Northeastern Vermont Regional Hospital

FY 2017 Budget Presentation to Green Mountain Care Board

August 25, 2016

NORTHEASTERN VERMONT REGIONAL HOSPITAL

I) INTRODUCTION

- Presenting today to the Green Mountain Care Board for Northeastern Vermont Regional Hospital (NVRH) are:
  - Paul Bengtson, MA, MBA, FACHE- Paul has been the Chief Executive Officer at NVRH since November, 1986
  - Seleem Choudhury, MSN, MBA, RN. CEN, FAEN - Seleem has been the Chief Nursing Officer/VP Professional Services at NVRH since October, 2013
  - Bob Hersey, MBA, FHFMA- Bob has been the Chief Financial Officer at NVRH since September, 1999
  - Matthew Prohaska, MD – Dr. Prohaska has been an Orthopaedic Surgeon at NVRH since July 2015
  - Laural Ruggles, MPH, MBA- Laural has been the VP of Community Health Improvement and Marketing since 2002. She has held a number of leadership positions at NVRH since 1995
  - John Sayles – CEO, Vermont Foodbank. John has been CEO of Vermont Foodbank since 2009
- There are no special circumstances related to our presentation today

II) BUDGET PRESENTATION

- Organizational chart showing parent companies and affiliations (See Page 18)
- 2017 major budget initiatives
  - Investment in Integrated Community Health System
    - Cal-Essex Accountable Health Community
  - Meet community need for essential services
    - Improve access to:
      - Orthopedics
      - General Surgery
      - Neurology
      - Pediatrics
      - Palliative Care
  - Reduce avoidable use of services
    - Primary care medical homes and community health teams (ongoing)
    - ED Care Manager
    - Community Mental Health Specialist
    - VT Health Care Innovation Project
  - Continue Investments Made Previously in Population Health Management and Other Health Care Reform Programs
    - Primary care medical homes and community health teams
    - Community Connections Team
    - Low Income Medication Assistance
    - Ambulatory Pharmacist
    - Other community health initiatives including work with community leaders to address poverty issues
  - Obtain Certificate of Need for new MRI machine
  - Obtain approval for NPR in excess of 3.4% growth cap

a) **Acute admission utilization has increased. The hospital explains it's a recapture of market share from New Hampshire. Do you expect this to increase more? Are you marketing in New Hampshire?**

RESPONSE: During the five year period 2010 to 2014 VHCures data, produced by GMCB staff, shows that residents in NVRH's service area with private health insurance spent $10 million at NH hospitals for orthopedic care. With the addition of another orthopedic surgeon NVRH has vastly improved access to orthopedic services at NVRH for our community. Access will be improved further when a physician assistant or nurse practitioner is hired in fiscal 2017 to join our orthopedic group. At that point NVRH we expect the community's need for timely access to orthopedic surgeons will be mostly met and minimal additional increases will occur.

We do not, and have never, considered NH part of our service area. Littleton Regional Hospital (NH) does consider our area of Vermont as part of their service area. As part of their $425,000 a year advertising campaign Littleton routinely advertises in our service area, including sending mass direct mailings to all postal addresses in our region of Vermont. The only time we advertise in NH is when there has been a lapse in essential services in that state. For example, when Weeks Medical Center in Lancaster NH closed its birth center in 2008 we advertised our birthing services in their service area to let residents know our hospital is available to serve their prenatal and birthing needs.

The marketing strategy at NVRH is twofold:

1. Let people in our area know what services are available locally
2. Health improvement related messages

Whenever possible we combine our 2 strategies. For example, our new ad featuring our orthopedic surgeons (below) offers a tip to maintain healthy joints. Our newest radio ad is a "tick safety tips" message from Ryan Sexton, MD our Emergency Department Medical Director

NORTHEASTERN VERMONT REGIONAL HOSPITAL

III) RESPONSES TO BUDGET ANALYSIS QUESTIONS

1) **The hospital's net patient revenues (NPR) are increasing 4.8% over 2016 budget. The hospital identifies this increase as being primarily related to hospital utilization experienced in 2016.**

RESPONSE: NVRH acknowledges its NPR increase of 4.8% exceeds the Green Mountain Care Board's 3.4% cap on revenue growth. We once again ask the GMCB to look at NVRH's NPR growth trend over a multi-year period rather than the growth rate for one year. As the table below shows during the period FY13 – FY17 in which a revenue growth cap was in place the cumulative GMCB authorized NPR growth was 15.6%. NVRH's requested FY17 NPR of $71,339,400 represents a growth rate of only 14.6% during that same time period (71,339,400/62,276,100=14.6%).

Budget Year	Authorized Growth	Authorized NPR	Requested NPR
FY 2013 Approved Budget - Net Patient Revenue		62,276,100	
FY 2013 - FY2014 Allowable NPR Growth @4%	2,491,044	64,767,144	
FY 2014 - FY2015 Allowable NPR Growth @3.8%	2,461,151	67,228,295	
FY 2015 - FY2016 Allowable NPR Growth @3.6%	2,420,219	69,648,514	
FY 2016 - FY2017 Allowable NPR Growth @3.4%	2,368,049	72,016,564	71,339,400
Total Growth Rate		15.6%	14.6%

Alternatively, we also ask the GMCB to consider our request to rebase FY 2016 net patient revenue to the actual amount for the year rather than the amount originally approved by the GMCB. This request is made to recognize that a significant increase in net patient revenue has occurred due to NVRH recapturing millions of dollars per year of lost orthopedic services revenue. This is a permanent increase in net patient revenue that should be recognized as FY 2016 will become the base year for 2017 and beyond. Assuming our request to rebase is approved, the FY 2016 to FY 2017 net patient revenue growth will be only 3.1% as shown below.

Description	Amount
FY 2017 Budgeted Net Patient Revenue	$71,339,600
FY 2016 Projected Net Patient Revenue	69,210,200
$$ Increase	2,129,400
% Increase	3.1%

b) Acute admissions are budgeted in 2016 to return to 2013 actual levels. Is the mix of admissions the same or are you budgeting to see changes based upon 2016 experience? Provide a schedule.

Response: The following table trends discharges at NVRH by Major Diagnostic Category for fiscal years 2013 – 2017 (budgeted)

		Number of Discharges				
MDC	MDC Description	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
0	Pre-MDC	4	7	9	10	10
1	Diseases and Disorders of the Nervous System	56	55	64	79	79
2	Diseases and Disorders of the Eye	2	0	1	0	0
3	Diseases and Disorders of the Ear, Nose, Mouth And Throat	12	6	13	7	7
4	Diseases and Disorders of the Respiratory System	228	177	141	181	181
5	Diseases and Disorders of the Circulatory System	167	137	179	163	163
6	Diseases and Disorders of the Digestive System	163	148	159	108	108
7	Diseases and Disorders of the Hepatobiliary System And Pancreas	68	46	51	50	50
8	Diseases and Disorders of the Musculoskeletal System And Connective Tissue	210	164	149	238	250
9	Diseases and Disorders of the Skin, Subcutaneous Tissue And Breast	34	22	28	43	43
10	Diseases and Disorders of the Endocrine, Nutritional And Metabolic System	47	45	46	42	42
11	Diseases and Disorders of the Kidney And Urinary Tract	45	55	40	67	67
12	Diseases and Disorders of the Male Reproductive System	3	2	4	4	4
13	Diseases and Disorders of the Female Reproductive System	4	10	9	11	11
14	Pregnancy, Childbirth And Puerperium	198	213	233	200	200
15	Newborn And Other Neonates (Perinatal Period)	196	211	219	190	190
16	Blood and Blood Forming Organs and Immunological Disorders	14	12	17	13	13
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	4	4	3	1	1
18	Infectious and Parasitic DDs (Systemic or unspecified sites)	48	42	51	43	43
19	Mental Diseases and Disorders	34	27	29	22	22
20	Alcohol/Drug Use or Induced Mental Disorders	29	15	11	35	35

21	Injuries, Poison And Toxic Effect of Drugs	38	22	22	42	42
22	Burns	0	1	0	1	1
23	Factors Influencing Health Status and Other Contacts with Health Services	51	101	69	71	71
24	Multiple Significant Trauma	2	5	4	5	5
25	Human Immunodeficiency Virus Infection	0	1	0	0	0
	Total	1,657	1,528	1,551	1,627	1,639

As the trended data reveals, NVRH has seen a significant increase in the number of discharges in category MDC 8, Diseases and Disorders of the Musculoskeletal System and Connective Tissue since the addition of another orthopedic surgeon improved access to essential orthopedic services at NVRH.

c) How does the hospital determine the right complement of physicians for the service area? What metrics and information are used?

RESPONSE: NVRH uses a combination of physician ratio to patient data (from sources such as the County Health Rankings, AHEC, BiState Primary Care), community feedback, and our internal data on appointment wait times to determine the right combination and amount of physicians.

d) If surgeries are increasing, why are you budgeting a decline in MRIs? Also, why do you think ER visits are decreasing?

RESPONSE: NVRH will not reach the level of MRIs budgeted for FY 2016 due in part to medical leave of a referring provider and in part due to the poor image quality and other issues related to our current MRI machine. Our current MRI machine is over 12 years old. Increasingly, patients requiring MRIs are referred elsewhere to help assure that an accurate diagnosis can be made from the MRI image. During 2017 NVRH will submit a Certificate of Need to replace our existing MRI unit. With the newer wide-bore technology volume is expected to increase as image quality will improve. Also, the wide-bore machine is more patient-friendly for those patients who are claustrophobic. Currently, claustrophobic patients must travel to another facility for an MRI exam. Our CON application will include anticipated changes in MRI volume that will result from a machine that produces better image quality and is more patient-friendly.

There are several specific interventions that in combination have helped reduce the avoidable ER visits:

- Our 6 NCQA recognized Patient Centered Medical Homes have embedded care coordinators (since 2008) who automatically receive a list of all the patients from that practice who was in the hospital (both ER and inpatient). This facilitates timely follow up with a patient's PCP.

- Package our own Unit Dose medications if there is a cost savings
- Fill employee prescriptions internally, which helps reduce the cost of our employee health plan

2) The GMCB is interested in understanding the changes occurring from budget to budget by payer. Explain your NPR changes at the budget hearing using the payer schedule (page 4) provided in the staff's analysis.

RESPONSE: NVRH will explain the budget to budget NPR changes at the budget hearing using the payer schedule (next page.)

- Community Connections employs community health workers who work to help people navigate the complex world of health, mental health, and social services.
- Our active Community Health Team work together to coordinate client needs – both medical and social – to prevent avoidable hospitalizations.
- NVRH employs a care manager full time in the ED. The care manager helps connect patients with no PCP to a primary care office, as well as facilitate a visit to their PCP for follow up care.
- Using our ACO shared savings and under the umbrella of our Accountable Health Community, NVRH, Northern Counties Health Care, and Northeast Kingdom Human Services pooled our financial resources to hire a social worker (MSW) to help coordinate outpatient mental health services for people presenting in the NVRH with a need for these services.
- Working through the VHCIP Care Management Learning Collaborative we have enhanced our team care approach to targeted patients with complex needs for specific interventions to prevent ER visits and hospitalizations.
    - For example, for patients with COPD we are ramping up referrals to tobacco cessation, the Better Breathing program, and pulmonary rehabilitation. All of these outpatient interventions help people with COPD better cope with their chronic illness and prevent the need for avoidable ER visits and hospitalizations.

e) Is the hospital seeing high increases in chemotherapies and other drug costs? What is occurring for those services

RESPONSE: As part of the collaborative agreement between NVRH and Dartmouth-Hitchcock NVRH transferred chemotherapy services to the Norris Cotton Cancer Center-North when Dartmouth opened the center in St. Johnsbury. Therefore, NVRH has not seen the steep increases in the cost of chemotherapy drugs that our colleagues have experienced.

NVRH has been able to keep the cost of drugs close to the budgeted increase, which was 8.5%. Our efforts to keep down the cost of drugs include:

- Maximizing use of drugs available at the 340B discounted price
- Maximize discounts through our Group Purchasing Organizations-Vizient and New England Pharmacy Collaborative
- Modify the NVRH formulary when appropriate
- Use generics when available, unless better contract price for branded product
- Standardized medication orders to specific IV concentrations and sizes to reduce inventory and waste
- Our pharmacists, on a daily basis, review each patient's record to optimize drug therapy, convert IV meds to PO meds as soon as possible, therapeutic substitution, and prevent therapeutic duplication

3) The hospital is requesting a 3.8% overall rate increase that will be applied to inpatient hospital services at 4.0%, outpatient services at 4.3%, and physician services at 0.5%. Is this the rate that is negotiated with commercial payers? Describe the strategy and basis for this increase.

RESPONSE: The first part one of NVRH's rate increase strategy is to achieve the highest net patient revenue yield per dollar of rate increase. Virtually all physician services are reimbursed on a fixed-fee schedule. Therefore, every dollar of rate increase for physician services yields very little additional net patient revenue. Conversely, based on existing contracts with commercial payers, every dollar of rate increase for hospital services yields approximately $.66 of additional net revenue. Based on our payer mix the 3.8% overall rate increase will yield a net patient revenue increase of approximately 1.9%. During 2017 NVRH does not anticipate any significant changes in the terms previously negotiated with commercial payers.

The second part of our rate increase strategy is to have the rate increase cover most of our inflationary-type cost increases. For fiscal 2017 the 3.8% rate increase will yield a 1.9% NPR increase, which is close to our overall inflationary increase of 2.2%.

4) The hospital has budgeted an increase of 12 FTEs over the 2016 budget. Also, 4 mid-levels are being added and physicians are down by 3. Are you recruiting for more physicians? Are the mid-levels intending to replace the 3 physicians? The narrative explains that the staff is being added to improve wait times in four essential services. What are the metrics you use for comparing wait times and/or other patient experiences? Provide some context.

RESPONSE: The increase in FTEs includes staffing for the new reform initiatives, 4 mid-level providers and clinical support staff for the new mid-level providers. A nurse practitioner/physician assistant will or has been added to the Pediatric, Surgical, Orthopedic and Neurology practices. These new providers are not replacing the 3 physicians.

We continuously monitor wait times in our practices to assure the community has timely access to essential services. There isn't any good data available to compare our wait times. Often, we rely on feedback from patients and use our experience managing physician practices to determine reasonable wait times. As noted below, in some instances the need to add providers was obvious.

A community-based pediatrician retired after 50+ years of service. Some of his patients have migrated to NVRH's pediatric practice. That practice also includes a pediatrician who now focuses only on child abuse services (she is the only Board Certified Child Abuse Pediatrician in Vermont.) To meet the community need for access to general pediatric services, NVRH recently hired a nurse practitioner to join the practice.

Northeastern VT Regional Hospital

NET PAYER REVENUECHANGE		FY2016	Projection FY2016	FY2017	B16-B17 $Change	B16-B17 % change	NPR From Rate	NPR From All Other
All Payers	**Gross Revenue**	**$141,089,000**	**$145,173,600**	**$152,171,500**	$11,082,500	7.9%		
	Allowances	($68,524,400)	($71,743,900)	($76,539,800)	($8,015,400)	11.7%		
	Bad Debt	($3,030,000)	($2,841,400)	($2,977,400)	$52,600	-1.7%		
	Free Care	($2,900,000)	($2,906,200)	($3,045,300)	($145,300)	5.0%		
	Disproportionate Share Payments	$1,460,700	$1,528,100	$1,730,400	$269,700	18.5%		
	Graduate Medical Education Payme	$0	$0	$0	$0	0.0%		
	Net Payer Revenue	**$68,095,300**	**$69,210,200**	**$71,339,400**	**$3,244,100**	4.8%	**$1,281,100**	**$1,963,000**
Commercial	**Gross Revenue**	$51,658,400	$52,071,600	$54,616,400	$2,958,000	5.7%		
	Allowances	($10,839,400)	($11,817,300)	($12,574,700)	($1,735,300)	16.0%		
	Bad Debt	$0	$0	$0	$0	0.0%		
	Free Care	$0	$0	$0	$0	0.0%		
	Disproportionate Share Payments	$0	$0	$0	$0	0.0%		
	Graduate Medical Education Payme	$0	$0	$0	$0	0.0%		
	Net Payer Revenue	**$40,819,000**	**$40,254,300**	**$42,041,700**	**$1,222,700**	3.0%	**$1,281,100**	**-$58,400**
Medicaid	**Gross Revenue**	$30,618,100	$33,846,600	$35,391,400	$4,773,300	15.6%		
	Allowances	($21,249,400)	($23,373,600)	($25,102,200)	($3,852,800)	18.1%		
	Bad Debt	$0	$0	$0	$0	0.0%		
	Free Care	$0	$0	$0	$0	0.0%		
	Disproportionate Share Payments	$1,460,700	$1,528,100	$1,730,400	$269,700	18.5%		
	Graduate Medical Education Payme	$0	$0	$0	$0	0.0%		
	Net Payer Revenue	**$10,829,400**	**$12,001,100**	**$12,019,600**	**$1,190,200**	11.0%	**$0**	**$1,190,200**
Medicare	**Gross Revenue**	$58,812,500	$59,255,400	$62,163,700	$3,351,200	5.7%		
	Allowances	($36,435,600)	($36,553,000)	($38,862,900)	($2,427,300)	6.7%		
	Bad Debt	$0	$0	$0	$0	0.0%		
	Free Care	$0	$0	$0	$0	0.0%		
	Disproportionate Share Payments	$0	$0	$0	$0	0.0%		
	Graduate Medical Education Payme	$0	$0	$0	$0	0.0%		
	Net Payer Revenue	**$22,376,900**	**$22,702,400**	**$23,300,800**	**$923,900**	4.1%	**$0**	**$923,900**
Bad Debt/Free Care	**Gross Revenue**				$0	0.0%		
	Allowances				$0	0.0%		
	Bad Debt	($3,030,000)	($2,841,400)	($2,977,400)	$52,600	-1.7%		
	Free Care	($2,900,000)	($2,906,200)	($3,045,300)	($145,300)	5.0%		
	Disproportionate Share Payments				$0	0.0%		
	Graduate Medical Education Payments				$0	0.0%		
	Net Payer Revenue	**($5,930,000)**	**($5,747,600)**	**($6,022,700)**	**($92,700)**	1.6%	**$0**	**-$92,700**

This schedule shows the NPR increase by each major payer, including those receiving care as bad debt or free care. The schedule identifies the NPR increase related to rates separate from all other increases.

The Commercial revenues reflect the planned rate increase dollars for 2017. The negative $58,400 is related to payer mix and service change.

The hospital will NOT receive any new funds from Medicaid because of their rate increase. The increase of $1.2 million is increased utilization and service mix.

This is primarily an increase related to Critical Access Hospital cost based reimbursement.

The hospital will explain the change in NPR for each payer as part of its budget presentation, including bad debt/free care changes.

Page 3 describes the 2017 NPR increase by major operational changes (rates, utilization, etc).

NVRH employs three general surgeons who we share with Cottage Hospital, Woodsville, NH. The addition of a physician assistant has allowed the surgeons to more efficiently cover two hospitals and minimize wait times for patients to be scheduled at both hospitals.

As previously noted, having a third orthopedic surgeon has stopped the leakage of patients to NH facilities. However, the wait time for a scheduled orthopedic surgery has risen to seven (7) weeks. An additional nurse practitioner or physician assistant will reduce the wait time to an acceptable level allowing us to maintain the excellent level of service the community has experienced recently.

NVRH has one very busy full-time Neurologist. She is so busy the practice was recently closed to new patients and existing patients are waiting over 2 months for an appointment. The addition of a nurse practitioner will allow us to open the practice to new patients, reduce the wait times to acceptable levels and better meet the community's need for this essential service.

Of the 3 FTE physician vacancies two are in the Emergency Department. The third is in one of our primary care practices. The ED budget assumes that we will not fill all physician open positions by the end of fiscal 2017. These vacancies will be filled by locum tenens physicians until a full complement of physicians is hired.

NVRH continues to recruit aggressively for a primary care physician to fill an unexpected vacancy and to fill known upcoming retirements. The budget assumes that a full FTE vacancy for primary care physician will exist during fiscal 2017.

5) Bad debt and free care are budgeted in total at 4% of gross revenues in FY 2017. The estimate is based upon 2016 projections, down slightly from the 4.1%experienced in 2014-15 and budgeted in 2016. This is much less of a decline than what we have seen at most other hospitals. Have you had discussions with your peers about why your numbers might be different? Have you noticed a change in cases or patients?

RESPONSE: NVRH has compared our uncompensated care (bad debts and free care) percentages to ourselves over time and to our peer group. While our trend is downward the decline is not as significant as it is for some of our peers. A couple of factors provide some explanation of why this is the case. In FY 2017 NVRH will expand eligibility for our Patient Assistance (Charity Care) program from 300% to 400% of the federal poverty income guidelines to better implement new patient assistance requirments. Based on our projection this change will maintain the amount of Patient Assistance near current levels. Without this change NVRH a further decline in uncompensated care would have been budgeted. Also, we have reported $400,000 in Charity Care for patient assistance provided to Medicare patients that Medicare is no

longer reimbursing NVRH for due to a cost report dispute. We are appealing this issue but a resolution is likely seven-ten years away.

6) The hospital narrative describes $272,000 in specific health care reform investments that is budgeted. Explain why you believe the items listed are considered reform investments.

RESPONSE: The $272,000 will fund four health reform related projects: The Cal-Essex Accountable Health Care Community (CAHC), an Emergency Department Care Manger, expansion of Palliative Care Services and a Community Mental Health Specialist. Individually and collectively these projects will help achieve several health care reform goals including; improving the health of the population we serve, improving access to providers, reducing the cost of health care and improving the patient experience.

CAHC is committed to the shared goal to improve the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services with an emphasis on reducing poverty in our region. CAHC includes most if not all of the agencies that can positively affect determinates of health in our community. CAHC will eventually be accountable for the health and well-being of the residents in our service area. Over the past year CAHC has developed the groundwork for collaboration among the organization's membership. In the next year CAHC will begin building a holistic strategy for addressing significant problems in the region.

The Emergency Department Care Manager is focused on reducing avoidable use of the Emergency Department. She does this by locating a primary care provider for ED patients who don't have one and eliminate those patients using the ED for primary care services. She also connects ED patients to local service organizations who can help patients obtain the appropriate level of care rather than seeking care in the ED. The Care Managers accomplishments to date include:

- Referrals to community agencies – 1,200
- Palliative Care and Hospice referrals - 100
- Follow up appointments with a PCP after being seen in the ED - 700

The third year of NVRH's Palliative Care Service was just completed. The number of patients benefiting from the service has grown from 145 to 375 patients a year. A total of 723 patients have accessed the Palliative Care Service since its inception. In order to maintain access to this essential and growing service, NVRH has increased provider time from a .33 FTE to a .75 FTE.

Services (NKHS), the regional nonprofit mental health agency; and the Vermont Foodbank. There are also strong connections with and monthly participation from the Vermont's Agency of Human Services through the Agency's regional directors, programs of the Department of Children and Families, the Vermont Department of Health, Green Mountain United Way, and many others – including school district leaders and regional planning and economic development agencies.

At this time, mental health needs, challenges related to misuse of substances, and the plague of obesity are the top health priorities in the CAHC community. Project collaborators fully understand that none of these problems arise in isolation from others such as a severe shortage of affordable housing, significant food insecurity, and lack of sufficient transportation to needed services. In addition, all of these challenges are exacerbated and made substantially more difficult to address in an environment of pervasive poverty.

NVRH's service area lacks a sufficient number of mental health workers providing outpatient mental health services. This is an identified funding gap for designated mental health agencies in the State. As a result patients needing mental health services present in our emergency department (ED). Through our CAHC, NVRH is partnering with other local agencies to fund and hire a mental health specialist to help address the community's need for outpatient mental health services. This person will be housed in the NVRH ED, as well as sharing consultation space with our Community Connections team. The desired outcome is to more pro-actively identify patients in need of mental health services, thereby breaking the cycle of ED use and reducing repeat visits to the emergency room and inpatient admissions. Unfortunately, even with this additional resource our service area still lacks a sufficient number of mental health workers providing outpatient mental health services.

10) The hospital does not budget general contributions. Does the hospital manage those in a different organization?
RESPONSE: Yes, general contributions are managed at the parent corporation level. The parent organization, NVR Corporation, is currently managing a $4 million capital campaign. To date, approximately 30% of the campaign goal has been met.

NVRH's service area lacks a sufficient number of mental health workers providing outpatient mental health services. As a result patients needing mental health services present in our emergency department (ED). Through our CAHC NVRH is partnering with other local agencies to fund and hire a mental health specialist to help address the community's need for outpatient mental health services. This person will be housed in the NVRH ED, as well as sharing consultation space with our Community Connections team. The desired outcome for this position is to more pro-actively identify patients in need of mental health services, thereby breaking the cycle of ED use and reducing repeat visits to the emergency room and inpatient admissions.

In addition to the above new health reform activities NVRH will continue funding the Community Connections Team, Low Income Prescription Drug Program, Ambulatory Pharmacist and Community Health projects that address our CHNA priorities.

7) Salary & benefits per FTE shows only a 0.3% increase over 2016 budget. Is this correct - please explain.
RESPONSE: As presented in the budget submission salaries and benefits show an increase of only .3%. It appears this is due to inconsistencies in reporting benefits between physicians and staff and how we account for FTEs who work at both NVRH and other organizations. NVRH will prepare a worksheet for GMCB staff that accounts for these factors consistently from year to year.

8) Are the FY 16 projections for net revenues, expenditures, and surplus as reported still valid? If not, describe any material changes.
RESPONSE: Yes, the FY 16 projections included in the FY 17 budget submission are still valid.

9) The hospital narrative (pages 1-3) does a nice job outlining the hospital's efforts with local mental health and other providers to strengthen community health services. You note that you are working to build an organization foundation that may be able to be replicated by others. Briefly highlight those successes and identify limitations of those efforts.
RESPONSE: The CAL-ESSEX Accountable Health Community (CAHC) was organized nearly two years ago, with a goal of using the collective impact model to drive community-wide outcomes in the NEK. It was founded and is led by the CEO of the Northeastern Vermont Regional Hospital (NVRH). The CAHC leadership group includes NVRH; Northern Counties Health Care (NCHC), the area's federally qualified health center and home health and hospice provider; Rural Edge, the regional low-income housing provider and developer; Northeast Kingdom Community Action (NEKCA); the Northeast Kingdom Council on Aging; Northeast Kingdom Human

NORTHEASTERN VERMONT REGIONAL HOSPITAL

IV) CAPITAL BUDGET

- Non- Certificate of Need
  - Upgrade Meditech System During FY17 and FY18
  - Estimated Cost $2.0 Million
- Certificate of Need
  - Replace MRI Machine
  - 12 Year Old Technology
  - Poor Image Quality
  - Not Patient Friendly

V) COMMUNITY NEEDS ASSESSMENT UPDATE

a. Poverty Related Issues
   i. Provide Bridges Out of Poverty Training
   ii. Expand Family SASH Program
   iii. Revitalize St Johnsbury Riverfront
   iv. Support and Expand "Reducing the Risk" Program

b. Substance abuse/mental health issues
   i. Facilitate Drug Fee Community Grant by Funding Consultant
   ii. Provide Financial Support for Dr. Bob House/Kingdom Recovery Center

c. Obesity related issues
   i. Provide Nutrition Consulting Services to Local Food Banks
   ii. Participate in the Northeast Kingdom Food Security Task Force
   iii. Provide Financial Support for Lamoille Valley Rail Trail Amenities

VI) RESPONSES TO HEALTH CARE ADVOCATE QUESTIONS

1. If you included a rebasing in your proposed budget, why do you believe the Green Mountain Care Board should agree to rebase your budget? How do you plan to contain your growth going forward?

Response: During the period January 1, 2010 to December 31, 2014 patients in NVRH's service area spent over $10 million (patients with private insurance only) at NH hospitals for orthopedic services. In July, 2015 NVRH added a third orthopedic surgeon to meet the community need and increased NVRH's net patient revenue by over $3.6 million. We believe this is a significant onetime event and our approved FY 2016 net patient revenue should be adjusted accordingly. NVRH has taken many steps to contain avoidable use of our services. A few examples include: We were one of the first NCQA certified medical homes in the country. Our providers were early adopters of the Choosing Wisely concepts. NVRH just hired a care manager in the ED to reduce overutilization of the ED by patients with no primary care provider.

11. For all community benefits that you listed on your Form 990 Schedule H, what is the dollar amount you are budgeting for each benefit by year (FY14 Actual, FY15 Actual, FY16 Budget, FY16 Projection, and FY17 Budget)?

Response: Below are the actual community benefits for fiscal years 2014 and 2015. NVRH doesn't budget specifically for all of these community benefit categories.

Category	FY2014	FY 2015
Financial Assistance at Cost	$987,598	$1,,008,924
Unfunded Medicaid Cost	5,967,761	6,126,143
Community Health Improvement	1,088,265	323,784
Health Professions Education	161,262	165,949
Subsidized Health Services	4,225,504	4,092,230
Cash and In-Kind Contributions	191,401	166,683
Total	$12,621,791	$11,883,713

12. What is your current level of community benefit as a percentage of revenues?

Response: Historically our community benefits have averaged 18% of revenues

a. What percentage level are you willing to commit to on an ongoing basis?

Response: We are committed to providing at least the same level of community benefits going forward.

b. Please provide a detailed breakdown of the programs and other components you include in your community benefit calculation.

Response: See Question 11.

16. **What percent of your employed primary care providers are participating in the Hub and Spoke program?**

Response: 34% of NVRH employed providers participate in the Hub and Spoke program.

a. **What is the average number of substance abuse patients that those providers treat?**

Response: The average number of patients treated is 6.

b. **How many additional providers would be required to fully meet your community's needs in a reasonable amount of time? Please take into consideration any waitlists for treatment.**

Response: Currently and for quite some time there is no waitlist at BAART for either methadone or suboxone treatment. That said we are still committed to increasing the number of both prescribers and patients treated by their primary care physician with the additional support provided by MAT staff. It would be helpful if commercial insurers and Medicare also paid for the MAT staff level of services (currently only paid by Medicaid)

c. **If your hospital is involved in any medication assisted treatment programs, do you have any information on your costs for these programs versus savings to your hospital?**

Response: NVRH is not involved in any MAT programs therefore there are no MAT associated expenses.

17. **Please explain to what extent mental health patients presenting at your Emergency Department impacts your budget?**

Response: NVRH hasn't done a complete financial review of costs for treating mental health patients in our Emergency Department. NVRH does provide 24/7 security coverage under contract with the Caledonia Sheriff Department at an annual cost of $250,000. Mental health patients are triaged in the ED and as soon as possible transferred to our medical surgical patient unit. NVRH provides a cadre for mental health patients and when necessary another sheriff. For some patients two sheriffs stay near the patient at all times. This coverage is provided by Northeast Kingdom Human Services under a contract with the Lamoille County Sheriff Department.

a. **Please explain how mental health patients are handled when they present to your Emergency Department or other triage location, including a description of any holding or isolation areas that you use, and how often you expect to use this type of area in FY17.**

Response: See Question 5a.

b. **How do you train your security staff, contracted or in-house, on handling situations involving people experiencing mental health crisis? If some security staff members have been trained but not all, please explain which ones and why.**

Response: All security staff are required to attend a "Management of Aggressive Behavior" training program.

NORTHEASTERN VERMONT REGIONAL HOSPITAL

nvrh

QUESTIONS ???

NVRH CORPORATE STRUCTURE

Northeastern Vermont Regional Corporation
(not for profit)

Northeastern Vermont Regional Hospital
(not for profit)

sole member
Northeastern Vermont Regional Corporation

Northeast Kingdom Healthcare Collaborative, LLC

Two Members:
Northeastern Vermont Regional Hospital
North Country Hospital and Medical Center

(HOLDING COMPANY)
Northeast Health Enterprises, Inc.
(for profit)
currently dormant

Northeast Vermont Health Care Systems, Inc

(REAL ESTATE)
Northeast Regional Investment Development Corporation