Rankings and Roadmaps.	All Vermont Counties + Counties in State Peer Group
92	Section 4	Community Data	Health Outcomes / Population Health	Age-Adjusted Suicide Rate	This measure lists age-adjusted suicide rates by county. It's important because suicide rates and other health outcomes help evaluate the efficacy of the health system. Measurement unit: county.	2023-2017	National Center for Health Statistics - Mortality Files (County Health Rankings)	Other Community Data	Age-adjusted suicide rates by county. The data is reported by the National Center for Health Statistics and sponsored by County Health Rankings and Roadmaps.	All Vermont Counties + Counties in State Peer Group

93	Section 4	Community Data	Health Outcomes / Population Health	Vermont Adults (20+) who are Overweight	This survey data lists the percentage of Vermonters who are overweight by BMI. It's important because health outcomes help evaluate the efficacy of the health system. Measurement unit: county.	2022-2017	The Behavioral Risk Factor Surveillance System (BRFSS) Data	Other Community Data	The percentage of Vermonters who are overweight. The data is reported and sponsored by the VDH as part of their BRFSS report. At the state level, it distinguishes rates by age, education, income, and other groups. Limitation from the report: "obesity status is calculated using body mass index (BMI), a singular, indirect indicator of body fat meant to identify weight-related health risk. Though useful at the population level, BMI has limited usefulness at the individual level."	All Vermont Counties
94	Section 4	Community Data	Health Outcomes / Population Health	ACG Health Status	The measure reports the percent of HSA residents that comprise each of five ACG health statuses: healthy, low-risk, moderate risk, high risk, and very high risk. It's useful for understanding the patient mix at each hospital and its relation to the patient mix of the local population. Measurement unit: HSA.	2021-2019	VT Blueprint for Health	Case Mix Index, Case Mix Index by Payer, Other Community Data	The measure reports the percent of HSA residents that comprise each of five ACG health statuses: healthy, low-risk, moderate risk, high risk, and very high risk. The groups are reported through VHCURES and have the relevant limitations.	All Vermont HSAs
95	Section 2	Operating Efficiency	Key Metric	Administrative to Clinical Expense Ratio	Numerous studies point to increasing administrative costs as a driver of health care spending growth and potential waste.	FY2022-FY2017	Medicare Cost Reports		https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10035469/	Peer group