Northeastern Vermont Regional Hospital
Response To Health Care Advocate Questions

1. Please describe all entities related financially to the hospital, the purpose of each entity, and the financial relationships between the entities (e.g., parent organization(s), subsidiary organization(s), membership organization(s), etc.). In particular:
    a. What non-profit and/or for-profit entities does the hospital or its parent organization own in part or in full and/or is the hospital owned by in part or in full?
    Response: Northeastern Vermont Regional Hospital is a subsidiary of Northeastern Vermont Regional Corp. Northeastern Vermont Regional Corp. has three other subsidiaries, which are dormant. They are Northeast Vermont Health Care Systems, Inc.; Northeast Health Enterprises and Northeast Investment Development Corp.
    b. Are hospital senior management paid by hospital-related entities other than the hospital? **Response: No**
    c. Are the revenues of these entities included in your budget submission? **Response: No**

2. Please describe any financial incentives/bonuses that your executives, providers, coders, and other personnel are eligible to receive that are tied to services that have the potential to increase your hospital's revenue. Please include both staff and subcontractors.
    a. As a part of your answer, please disclose for which procedures the hospital pays providers volume-based incentives.
    Response: All of NVRH's standard contracts with providers include expectations for minimum hours of work. Many provider contracts also include a measurement of work volume based on RVUs. Those contracts provide additional compensation for additional worked hours or RVU volume above the base RVU number, which will increase hospital revenue. No executives, coders or other personnel are eligible to receive bonuses that have the potential to increase hospital revenues.
    b. Are these incentives the same for OneCare attributed patients as for non-attributed patients? **Response: Not applicable at this time. There are no OneCare patients attributed to NVRH.**

3. Please delineate the hospital's financial performance and patient distribution by capitated business, fee for service business, and any other payment methodologies. (If you only have one type of business please state which type.)
    a. Please indicate which entities the hospital has capitated or other alternative payment agreements with (e.g., insurer(s), ACO(s)).
    Response: At this time all NVRH revenues are based on fee for service. NVRH has given notice of intent to participate in Next Gen agreements with OneCare Vermont. NVRH is also working with DVHA on a risk-based pilot through the CAHC Transformation LLC, a new Accountable Health Community organization. Details of the pilot program are being developed.

4. Please provide data on the experience of mental health patients at your hospital, including:
    a. The total number of mental health beds at your hospital;

Response: NVRH does not have mental health beds. However, rather than keeping mental health patients in the ED for hours, days or weeks, NVRH transfers patients awaiting an available mental health bed to our inpatient medical surgical floor.

b. The range and average wait time for placement of mental health patients who report to your hospital in need of inpatient admission;
Response: Not applicable. NVRH doesn't have any inpatient mental health beds

c. The range and average time patients have spent in your emergency department awaiting an appropriate mental health placement; **Response: The average time patients spent in the emergency department awaiting an appropriate mental health placement was 14 hours. The range was 22 minutes to 85 hours. These results only include time spent in the hospital's emergency department. Typically, NVRH does not keep patients in the emergency department waiting for placement for extended periods of time. When it becomes apparent a timely transfer to an appropriate mental health facility is not going to happen patients are transferred from the emergency department to our inpatient medical surgical floor.**

d. The total number of patients who waited in your emergency department for an available mental health bed at your hospital or at another facility.

5. Please describe any initiatives that you have implemented to address the inadequate access to mental health treatment experienced by Vermonters.
    a. What other avenues are you pursuing to address this crisis in a sustainable way?

Response: The programs NVRH has implemented and/or plans to implement to assure access to high quality timely and appropriate mental health treatment include: Use of behavioral health specialists in all primary care group practices, including pediatrics and women's wellness practices. NVRH hired a part time psychiatrist who has 1:1 consult sessions with mental health patients, works with providers, nurses and support staff on the inpatient medical surgical floor in the emergency room and with the Hospitalist service to develop care plans for mental health patients. NVRH will be hiring recovery coaches in partnership with the Kingdom Recovery Center and contract with the local Designated Agency to embed mental health clinicians in the emergency department. The recovery coaches will be available to patients in our emergency department who express an interest in intervention with their substance abuse disorder. Research data shows that early intervention is cost effective and one of the key factors for a successful outcome. Embedded mental health clinicians reduce unnecessary medical utilization, decrease length of time to see a mental health clinician and reduce time patient spends in the emergency department.

6. Please provide data on substance use treatment at your hospital, including:
    a. The number of patients currently enrolled in medication-assisted treatment at your hospital;
    Response: There are currently 8 patients enrolled in the MAT program at Kingdom Internal Medicine and 2 additional patients that are prescribed suboxone but are not eligible for the MAT program (non-Medicaid).
    b. The number of MAT providers employed by your hospital;
    Response: There are 3 MAT providers at the Kingdom Internal Medicine group practice

7. Please describe the hospital's plans for participation in payment reform initiatives in this fiscal year and over the next five years.
    a. How do you plan to manage financial risk, if applicable, while maintaining access to care, high quality care, and appropriate levels of utilization?
    b. How much money will the hospital be at risk for in FY19?
        i. What will happen if a hospital loses that money?
        ii. How will the hospital fill in this gap, if necessary, without increasing rates?
        iii. How does the hospital track access to care, utilization, and quality of care to ensure that provider financial incentives do not have a negative impact on patient care?

Response: Our most recent work on payment and delivery reform came at the request of the Department of Vermont Health Access (DVHA). NVRH and certain members of CAHC recently formed a limited liability corporation, CAHC Transformation LLC, to work with DVHA on a pilot project involving Medicaid beneficiaries in our geographic area. If successful, the pilot project will take the Accountable Care Organization concept to the next level; population based payments for an Accountable Health Community for the next five years and beyond.

The DVHA pilot project will likely be a model for:

- **Allowing local empowerment for decision making on how health care dollars can be best deployed to address population health**
- **Invest health care dollars in the community by creating a prevention fund to address the social determinants of health**
- **Looking at alternative ways to auto-attribute the defined population based on geography**

Representatives from NVRH, the CAHC Transformation LLC, the local Accountable Health Community organization, and OneCare will meet on July 25th to have initial discussions on how to align the organizations to move the pilot project forward. NVRH will keep the GMCB apprised of progress with this exciting project.

NVRH has also provided OneCare Vermont with a letter of intent to participate in the Next Gen Medicaid, Medicare and Commercial products during fiscal 2019. If NVRH doesn't participate in this products during fiscal 2019 we will in fiscal 2020 and thereafter.

As of now, NVRH does not have any money in "at-risk" contracts.

Our Quality Management staff, and the Board QIPS Committee, continuously monitors utilization, access to care and quality of care metrics.

8. Please describe the hospital's shared-decision making programs, if any, and any plans for expanding those programs.
    a. Please describe the initiative(s), which departments have participated, how you have chosen which departments participate, which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement, and the number of patients served by these programs.

Response: Hospital and Ambulatory wide - Ask Me Now is an educational program that encourages patients and families to ask three specific questions of their providers. The patient is supported to ask three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy. Promoted via the Patient Experience committee it is intended to help patients become more active members of their health care team, and provide a critical platform to improve communications between patients, families, and health care professionals. SDM with Consent - All providers' ensure a two-way exchange of information and preferences in making an informed decision this typically involves our clinician and a patient discussing a treatment decision at the point of care. The clinician, is guided by unbiased and up-to-date evidence, and he or she discusses the risks and benefits of treatment options with the patient, as well as understand the patient's preferences and personal situation.

Patient Portal – NVRH believes the Patient Portal is an important technological means to support patient-centred care. Our portal offers advanced communication functions and services that are targeted towards enhancing medical treatment for example, Patients and Families an opportunity to connect directly with their provider. It also allows medication refills, appointment checks, lab and report access and soon the ability to access their financial bill

b. What is the extent of your Choosing Wisely initiative(s), if any?
Response: We have incorporated the principles of Choosing Wisely in our day-to-day work. Nearly every specialty now has contributed a list of recommendations. For example in Hospital Medicine they've chosen to: limit daily blood draws wherever possible, to limit transfusions to strict clinical indications, to limit telemetry on the Med/ Surg floor to specific indications, to remove urinary catheters as soon as possible, and limit prophylactic use of medication for stress ulcers. The Hospital Medicine group use Choosing Wisely principles to help guide our Antibiotic Stewardship efforts. They avoid treating asymptomatic bactiuria, reassess antibiotic therapy at 48 hours and limit the use of prophylactic antibiotics to specific clinical indications.

c. What are you doing to ensure/increase provider buy-in in these programs?
Response:Provider buy-in is achieved through continuous process improvement, didactic sessions, poster reminders, and in our monthly medical staff meetings.

9. Please provide copies of your financial assistance policy, application, and plain language summary (noting any changes from your last submission) as well as detailed information about the ways in which these three items can be obtained by patients.
    a. Please provide the following data by year, 2014 to 2018 (to date):
        i. Number of people who were screened for financial assistance eligibility;
        ii. Number of people who applied for financial assistance;
        iii. Number of people who were granted financial assistance by level of financial assistance received;
        iv. Number of people who were denied financial assistance by reason for denial.
        v. What percentage of your patient population received financial assistance?

b. Please provide the statistics and analyses you relied on to determine the qualification criteria and the amount of assistance provided under your current financial assistance program
Response. Our response to HCA's request for information has been uploaded to the GMCB portal.

10. For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2018 budget and projected) and 2019 (budget).
Response: As a Critical Access Hospital, NVRH does not capture case-mix data. A table summarizing discharges and cost per discharge is presented below

	FY14	FY15	FY16	FY17	FY18 Bud	FY18 Proj	FY19 Bud
Discharges	1519	1551	1694	1586	1650	1720	1695
Cost per Adjusted Discharge	$ 11,900	$ 12,263	$ 11,269	$ 12,770	$ 12,381	$11,742	$ 12,792

11. As part of the GMCB's rate review process during the summer of 2017, Blue Cross Blue Shield of Vermont (BCBSVT) was asked to "explain how the cost shift factors into your approach when negotiating with providers." BCBSVT responded: "Since the creation of the GMCB hospital budget and the greater transparency that it has created, providers insist that it is the responsibility of BCBSVT's members to fund the cost shift. Providers acknowledge that they manage to a revenue target, insist that commercial members must fund the cost shift in order for providers to meet their revenue targets, and remind BCBSVT that the GMCB has approved the revenue target." (GMCB 08-17rr, SERFF Filing, July 5, 2017 Response Letter). Do you agree with this statement? Please explain why or why not. If you disagree, please point to any data available that supports your position.
Response: We agree the need for cost shifting continues and is required to generate patient revenue levels high enough to cover expense increase. NVRH is always working to reduce the amount of cost shift passed on to BCBSVT members and to members of other commercial insurers. Maximizing savings for drug and supply costs through New England Alliance for Health purchasing contracts and the 340B program. A recent change to LED lighting will save $40,000 annually. Despite our expense reduction efforts, cost shifting to the commercial payers is still required. There are two major factors for the continuing rise in the cost shift. Medicaid reimbursement levels haven't kept base with inflation for several years. Also, since July 2016 NVRH's Disproportionate Share Revenue has declined by $850,000. During the same period the Provider Tax assessment has increased by $450,000. The combined $1.3 milliion hit would fall directly to the hospital's operating margin if a portion wasn't cost shifted to commercial payers.

12. Please provide updates on all health reform activities that you have submitted under the GMCB's extended NPR cap during previous budget reviews including

a. The goals of the program;
b. Any evidence you have collected on the efficacy of the program in meeting these goals;
c. Any other outcomes from the program, positive or negative;
d. Whether you have continued the program and why.
e. If you have discontinued one or more of these programs, please describe how you have accounted for this change in past or current budgets.

Response: The following summary is provided in response to this question:

FY 2016

Health Reform Investment: Ambulatory Pharmacist
Amount: $160,000
Goals: Reduce health care costs by assisting primary care providers with medication management, coordination of care, wellness and health promotion, patient education and self-management. Additional goals include optimizing safe medication use and optimizing medication therapy for patients with chronic conditions. The ambulatory pharmacist also improves access to primary care by focusing on patient's medication management concerns/needs thereby freeing up primary care provider time that would otherwise have been spent with patients on medication issues.
Evidence Goals Met: Specific examples include patients with improved medication management that have returned to work, lowered their HbA1c levels, lost significant weight and are now able to exercise regularly.
Other Outcomes: Removing unused medications from homes decreasing likelihood of mis-use
Ongoing or Limited: Ongoing
Budget impact, if discontinued: N/A.

FY 2017

Health Reform Investments: Cal-Essex Accountable Health Community Organization; Emergency Department care manager; Community Mental Health Specialist; Expansion of Palliative Care Program
Amount: $272,000
Goals: The goal of the Cal-Essex Accountable Health Community (CAHC) is 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's priorities and desired outcomes include a population that is:

- **Financially secure**
- **Physically healthy**
- **Mentally healthy**
- **Well-nourished**
- **Well-housed**

The work of CAHC was described in detail in response to Question 2.

The goal of the care manager is to reduce unnecessary visits to the emergency department by linking ED patients to a primary care provider when one isn't indicated during the ED visit.

In lieu of the community mental health specialist, NVRH expanded the emergency department care manager from 1.0 to 1.4 FTE.

The goal of the Palliative Care Program is to provide medical emotional, social, spiritual and comfort care to patients who are dealing with a serious or challenging illness in an appropriate setting. A successful Palliative Care Program will reduce visits to the emergency department and use of other health care services.

Evidence Goals Met: For CAHC one key indicator the goal has been met is the Veggie Van Go program. Our strong partnership with the Vermont Foodbank continues with the once a month produce market called Veggie Van Go. Each month we supply over 250 families with fresh seasonal produce, recipe ideas, and food demos and samples.
Evidence of the ED care manager program goal has been met is the 700 follow up appointments with primary care providers, annually, after a visit to the ED by patients that previously did not have a primary care provider.
Evidence the Palliative Care program goal has been met is the dramatic increase in program visits. Since 2016 the average number of monthly visits has doubled, from 38 visits per month to 76 visits per month.

Other Outcomes: Not determined yet.

Ongoing or Limited: All of these programs are ongoing
Budget impact, if discontinued: Not applicable
<u>FY 2018</u>
Health Reform Investments: Registered nurse for home skilled nursing; community paramedic service; mental health screening and referral services in Emergency Department
Amount: $180,000
Goals: The hospital used the funds originally set aside for the home skilled nursing program to expand staffing of the Emergency Department care manager by adding a .4 FTE position. The goals for the ED care manager were previously described.
The goal of the community paramedic service is to provide in house follow up following discharge from the hospital for inpatients and Emergency Department patients meeting certain criteria, thereby reducing avoidable hospital readmissions and visits to the Emergency Department.
NVRH's plans for the mental health screening and referral services were set aside when we had an unexpected opportunity to hire a local psychiatrist. The goals for this position include; supporting providers to better meet needs of mental health patients; provide consulting and outpatient mental health services to individuals and to help reduce number of suicides
Evidence Goals Met: The community paramedic service will be piloted in July. NVRH will track rates of readmissions to hospital and Emergency Department for patients visited by the paramedics help determine effectiveness of the paramedic program.
Evidence the goals for the new psychiatrist are being met include include the significant number of patients she has counseled 1:1, her work with primary care practice to reduce the risk of suicide and strengthening of patient relationships with their primary care provider. Patients with co-prescriptions for benzodiazepines and opiates are at significantly higher risk of accidental death. Combining these medications can also be used as means for death by suicide. She is working with providers to create awareness of these risks with the goal of reducing the number of co-prescriptions of benzodiazepines and opiates. Weekly meetings

with providers in each of primary care, pediatric and women's health practice have led to the strengthening of relationships between providers and patients with mental health needs. Patients with a strong relationship with their providers are more likely to regularly seek care early on when the need arises.
Other Outcomes: None expected
Ongoing or Limited: The community paramedic program, employed psychiatrist and expanded staffing of the emergency department care manager will be ongoing services.
Budget impact, if discontinued: Not applicable