

RRMC Response to GMCB FY23 Hospital Budget Wait Times Metrics
August 5, 2022

For any referrals or appointments requested in the first two weeks of June 2022, please report the following:

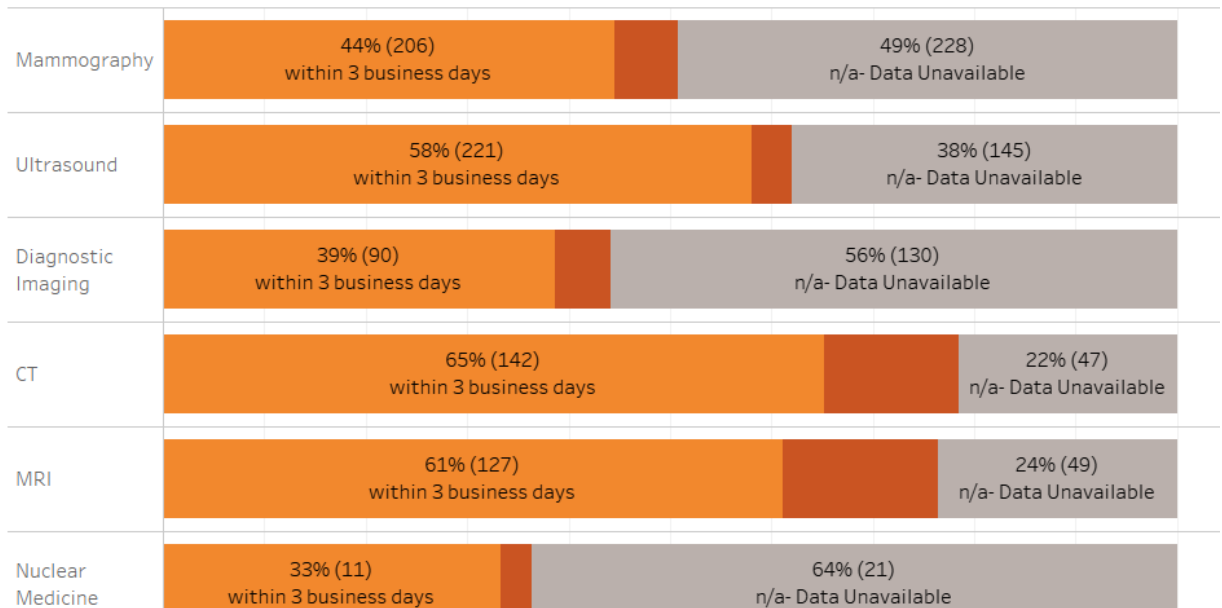
Ai. Referral Lag: The percentage of appointments scheduled within 3 business days of referral (percentage of referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date the appointment will take place.)

a. Practices

Referral lag data is unavailable for our clinics, as date of referral is not captured as a reportable field in our medical record.

b. Imaging

Imaging Referral Lag



Source: RRMC Medical Record data, June 6, 2022 – June 17, 2022.

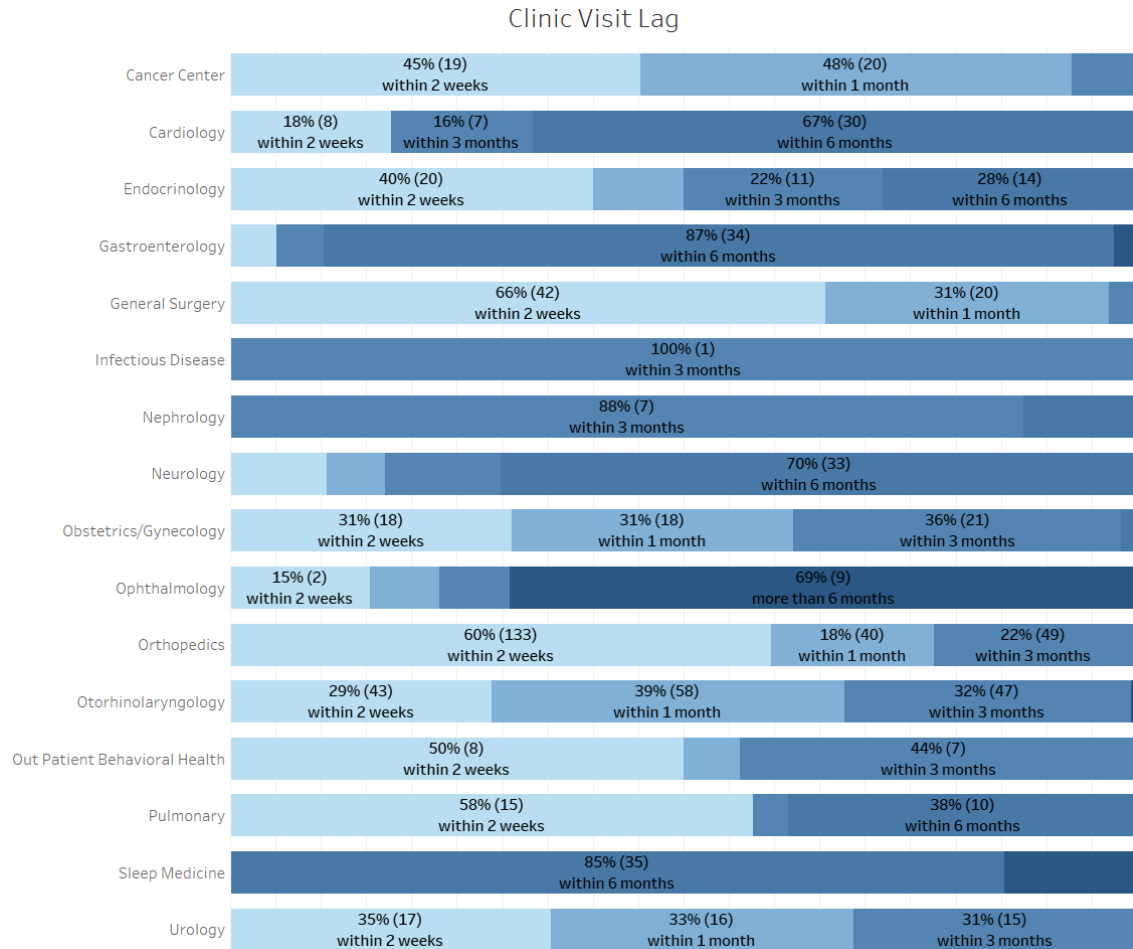
Note: Referrals are reportable for imaging if they are electronically ordered; the missing data represents volume that was ordered via paper or fax. Of note, orders are often placed in advance for imaging, with scheduling occurring closer to the appointment date, which extends the referral lag time.

Imaging Referral Lag						
Clinic	within 3 business days		more than 3 business days		n/a- Data Unavailable	
	%	Appt Count	%	Appt Count	%	Appt Count
Mammography	44%	206	6%	29	49%	228
Ultrasound	58%	221	4%	15	38%	145
Diagnostic Imaging	39%	90	6%	13	56%	130
CT	65%	142	13%	29	22%	47
MRI	61%	127	15%	32	24%	49
Nuclear Medicine	33%	11	3%	1	64%	21

Source: RRMC Medical Record data, June 6, 2022 – June 17, 2022.

Aii. Visit Lag: The percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date the patient will be seen.

a. Practices



Source: RPMC Medical Record data, June 6, 2022 – June 17, 2022.

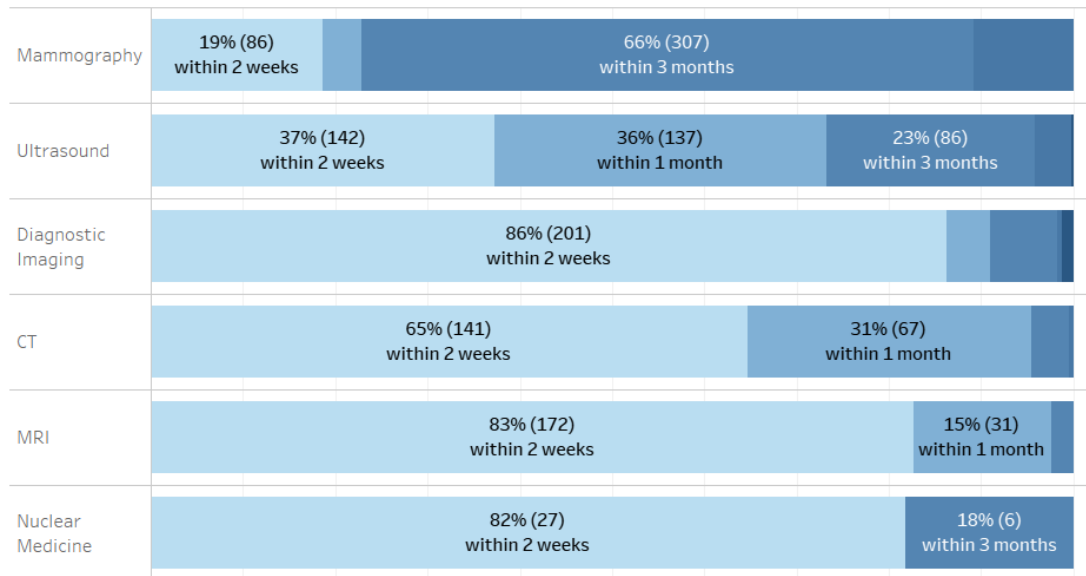
Note: Many of the clinics with higher wait times are the result of provider vacancies, for which we are actively recruiting. In some areas we can offset the loss of a physician by recruiting, hiring and training an advanced practice provider. In some specialties where we have had difficulty in recruiting a physician, and an APP is not an option, we are able to engage locum physicians as rates are approaching up to a million dollars a year. Our staff triage patients to accommodate appointment needs as clinically necessary. One additional contributing factor to access that we are seeing are patient requests for appointment in our clinics that are from outside our normal catchment area, due to a lack of availability within their local market.

Clinic Visit Lag										
	within 2 weeks		within 1 month		within 3 months		within 6 months		> than 6 months	
	%	Appt Count	%	Appt Count	%	Appt Count	%	Appt Count	%	Appt Count
Cancer Center	45%	19	48%	20	7%	3	-	-	-	-
Cardiology	18%	8	-	-	16%	7	67%	30	-	-
Endocrinology	40%	20	10%	5	22%	11	28%	14	-	-
Gastroenterology	5%	2	-	-	5%	2	87%	34	3%	1
General Surgery	67%	42	32%	20	2%	1	-	-	-	-
Infectious Disease	-	-	-	-	100%	1	-	-	-	-
Nephrology	-	-	-	-	88%	7	13%	1	-	-
Neurology	11%	5	6%	3	13%	6	70%	33	-	-
Obstetrics/Gynecology	31%	18	31%	18	36%	21	2%	1	-	-
Ophthalmology	15%	2	8%	1	8%	1	-	-	69%	9
Orthopedics	60%	133	18%	40	22%	49	0%	1	-	-
Otorhinolaryngology	29%	43	39%	58	32%	47	-	-	1%	1
Outpatient Behavioral Health	50%	8	6%	1	44%	7	-	-	-	-
Pulmonary	58%	15	-	-	4%	1	38%	10	-	-
Sleep Medicine	-	-	-	-	-	-	85%	35	15%	6
Urology	35%	17	33%	16	31%	15	-	-	-	-

Source: RPMC Medical Record data, June 6, 2022 – June 17, 2022.

b. Imaging

Imaging Visit Lag



Source: RPMC Medical Record data, June 6, 2022 – June 17, 2022.

Note: For the scheduling of imaging procedures, standard guidelines for screening spacing and time to follow-up will impact lag times; this is reflected in the longer lag times for Mammography. For Ultrasound and CT imaging, outside factors such as pathology or radiologist availability may have an impact on visit lag.

Imaging Visit Lag										
Clinic	within 2 weeks		within 1 month		within 3 months		within 6 months		> than 6 months	
	%	Appt Count	%	Appt Count	%	Appt Count	%	Appt Count	%	Appt Count
Mammography	19%	86	4%	20	66%	307	11%	50	-	-
Ultrasound	37%	142	36%	137	23%	86	4%	15	0%	1
Diagnostic Imaging	86%	201	5%	11	7%	17	0%	1	1%	3
CT	65%	141	31%	67	4%	9	0%	1	-	-
MRI	83%	172	15%	31	2%	5	-	-	-	-
Nuclear Medicine	82%	27	-	-	18%	6	-	-	-	-

Source: RPMC Medical Record data, June 6, 2022 – June 17, 2022.

Current State:

- **How do you currently measure and benchmark wait times?**

Our organization measures 3rd next available appointments to measure access to our clinics. We track an organizational level target related to this measure, which we benchmark and compare to the previous year. In FY23, we are rolling out wait time metrics that are in alignment with those requested by the GMCB, focused on days from scheduling to initial appointment.

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

For clinic appointments, we review wait times monthly. We work to address wait times through provider recruitment, where vacancies exist, and adjust operations as necessary. We also work with the primary care provider and patient to evaluate the appropriate provider type (i.e., MD, NP, PA) to see the patient. In addition, we also evaluate and initiate pre-appointment testing and evaluations that can occur prior to being seen by a specialist.

To increase access for imaging appointments and meet pent-up demand due to the pandemic, RPMC has expanded the daily hours of operation and added weekend appointments. In addition, we stood up a mobile MRI unit, as approved.

- **What EHR system does your organization use and how does that impact your ability to measure wait times?**

We use Cerner PowerChart. Medical Record data is limited in its ability to automate tracking of the 3rd next available metric; however, it more easily supports tracking and reporting of scheduling lag times. Our system has not been configured to capture referral date for clinic appointments, so we are unable to report on the clinic referrals lag time requested; however, we do capture and can report on this for imaging procedures, if ordered electronically.

Processes:

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

Each specialty clinic manages the scheduling of their appointments. Our imaging appointments are managed through a centralized scheduling team.

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

For clinics, external referrals are received via paper or fax only. Appointment requests are triaged for acuity and scheduled based on clinical guidelines, as well as accommodating patient schedules. Clinic staff contact the patient to schedule appointments. Because each clinic manages their scheduling independently, they each employ a varied process for referral tracking (i.e., logs, filing, etc.), and all referrals are scanned to the medical record.

For imaging, referrals are received electronically or via paper or fax. They are verified for Medical Necessity (if needed), and sent to Prior Authorization for review/ authorization, as required. After authorization, they return to scheduling who reaches out to the patient to schedule. Triage is based on the status that the provider places on the order (i.e., Stat = same day/next day (whenever possible), Urgent = 3 to 5 days, and all others are next available appointments that work for the patient's schedule.) Referrals are scanned into the patient's electronic medical record at the time the patient is scheduled to avoid loss.

Recommendations:

- **What metrics (qualitative and quantitative) would you suggest using to track and report wait times?**

The lag time metrics in this request are directionally aligned with the 3rd next available appointments metric but are easier to report and are a better representation of when patients are actually seen.

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

The metrics are best viewed through the lens that all clinics/ imaging requests are triaged for acuity and scheduled based on clinical guidelines, as well as accommodating patient schedules, which will result in natural variation and patterns in the lag times unique to that service/ specialty. The variation in service offerings at each clinic across the state will make comparison difficult.

Data:

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

An automated search of all RRMC social media platforms from July 2021 to July 2022 did not return any comments referencing "wait time," "waiting" or "delay." We also reviewed comments from our patient satisfaction surveys and only found "wait time" responses in reference to length of time patients spent in clinic waiting rooms before seeing a clinician.

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

RRMC reviews our Press Ganey patient satisfaction surveys regularly, which includes 2 questions specifically focused on access to appointments.

Patient Satisfaction Survey Questions, YTD FY22 (Oct - June)	Top Box Score
When you made this appointment for care you needed right away , did you get this appointment as soon as you thought you needed it? (Yes/ No)	85.48
When you made this appointment for a check-up or routine care , did you get this appointment as soon as you thought you needed it? (Yes/ No)	94.72

Top Box Score = % of survey respondents to the question who answered with the most positive rating.

FY 2023 SUPPLEMENTAL DATA MONITORING

1. Market Share Report

Exhibit 1 summarizes the change in market share for key service lines as reported by the Vermont Uniform Hospital Discharge Data System (VUHDDS), the state’s hospital discharge database. Market share is defined as the percentage of service line volume from local residents (within a hospital’s service area) versus nonlocal residents (outside a hospital’s service area). Market share has been disaggregated by primary payer and spans from FY 2017 Q1 to FY 2021 Q4.

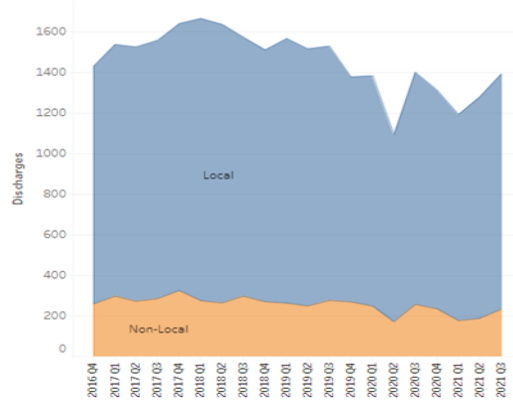
Link to Exhibit 1 (Market Share Report): <https://gmcboard.vermont.gov/hospital-market-vahhs-nso>

Questions for Response

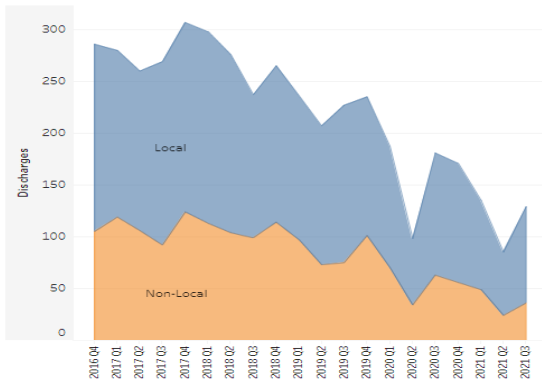
1. Does Exhibit 1 reflect material changes in your Net Patient Revenue (NPR) actuals over this time period?

There has not been a material change in Rutland’s local market share. For inpatient care 90% of our volume is derived from local residents, this has been consistent over time. There has been a slight decline in discharges over time which is the result of a change in payment methodology for orthopedic major joint procedures that were moved to an outpatient service.

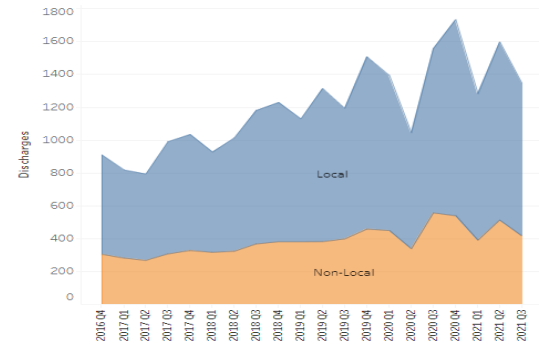
Inpatient Discharges for All Services



Inpatient Discharges for ORTHOPEDICS Services

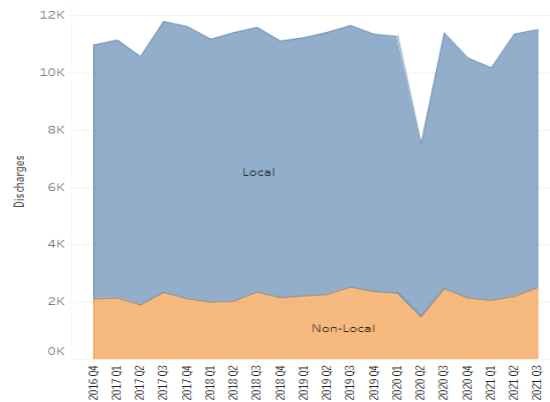


Outpatient Discharges for Musculoskeletal Services



For outpatient care roughly 87% of our revenue is the result of treating local residents, like inpatient care outpatient market share has not changed.

Outpatient Discharges for All Services



2. If not, explain how Exhibit 1 distorts or omits components of NPR?

Any change in net patient service revenue is related to changes in charges and not necessarily changes in market share.

2. Reimbursement Analysis

Exhibit 2 summarizes the volume, Medicare-allowable costs, and payments for hospital inpatient and outpatient services. Originally, the GMCB planned to update the analysis to use FY 2020 data. The effects of the COVID-19 global pandemic distorted the results substantially. In lieu of requesting a response to such an unrepresentative timepoint, the GMCB is using the same data set from its initial study performed by the Burns & Associates Division of Health Management Associates. To increase volume, the GMCB grouped data for fiscal years 2017, 2018, and 2019.

The GMCB understands that looking at data prior to the pandemic may have significant limitations. However, the GMCB also believes that it can serve as a helpful means of validating data and methodology as its monitoring evolves.

The GMCB plans to update the analysis through FY 2021 in time for the August hearings.

Link to Exhibit 2 Summary:

T:\Oracle_EPBCS\Fiscal 2023 Budget\GMCB Submission\Exhibit 2 Supplemental Data Reporting FY23.pdf

Questions for Response

1. 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.

As reported: Rutland Medicare allowable cost per service is above the reference range for deliveries and mental health services.

Inpatient

Inpatient Deliveries: Our delivery payer mix is 50% Medicaid and 50% commercial. Delivery Services at Rutland Regional Medical Center are above reference range due to fixed costs for core staffing in the Labor and Delivery Service areas.

Inpatient Mental Health: Psychiatric services at Rutland Regional include a 6 bed Intensive Care Psychiatric unit designed for voluntary and involuntary admissions. This unit is operated in collaboration with the State of VT and has long length of stay due to the severity of illness and limited post-acute stepdown placement options. Total staffing costs are higher for the psychiatric patient population.

Outpatient

Case Mix Adjusted Medicare Allowable Cost per Service

Above Reference Range

Urology: RRMC provides comprehensive testing and treatment services in the provider based Mid-Vermont Urology clinic along with broad range of urology OP surgical services in this service category.

Case Mix Adjusted Payment to Medicare Allowable Cost Ratio

Below Reference Range

Urology: The urology testing and treatment services include drug therapies and surgical service charges including supplies that are not reimbursed to cover associated costs.

Outpatient Cardiac Procedures: RRMC provides comprehensive cardiac testing in the provider-based Rutland Heart Center clinic.

Case Mix Adjusted Medicare Allowable Cost per Service

Above Reference Range

ED Visits: RRMC ED services provided to Medicare patients includes testing and services associated with severity of illness, comorbidities, and related supportive care for the next care setting.

2. Are there any errors in the data as shown? Cite your own data where possible.

While we have not cited any errors in the data, we have also not evaluated the data in detail nor validated it against our own data sets.

3. Demographic Report

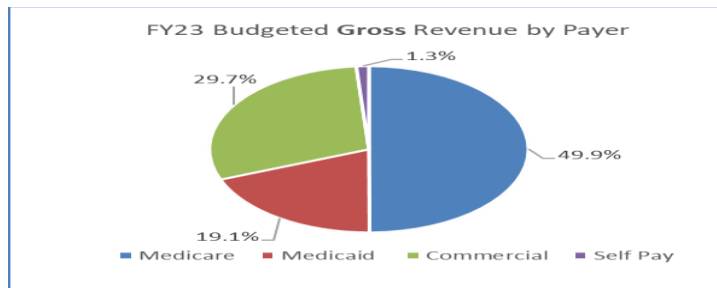
Exhibit 3 summarizes demographic changes per hospital service area. The GMCB had originally planned to use 2020 Census data, but it turned to American Community Survey Five-Year Estimates because high resolution Census data is not yet available. In addition, Annual Deprivation Index (ADI) averages and Rural Urban Commuting Area (RUCA) code modes have been calculated for each hospital service area. All methods are outlined in the 'Notes' tab of the spreadsheet. The GMCB will adopt Census 2020 data as it becomes available.

Link to Exhibit 3:

T:\Oracle_EPBCS\Fiscal 2023 Budget\GMCB Submission\Exhibit 3 Supplemental Data Reporting FY23.xlsx

Questions for Response

1. How does the current makeup of your service area affect your budget assumptions planning? RPMC's patient demographics does impact our budget assumptions and need for rate increases. As referenced below, 69% of our revenue base is generated from patients who are enrolled in the Medicare and Medicaid program. Medicare and Medicaid reimbursement is based on fixed payment methodologies that are not linked to inflation or the actual cost of care, the result is that commercial payer assume more of the burden of health care costs – this is referred to as the “cost shift.” Based on our 2021 Cost Report, combined the reimbursement from Medicare and Medicaid was \$53 million less than the cost of providing the care.



Based on the population statistics that were provided as part of the supplemental information we see an increase on the percent of our population with disabilities with the data indicating an increase of 5.4% for one disability and 11% for disabilities. This information is directionally aligned with the acuity of the patients that we are treating in our facility, demonstrated in both our Emergency Room and Intensive Care Unit.

Additionally, we do see that our community continues to age which supports the fact that we continue to see half of our volume related to Medicare. As of 2019, 21% of our service area was 65 years of age or older, this represented a 20% growth from 2014.

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

We believe that the most significant impact from other service areas is not necessarily related to population characteristics but rather to access to care. When access issues are prevalent in other service areas, we see migration of patients seeking services. Smaller hospitals do not have the scale or financial resources to provide access to many specialty services. This access problem has been exacerbated by the pandemic, when staffing constraints have caused hospitals to go on diversion and otherwise reduce bed capacity. In addition, the tertiary care hospitals are experiencing capacity constraints which is resulting in increasing delays in accepting patient transfers, some of which are now coming to Rutland Regional. Due to these critical needs, the Rutland Regional Board of Directors and Management feels a responsibility to ensure access by paying traveling nurses and providing costly recruitment and retention incentives to ensure access to care.