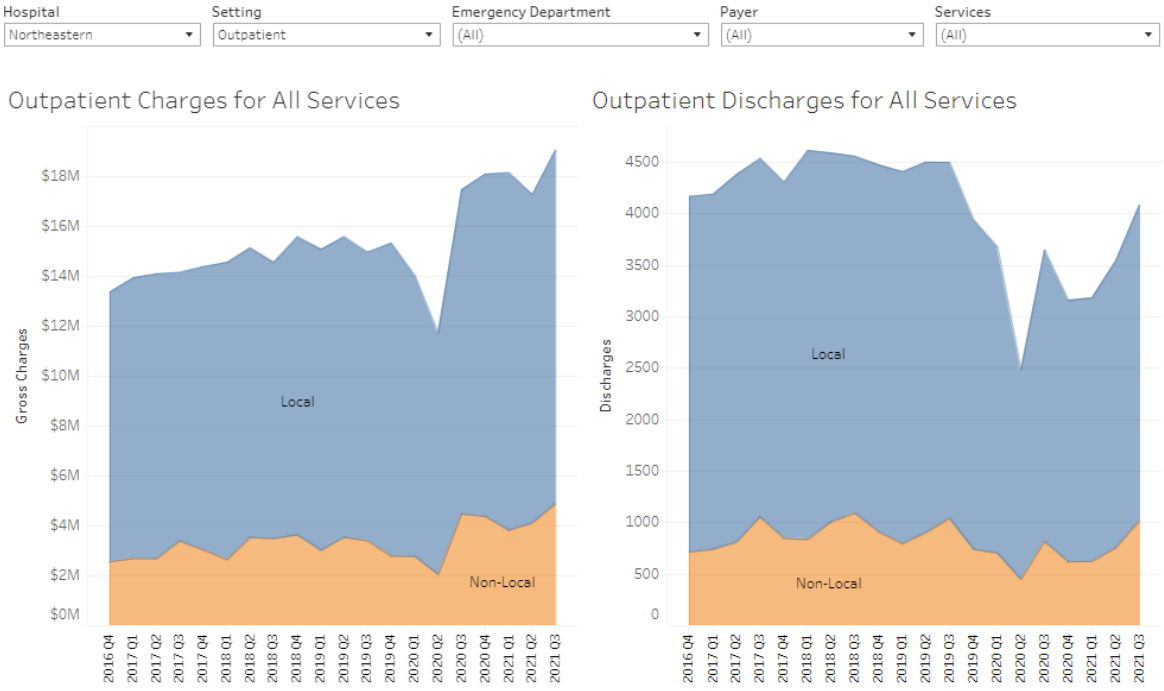
Northeastern Vermont Regional Hospital
FY 2023 Budget Submission
Response to GMCB Supplemental Data Requests

1. Market Share Report
   - **i. Does Exhibit 1 reflect material changes to your Net Patient Revenue (NPR) actuals over this time period?**

COPIED FROM EXHIBIT 1USING LINK PROVIDED BY GMCB STAFF



Origin	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Local	13,955	14,287	14,235	11,035	10,953
Non-Local	3,325	3,788	3,655	2,717	3,017

Origin	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Local	$44M	$46M	$48M	$46M	$55M
Non-Local	$11M	$13M	$14M	$12M	$17M

The data in Exhibit 1 above, does indicate a higher percentage of outpatient NPR is coming from outside NVRH's service area. Based on revenue, the percentage of non-local patients increased from 20% in FY17 to 23.6% in FY21

- Increases noted in musculoskeletal and ophthalmology
- This trend continues into FY 22

2. Reimbursement Analysis
   - **i. For any service lines in which your hospital is highlighted, comment on any observations about this service line and how it may be reimbursed differently from other service lines you provide**

NVRH was identified in the detailed Reimbursement Analysis having payments or costs above the calculated ranges. Those identified areas are summarized below. The data represents an aggregation of three years (2017-2019) of information. There are only a few areas where NVRH's cost or payment was significantly higher than the upper limit of the

range. We could not discern reimbursement differences between service lines that would create those variances..

	CM Adjusted Payment Per Service			
			Range	Range
Inpatient	**Digestive System**	NVRH	Low	High
	Medicaid	$ 11,380	$ 9,637	$ 11,240
	Mental Health/SUD			
	Medicare	$ 16,256	$ 7,282	$ 15,155
Outpatient	**Clinic Visits**			
	All Payer	$ 265	$ 108	$ 233
	Radiation			
	All Payer	$ 1,659	$ -	$ 1,469
	Skin Procedures			
	All Payer	$ 479	$ 110	$ 337
	Medicare	$ 315	$ 76	$ 263
	Minor Procedures			
	All Payer	$ 357	$ 191	$ 305
	Adjusted Medicare Allowable Cost Per Service			
Inpatient	**All Other Services**			
	Commercial	$ 22,091	$ 11,921	$ 21,824
	Circulatory System			
	Commercial	$ 27,420	$ 9,155	$ 23,045
	Digestive System			
	Mediciad	$ 19,253	$ 10,957	$ 16,140
	Kidney Related			
	Commercial	$ 33,919	$ 11,273	$ 23,364
	Medicaid	$ 19,691	$ 9,154	$ 17,607
	Respiratory System			
	Medicaid	$ 20,908	$ 7,520	$ 20,032
Outpatient	**ED Visits**			
	Medicare	$ 412	$ 252	$ 397
	Imaging w/out contrast			
	Commercial	$ 490	$ 457	$ 498
	Skin Procedures			
	Medicaid	$ 788	$ 246	$ 700

ii. Are there any errors in the data as shown? Cite your own data where possible
We could not discern any errors other than a few areas where NVRH was identified as being out of range, but was actually not.

3. Demographic Report

Table 2-2. Population Characteristics by Hospital Service Area, 2019

	Disability			Age			Poverty		
	None	One	Two or more	Under 18	18-64	65 plus	No	Yes	Unknown
Barre	86.0%	7.5%	6.5%	18.9%	62.7%	18.4%	87.1%	10.1%	2.8%
Bennington	82.3%	10.1%	7.6%	19.2%	59.0%	21.8%	86.8%	10.7%	2.4%
Brattleboro	82.7%	9.5%	7.8%	17.5%	60.6%	21.9%	83.5%	12.8%	3.7%
Burlington	88.3%	7.0%	4.6%	18.5%	67.2%	14.2%	84.3%	10.9%	4.8%
Middlebury	84.6%	8.9%	6.5%	17.0%	63.8%	19.2%	83.9%	7.0%	9.1%
Morrisville	85.8%	8.4%	5.8%	20.7%	60.1%	19.1%	88.5%	11.2%	0.3%
Newport	83.0%	9.6%	7.4%	19.7%	58.7%	21.6%	86.6%	12.8%	0.6%
Randolph	83.4%	9.6%	7.0%	17.2%	61.3%	21.6%	87.8%	9.4%	2.8%
Rutland	83.7%	8.7%	7.6%	18.0%	61.0%	21.0%	87.5%	9.8%	2.7%
Springfield	82.8%	9.3%	7.9%	18.5%	58.8%	22.7%	86.1%	13.6%	0.3%
St. Albans	86.0%	8.4%	5.6%	21.2%	62.4%	16.4%	89.6%	10.1%	0.3%
St. Johnsbury	83.1%	9.1%	7.8%	19.5%	60.2%	20.3%	84.5%	13.3%	2.2%
White River Jct	85.0%	8.7%	6.3%	19.4%	59.0%	21.7%	91.3%	8.1%	0.7%
Vermont	*85.5%*	*8.3%*	*6.2%*	*18.8%*	*62.8%*	*18.4%*	*86.3%*	*10.6%*	*3.1%*

i. **How does the current makeup of your service area affect your budget assumptions and planning**?

The population NVRH serves has higher than average percentage of people with disabilities and a higher percentage of people age 65 and older. This affects are budget assumptions in a few ways:

- Those factors contribute to inpatient days increasing due to higher acuity of patients admitted.
- NVRH is adding or expanding services to meet the needs of this population. Examples include recently added Pulmonology Clinic and transitioning Podiatry Clinic from community-based to NVRH-based service. The latter was done to assure Podiatry was available to the elderly and those with diabetes.

ii. Does the makeup of other service areas affect your budget assumptions and planning? Explain.

NVRH is considering adding an advanced practiced provider in the pulmonology clinic. The need for additional provider is due in part to increasing number of patients from outside our service area requiring pulmonology specialists. NVRH's podiatrist will also serve a significant number of patients from outside our service area due to lack of local available podiatrist.

4. Wait Times

Wait time data July 4 - July 15, 2022						
Department/Medical Practice	Appointment / Exam Type	Referral Lag % or appointments scheduled within 72 hours	Visit Lag %			
			< 2 weeks	1 mon	3 mon	6 mon
Diagnostic Imagining	Chest X-Ray	94 %	82%	18%		
	CT Lung Cancer Screening	47%	82%	12%	1%	
	MRI Brain wo contrast	75%		100% (3 wks)		
	US Echocardiogram	75%	10%	5%	85%	
	US Pelvic and Transvaginal	100%	12.5%	75%		12.5%
Corner Medical	New patients	100%		22%	88%	
(Family Medicine Practice)	ED Follow-Ups	100%	80%	20%		
	Inpatient discharge follow-up	100%	100%			
St. Johnsbury Pediatrics	New patients	100%	100%			
	ED Follow-Ups	100%	100%			
Women's Wellness		100%	88%	12%		
Cardiology		100%	14%	18%	68%	
Urology		100%	50%	50%		
Neurology		100%	22%	28%	28%	22%
Pulmonology		9%				100%
Surgical Associates		60%	22%	20%	40%	18%
Four Seasons Orthopaedics		87%	69%	21%	10%	
ENT & Audiology		69%	43.80%	31.30%	15.60%	
Palliative Care		100%	50%	50%		
Kingdom Internal Medicine		80%			100%	

1. CURRENT STATE:
   - **i. How do you currently measure and benchmark wait times?**

     We utilize the Third Next Available Appointment (TNAA) metric to monitor wait times quarterly. We utilize our own standards/policies to ensure we are providing the access our community deserves.

   - **ii. What efforts is your organization making to improve wait times, particularly in areas where your organization records wait times longer than available benchmarks?**

     We utilize the wait list feature within our EMR to help quickly fill open spots due to cancellation or no-shows. Our most undesirable wait times are in many of our specialty offices. To help ensure patients get the care they need we are currently utilizing referral triage, and limiting referral acceptance to our HSA where absolutely necessary. In addition, specialty providers are working directly with referring providers to provide testing and care recommendations to be done prior to, or in place of, scheduling Specialty Consults. This eliminates additional specialist appointments due to insufficient information and can

eliminate initial consults if there is negative testing results, providing more room for appropriate appointments.

When appropriate we have added additional providers (APPs) to help reduce wait times and ensure access; we are currently working towards adding an APP in Pulmonology.

Here are some additional steps we are taking outside of our norm to ensure Specialty patients are cared for:

- Surgical blocks do not get filled and we move pts up or add urgent new referrals to the schedule (from ER etc).
- Pts cancel and we use those slots to get urgent pts in.
- Often we shuffle the schedule to accommodate urgent pts.
- We double book, use lunch and extended hours to see urgent pts.
- We review every referral (either nurse, provider or both) doing a deep dive to determine urgency. We are chasing records and results before scheduling to ensure correct scheduling time frames.
- Providers are reviewing and working with referring providers to start the care process; making recommendations regarding tests that need to be done etc. prior to a specialty appointment
- Providers are working to educate referring providers on appropriate referrals, what tests need to be done before making the referral initially.

We are working with the ER to eliminate unnecessary referrals to specialists, opening up more time for appropriate referrals. Often it is best to refer back to PCP to ensure proper testing is done before seeing the specialist.

iii. **What EHR system(s) does your organization use and how does that impact your ability to measure wait times?**

We utilize Meditech Expanse. We calculate TNAA manually to ensure accuracy.

2. PROCESS

i. Please overview your clinic scheduling process, including centralized scheduling if applicable.

Each Medical Practice/department schedules their own patient appointments.

ii. Please describe how referrals enter your system, and how staff triage, schedule and prevent the loss of those referrals.

iii.

In Primary Care most of our referrals are self-referral, but we do get referrals from the Emergency Department, Northern Express Care locations and community partners. If a patient has an acute need we schedule the patient an appointment to address that need and schedule a new patient appointment once their prior medical records are received. Our medical secretaries keep a registry on New Patients to track receipt of their prior medical records and ensure timely scheduling.

In Specialties, we receive internal referrals electronically via our Medical Record, external referrals come via fax or self-referral. Depending on the wait time of the

specialty the referral is triaged by and RN and reviewed by the provider if necessary and an appropriate appointment is made. If triage is not required the patient is contacted and an appointment is scheduled. We utilize "Authorization & Referral Management" (ARM) within Meditech to track all of our referrals. If a patient does not respond to schedule an appointment/declines appointment/no shows a specialty appointment the PCP office is notified to follow up with the patient.

(*) ARM is also utilized to track our outgoing referrals to ensure patients are seen and notes are received back.

3. RECOMMENDATIONS
   i. **What metrics (qualitative and quantitative) would you suggest using to track and report wait times?**

      TNAA is a National standard of measure. State regulators should utilize healthcare quality and research sources to assist in determining best practice measures as well as analyze what recommendations are in place to improve the measure. Key Performance Indicators (KPIs) exist in several trusted healthcare forums to outline such quality improvement plans, such as at the Agency for Healthcare Research and Quality (AHRQ), the Institute for Healthcare Improvement (IHI), and the Medical Group Management Association (MGMA). Learning from well-researched and established best practices could help increase efficiency, accuracy, and improve outcomes.

      When practices are not inundated with referrals TNAA works well for measuring various appointment types, setting goals and adjusting schedules in a timely manner.

      When practices are working in an overwhelmed system, no metric is going to capture what is really occurring. Asking the questions, such as the ones above, to allow organizations to tell their story is important.

   ii. **In your opinion, how should state regulators best account for and measure the intricacies (e.g. acuity, uniform reporting) of wait times?**

      Interviewing practices to gain their opinions and experiences in regards to wait times. For example, when a healthcare system is overwhelmed, do practices believe the TNAA is still an accurate unit of measure- why or why not? And what does being overwhelmed consist of- how many referrals equals being overwhelmed? At what point do practices reach their felt capacity versus their actual capacity?

4. DATA
   i. **Please submit a sample of recent anonymized patient feedback concerning wait times, if available.**

      See attached files

ii. **Please submit, if available, any aggregate reports based on patient satisfaction surveys regarding wait times produced by the hospital/health system**

See attached files.