HSF QUESTIONS FOR HOSPITALS

VERMONT
GREEN MOUNTAIN CARE BOARD

HOSPITAL 7: NORTH COUNTRY HOSPITAL (NCH)

Follow-Up Questions and Requests Related to Your Budget Submission

On labor expenses

1. Why do you expect LOCUM expenses to decrease by such a significant margin nextyear?

We have filled several nursing positions in Maternal Child Health and on the Progressive Care unit with staff so there is no locum dollars budgeted for these. We have also recruited three new primary care physicians to start this fall. Two of these physician positions have been staffed with locums this fiscal year to provide access to our patients.

On utilization

2. How were you able to increase patient access in primary care clinics without additional staff? What lessons would you pass onto other hospitals?

We were able to increase patient access in primary care without additional staff by putting forth a lot of effort to decrease the no show rate in the clinics. We did not need to add staff because the staff already exists and is there to take care of the patient that does not show up. We also changed our new patient process to allow for acute visits before the patient is established. We worked to best leverage the existing schedules, with existing staff, to see the most patients.

A lesson we would pass onto other hospitals is to if necessary to engage a known consultant with expertise in Primary Care. Outside eyes can help to identify areas for improvement and provide suggestions. It is necessary to be fully transparent with the providers. You need to work closely with the providers and staff on any changes you make, to get their feedback, and to adjust as necessary.

On cost inflation

3. Why do you predict pharmaceutical inflation will be 5%?

5% is based on what we have been experiencing this year to date. We also referenced Vizient and their projections were 3.81%. With these two pieces of information, we determined 5% was reasonable.

4. Why do you predict insurance inflation will be 13.5%?

This applies to our Umbrella and Liability insurance. This expected increase percentage was directly from our insurance carrier.

On workforce development

5. What is the cost-benefit of these programs, particularly the preceptor? Do you find these programs help attract labor to the area?

The partnerships with North Country Union High School and Vermont State University are invaluable. Engaging with high school students and adult learners for our LNA program gives them a glimpse into healthcare to see if this is the path they want to take.
Once they begin building relationships with hospital staff and leadership and realize they do want to pursue a career in healthcare, we can help facilitate enrollment into VSU. The clinical instructors are employees of both North Country Hospital and Vermont State University.

The new grad residency program has been a great recruiting tool. New grads can choose to work in the Emergency Department, Surgery or one of the inpatient units. It's a 9-month program that includes monthly education, a unit-based project and time on their unit with a preceptor. New grads are paid $2,500 after three months into the program and an additional $2500 at the end once they've presented their project. Each new grad is paired with a mentor who works in another department. Mentors volunteer their time each month to meet with their mentee. But mentorship offers another layer of support.

Preceptor pay is given to nurses who make the commitment to invest in a new hire or new grad. The orientation for surgery, maternal child health and the emergency department is six months long. Our progressive care unit's orientation is three months. The small amount we pay preceptors is for retention of our preceptors.

The clinical ladder is another program for retention. Each level has a set of commitments, and a dollar amount associated with those commitments. For example, to work on another unit, get a clinical certification, monitor patient records for quality metrics are all part of the clinical ladder program. Each level encourages professional development and growth and some of the options require time outside the shifts they are already scheduled.

On investments in mental health, SUD, LTC, and primary care

6. Could you speak a little more to the current state and investments in long term care, considering the population age in your county?

For mental health and substance use disorders, the emergency department renovation included four private rooms. The rooms are multi-purpose equipped with negative pressure for patients with respiratory and airborne illness and cardiac monitoring for acutely ill patients. By closing a door and blocking all the equipment, the rooms become ligature resistant for our community members who are in mental health crisis seeking help. Each patient presenting with suicidal or homicidal thoughts/actions must have a private room and a sitter for safety.

Our case managers for the emergency department and inpatient units assist with assuring patients without a primary care physician, have an appointment with one. They assist families with applying for Medicare, Medicaid and long-term care insurance. As an inpatient our case managers begin the conversations and offer resources for long-term care facilities available in our community.

On network efficiencies

7. Do you have any collaborations already in place with NVRH? If so, please detail such collaborations.

We currently have several collaborations with NVRH in Progress, our LLC which is our joint venture on a Sleep Lab in St. Johnsbury has been up and running for better than a decade, we are also beginning operational, educational and policy collaboration. We are discussing shared educational opportunities, joint recruitment of specialty services, referrals around Orthopedics and Urology as well as back-office leadership sharing. The biggest need we currently have is around compliance, we are hoping to develop that shared compliance model with NVRH.

In addition, we are planning a joint board get together in the October time frame.

8. To the best of your ability, please provide an estimate of when you hope to implement your joint network ventures with NVRH.

Actual implementations will be occurring during the 1st quarter of FY 25.

On your income statement

9. Can you provide more context on how you've been able to increasingly utilize FPPs for revenues?

The majority of the FPP revenue reported is our Medicaid payment from the ACO. It is revenue to partially cover the cost of care for the patient lives attributed to the ACO.

What lessons would you pass on to other hospitals.

10. We commend you on reducing expenses year over year. How did you achieve the reduction?

From budget 24 to budget 25 we have reduced expenses by $2.2 million.
We have made very difficult decisions to improve our financial outlook, we have made a major effort to instill financial discipline throughout the organization and we have worked on culture to retain and recruit employees. This budget reflects a savings of $1.6 million dollars in salaries. We have one less Orthopedic surgeon, we will no longer have a Urologist, or a nurse practitioner in Primary Care. Many departments have seen reductions in staff due to attrition and have not replaced these positions. Roles have been combined to eliminate other salary costs and positions previously filled by RN's are being filled with LPN's and MA's if appropriate. Locums have decreased by $800,000. We have been able to fill nursing positions with staff that were previously travelers, and we have hired Primary Care physicians to replace the locums we have been using. We have also reduced non salary expense in several areas including in the pharmacy by replacing name brand drugs with generics, in the lab by changing lab suppliers, and in many other areas.

On your workbook submission

11. Table 7 in the workbook (Clinical Productivity) still appears to be missing. This information is required for any hospitals submitting budget requests that do not meet the Section I benchmark for commercial price growth. May you please provide it?

This table has been completed and uploaded into Adaptive on August 2nd.

12. In Table 8 of the workbook, it appears many nurses have left but few vacancies remain. Have you cut back on the number of nursing staff and if so, where? If so, has this negatively affected patient experience?

We evaluate the need to fill each open position based on census and volume. The request to replace a position goes to the senior team for approval. Based on peak times in the emergency department we were able to eliminate two 3pm positions once all the earlier mid shift positions were filled.

For the progressive unit, the inpatient census has been trending down. We staff to census. Staff have had to use their paid time off to supplement the days they aren't needed. As nurses resign, we aren't filling every position so they can get their scheduled hours and use less PTO.

Last year we had five new grads complete their residency and each of them replaced a traveler or were put in an open position.

13. Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):
    a. How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?

When we begin working on the budget, we start with the actual year to date. We then make assumptions based on what we know or anticipate for changes in providers which will drive the changes in volumes. For example, in our case we knew when we did the budget that we would have one less Orthopedic physician, no urologist, and would have staff primary care physicians instead of locums. We made those adjustments in our Budget 2025. Regarding payer mix, payer mix is based on what the actual is year to date. Regarding this year, we have no additional information that would necessitate us changing the payer mix. The price increase is a product of the net revenue, expense, and profit margin from budget to budget.

    b. For non-zero values in the "other" column, how did you derive these estimates?

This question may have been based on a previous version of the spreadsheet. A revised version was submitted on August 2nd and there are not values in the "other" column.

Other

14. Do you think Medicaid is underfunding the cost of delivering care to your Medicaid patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

    Yes, we do think Medicaid does not cover the cost of delivering care to our Medicaid patients. Per our 2023 Medicare Cost report – Worksheet S – 10, line 8 – Difference between net revenue and costs for Medicaid program is $7,319,794.

15. Do you think Medicare is underfunding the cost of delivering care to your Medicare patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

    Being cost based reimbursed we are paid the cost for a large amount of care delivery. There is also a portion that we do not receive cost-based reimbursement for. Per our 2023 Medicare Cost report – Worksheet A -8, line 50 – the amount of costs not reimbursed is $17,313,581.

16. In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.

    We have reviewed the calculations. The calculation that differs is the Debt Service Coverage ratio. We calculate with the formula provided by our bank for the purpose of monitoring bond compliance. The formula used is Income available for Debt Service (excess of revenue or expense less depreciation, interest and amortization divided by Maximum annual debt service.

Narrative Questions That Still Need to Be Answered

Question C.e (administrative vs. clinical expense): Using the Medicare Cost Report definition of administrative clinical, and mixed expenses in Wang & Bai (2023), also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time.

Administrative and general costs for budget 2024 were 35% of the total expenses. For the budget 2025 they are 38% of the total expenses. Clinical costs were 65% and 62% for the same two time periods. The increase in administrative and general costs by 3% is a reasonable increase based on inflation in the past year. The largest factor in the clinical cost decrease would be the large reduction in travelers.