VT Legal Aid, Inc., Office of the Health Care Advocate Questions

Re: Hospital Budge Guidance FY2019

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? Grace Cottage Family Health and Hospital is a single non-profit entity consisting of a critical access hospital, a rural health clinic and a retail pharmacy.
    b. Are hospital senior management paid by hospital-related entities other than the hospital? N/A
    c. Are the revenues of these entities included in your budget submission? The revenues of these entities are included in our budget submission.
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. Financial incentives/bonuses are available to one executive (the President and CEO) and one group of providers (the Family Practice Physicians working in the Rural Health Clinic).
    - The President and CEO incentive/bonus is based on the attainment of certain performance goals, including some of which are based on financial performance.
    - The Family Practice Physicians have the potential to earn incentive/bonus based on RVUs billed over an annual threshold.

        a. As a part of your answer, please disclose for which procedures the hospital pays providers volume-based incentives. The RVU incentive/bonus for the Family Practice Physicians is based on all procedures billed for services provided as part of the Rural Health Clinic.

        b. Are these incentives the same for OneCare attributed patients as for non-attributed patients? N/A as we do not currently have any OneCare attributed patients, however if we do sign a contract with OneCare, the incentive would continue to be the same for both attributed and non-attributed patients.
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.) Grace Cottage Family Health & Hospital is a fee for service business.
    a. Please indicate which entities the hospital has capitated or other alternative payment agreements with (e.g., insurer(s), ACO(s)).
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; zero – we don't admit mental health patients.
b. The range and average wait time for placement of mental health patients who report to your hospital in need of inpatient admission; range 2 hours 28 minutes to 42 hours 29 minutes; average 14 hours 17 minutes.
c. The range and average time patients have spent in your emergency department awaiting an appropriate mental health placement; same as above.
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. Between Jan 1, 2017 – March 31, 2018, we transferred 33 mental health patients to other facilities.

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?

   None, because we offer a complete set of mental health programs embedded right into our family medicine clinic.

   - A full-time Psychiatric APRN (PMHNP-BC) whose specialty is medicine (prescription drug) management for patients of age > 10 and who also oversees limited family sessions. He also consults with inpatients and emergency department patients as needs arise.
   - A full-time Licensed Independent Clinical Social Worker who offers long-term counseling for children, adults, couples and families. She also consults with inpatients and emergency department patients as needs arise.
   - A full-time Licensed Mental Health Counselor/Psychotherapist who offers acute, short-term counseling for children, adults and families. She also consults with inpatients and emergency department patients as needs arise.
   - A SPOKE program linked to the Brattleboro Retreat HUB system for MAT for opioid addiction, 3 days a week with 2 addiction specialists and 2 clinic providers.
   - Patients in mental health crisis referred to the emergency department for evaluation by the ED provider and the crisis team of HCRS.
   - The emergency department now has a brand new safe room to ensure patient and staff safety for high-risk psychiatric symptoms and behavior.

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; currently there are 72 patients enrolled.

   b. The number of MAT providers employed by your hospital; 1 current and 1 in training.

7. Please describe the hospital's plans for participation in payment reform initiatives in this fiscal year and over the next five years.

   Grace Cottage does not currently participate in any payment reform initiatives. While we have submitted a Non-Binding Intent to potentially participate in OneCare Vermont's 2019 Risk-Based Programs, we are awaiting the promised modeling analysis from OneCare Vermont to assist us in making the final decision as to whether or not we will be able to financially absorb the

potential risk of participation. Without that modeling we are unable to answer this question fully.

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?

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.

Shared Decision-Making:

As you know, the Agency for Healthcare Research and Quality explains that "*shared decision-making is "a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health. It operates under two premises:*

- *First, consumers armed with good information can and will participate in the medical decision-making process by asking informed questions and expressing personal values and opinions about their conditions and treatment options.*
- *Second, clinicians will respect patients' goals and preferences and use them to guide recommendations and treatments.*

The aim of shared decision making is to ensure that:

- *Patients understand their options and the pros and cons of those options and*
- *Patient's goals and treatment preferences are used to guide decisions.*

A key step in shared decision-making is making sure that patients are fully informed about their medical condition and their options. Consumers have access to a variety of sources for such information, including physicians, friends and family, Web sites, and printed materials such as pamphlets and journal articles. Patient decision aids go beyond that kind of information to explain the issues fairly and clearly, highlighting the pros and cons of each option, and providing support for users to clarify and express their personal goals and preferences. Good decision aids, whether Web-, video- or paper-based, are balanced and do not encourage one treatment approach over the others. They can be used before, during and after visits for medical care,[11] and may be applied to a variety of medical conditions as well

as general preventive medicine. Educational applications may also be used to prepare patients for various procedures or explain what they need to know after surgery." (https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html)

You will be happy to know that shared decision-making is the normal practice here at Grace Cottage and has been for decades. It is at the very heart of our patient-centered health care model, our level 3 medical home and every community health team endeavor.

Common examples of where it is practiced:

- All wellness, preventive health and anticipatory guidance visits.
- All advance care planning, end-of-life care and hospice sessions.
- All chronic care management decisions.
- All personal health goals attended by our community health team.
- All informed consent decisions whether they in an outpatient or hospital setting.
- We have educated the public with newspaper columns and a local TV programs.

Proof of our success is our hospital being cited as one of the top 20 highest ranked critical access hospitals (CAHs) in the country in the category of best practice recipients for patient satisfaction for two years in a row as the below decal points out!. If we weren't practicing patient-centered, shared decision-making healthcare, this recognition and honor would have never happened.

b. What is the extent of your Choosing Wisely initiative(s), if any?

As you know, the Choosing Wisely campaign has generated a 186 page list of 490 "recommendations" involving 75 specialty and subspecialty aspects of medicine. These "recommendations" are not published as protocols, policies or standards of care. They were generated by these specialties to identify "tests or procedures commonly used in their field whose necessity should be questioned and discussed." Each list is headed with "Things Providers and Patients Should Question" and the lists "are intended to spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments." In other words, these recommendations are to serve as talking points during shared decision making discussions between a provider and his/her patient.

What we have done in the past and still do is to make those recommendations that are pertinent to our primary care providers known to them. We use these recommendations in our peer review discussions when applicable.

Some of these recommendations had already been accepted as standards of care (ex. no antibiotics for viral diseases or sinusitis; no cough or cold meds for young children; no CT scanning for minor head bumps, febrile seizures or routine abdominal pain in children, no routine PSA screening for prostate cancer).

Some of these contradict quality demands by other organizations (ex. blood pressure control in those aged 60 and over; pain relief using narcotics for acute disabling back pain).

We have had presentations at our med staff meetings of the most useful and applicable recommendations for primary care settings.

As regards to measuring outcomes, we have decided to focus on outpatient antibiotic stewardship beginning with a major initiative in December. We have no data on cost savings.

c. What are you doing to ensure/increase provider buy-in in these programs?
We have prioritized some of these and are measuring adherence (antibiotic overuse & unnecessary transfusions).
We have circulated the most pertinent ones in clinical update emailings.
The providers have been notified of the website.
We have placed the most pertinent recommendations in a folder on our intranet page.

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. The information is available in all of our clinic and hospital waiting rooms; available through all registration staff; posted in the elevator between the hospital and the clinic; and available online from our Grace Cottage website. The information is listed on billing statements and can be requested over the phone to be mailed (USPS) to patients. There has been outreach to agencies in the area that assist people in need such as Visiting Nurses, Senior Solutions, and soup kitchens, in an effort to connect with those folks who might need assistance.

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. See Reduced Fee/Free Care Policy.

		2014	2015	2016	2017	2018 TO 04/20/2018
i.	**# of people who were screened for financial assistance eligibility**	229	179	169	243	55
ii.	**# of people who applied for financial assistance**	229	179	169	243	55
iii.	**# of people who were granted for financial assistance by level of financial assistance received**	**122**	**108**	**98**	**129**	**32**
	LEVEL 1	12	4	4	8	1
	LEVEL 2	15	3	11	8	2
	LEVEL 3	20	10	26	20	2
	LEVEL 4	15	28	19	28	4
	LEVEL 5	60	63	38	65	23
iv.	**# of people who were denied financial assistance by reason for denial**	**107**	**71**	**71**	**114**	**23**
	Out of Service Area	4	2	6	8	0
	Over Income	4	5	10	8	0
	Has not ehausted all benefit options	0	0	0	1	0
	Non compliant with RF Policy	0	0	0	1	0
	Individual- Must apply separate	0	0	2	0	0
	Incomplete Application	99	64	53	96	23
v.	**What percentage of your patient population received financial assistance?**	1.77%	1.60%	1.41%	1.76%	1.02%

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).

	Actual	Actual	Actual	Actual	Proj	Bud
	2014	2015	2016	2017	2018	2019
CMI - Acute	0.8830	0.8763	0.9178	0.8761	0.9267	0.9267
CMI - Swing Bed	1.2920	1.1641	1.1469	1.1022	1.1464	1.1464
Discharges - Acute	179	130	131	137	149	149

Discharges - Swing Bed	266	242	232	215	231	231
Gross Price Per Discharge	3,152	3,195	3,511	3,765	3,901	4,029

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.
    Grace Cottage does not agree with the statement "providers insist that it is the responsibility of BCBSVT's members to fund the cost shift". While it is true that BCBSVT's members are picking up a portion of the cost shift, all other commercial insurers and private pay patients are as well. Grace Cottage does not only manage to a revenue target, but in fact strives to manage continued emphasis on keeping expenditures as low as possible.

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
    Grace Cottage did not submit any health reform activities under the GMCB's extended NPR cap.
    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.