Northeastern Vermont Regional Hospital
Response to Health Care Advocate Pre-Hearing Questions- Fiscal Year 2018 Hospital Budget Review
August 11, 2017

1. **What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?**
   Response: NVRH plans to participate in payment reform initiatives in 2018 by continuing our participation in the Community Health Accountable Care (CHAC) Accountable Care Organization (ACO.)
   a. **What steps will the hospital take to meet these goals?**
      Response: #1a. NVRH is also hoping the state considers more forwarding thinking and innovative payment reform options; such as the blending or braiding of funding sources (such as Medicaid) to eliminate funding silos and create more flexibility and encourage cross-sector collaboration among community partners and agencies. Braiding and blending models of funding better address the root causes of poor health, the socioeconomic determinants of health, and help build a seamless system of care for the most vulnerable Vermonters.
   b. **Please describe the reasons why the hospital has chosen not to participate in the risk- based Accountable Care Organization payment models offered to date. If the decision was informed by financial modelling, please provide the model specification, model inputs and results**.
      Response: NVRH chose not to participate in the Next Gen Risk-Based program during fiscal year 2018. Several factors led us to make that decision. First, NVRH wanted to align its strategy with that of Northern Counties Health Care, another significant primary care organization in our community. NCHC also elected to not have a risk-bearing contract during 2018. Also, at the time our budget was prepared, financial-modeling data was not available to allow us to make an informed decision to take on risk. Lastly, one significant question remained unanswered: Would NVRH maintain its Critical Access Hospital (CAH) status if we joined the Next Gen Risk-Based program?
   c. **Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:**
      Response: NVRH does not participate in any capitated payment agreements directly with insurers. Therefore questions c.(i) – c.(iii) are not applicable.
      i. **Whether the capitated payments save the insurer money compared to fee for service payments;**
      ii. **Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average; and**
      iii. **How the hospital ensures that patients continue to receive appropriate services under capitated payments**.

2. **Please describe the financial incentives that the hospital currently includes in provider, coder, and other personnel salaries and/or contracts.**
   Response: Financial incentives apply only to provider contracts. Incentives are tied to productivity (e.g. RVUs above a target amount), improved patient experience (e.g. improved door-to-doc time in the ED) and patient satisfaction (e.g. improved Press Ganey scores)
   a. **How has the use of incentives by the hospital changed over time?**
      Response: Earlier financial incentives at NVRH were based only on productivity.

3. **Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?**
   Response: No one at NVRH receives any benefits for using specific pharmaceuticals. Therefore, 3.(a) is not applicable
   a. **Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.**

4. **With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models**.

a. **Do you commit to implementing shared decision-making throughout your hospital system in 2018?**
Response: Shared decision making is practiced every day. Providers use the principles of informed consent for any procedure or treatment. We have tablets with informative videos to explain DNR/DNI decisions. Our Care Managers and Chaplain offer help with Advanced Directives and can Notarize and file these with the registry. Our goal is to have every patient have an Advanced Directive on file

b. **Please describe your plan for doing so and how you will measure the plan's implementation progress.**
Response: We started with an effort to get all NVRH employees to have an Advanced Directive on file. To date we have about 40% of the employees on board. We set as an expectation that Code Status must be discussed with every inpatient. For those patients that are struggling with these decisions we provide help with their Advanced directive paperwork. For those patients struggling with a chronic illness we have a very active Palliative Care service and provide a Palliative Care consultation. Our Palliative Care consults are tracked closely and have grown in number year by year.

5. **What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement**.
Response: We have participated and implemented the principles of Choosing Wisely since its inception in 2012. The concepts of Choosing Wisely have been introduced to providers through Grand Rounds presentations, posters and literature, and in Order Set development. We have tried to integrate Choosing Wisely principles into our everyday clinical activities. We try to help patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Examples include:
1. We avoid feeding tubes in patients with advanced dementia or terminal illnesses
2. We try not to start antibiotics for asymptomatic bactiuria
3. We avoid neuroleptic medications in the elderly with symptoms of dementia
4. We do not routinely prescribe lipid lowering medications in patients with a limited life expectancy
5. We avoid indwelling urinary catheters for patients with incontinence
6. We avoid physical restraints in hospitalized patients and have fail-safe order sets that require re-evaluation frequently if used

We do not have a research department or data management capacity to measure before and after effects of these initiatives but are able to, anecdotally, observe improvement through patient satisfaction scores and comments. We are tracking antibiotic usage by provider and have seen some changes in prescribing patterns. In 2016 we began an Antibiotic Stewardship Program to more effectively use antibiotics in the inpatient setting. We have had a Grand Rounds with Dr. Marsh, an Infectious Disease specialist from Dartmouth-Hitchcock Medical Center to discuss the initiative. We began a process of justifying and tabulating the use of three categories of antibiotic, Quinolones, Vancomycin, and Carbipenums, in an effort to curb indiscriminate use. We have an Antibiotic Stewardship Committee that meets regularly to discuss other educational and monitoring initiatives that will improve antibiotic usage at NVRH.

6. **Please provide copies of your financial assistance policy, application, and plain language summary 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 2017 (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 by reason for denial**.

Response: Copies of NVRH's financial assistance policy, application and plain language summary are attached. These documents are available on the NVRH website, at our physician practice offices, the Access Department, Community Connections office as well as laboratory, diagnostic imaging and day surgery waiting rooms. NVRH did not start tracking the number of patient assistance applications until 2016. The following tables provide responses to 6.(i) – (iv). NOTE: Our patient assistance policy changed in October 2016. The changes benefited patients by increasing the qualifying income levels and increasing the available write-off percentages. Only patients with incomes above the qualifying level were denied patient assistance.

Fiscal 2016	Number Of People		Fiscal 2017 @7/31/17	Number of People
Total Applications	1,273		Total Applications	841
100% write off	891		100% write off	506
75%	170		85%	105
50%	116		70%	109
25%	76		57%	51
			47%	36
Exceeded Income Limits	26		Exceeded Income Limits	34

7. **As a nonprofit with a duty to benefit the community, how does the hospital ensure that its commercial rates are in the best interest of consumers? Please provide specific metric(s) that the hospital uses to determine this. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date)**.

   Response: Our strategy begins with maintaining low charges for services provided in our physician offices in order to minimize barriers to patients accessing primary care providers. The second part of our strategy is to establish rates for hospital services at the lowest possible level while covering the cost shift created by Medicare, Medicaid, DSH/Provider tax and uncompensated care shortfalls. This strategy helps assure NVRH's financial health so that we can remain viable health care provider and meet the needs of the community.

   We review comparative charge data available on the GMCB website as a rough guide to appropriateness of charges. Because our payer mix is generally unfavorable compared to other VT hospitals, NVRH has a large cost-shift to overcome and over a smaller commercial revenue base. As a result, our charges tend to be at or above the median. We do not use other financial or quantitative metrics to review appropriateness of charges.

8. **We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how does the hospital ensure that the prices of its services are set appropriately?**
   a. **What factors are considered in setting prices?**
   b. **What financial or quantitative metrics does the hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).**

   Response: Our response to Question 7 regarding pricing strategy for physician services applies to Questions 8a. and 8b. We do not otherwise charge extra for services to fund core services.

9. **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 (2017 budget and projected) and 2018 (budget).**

   Response: NVRH does not calculate a case-mix index. The number of discharges (admissions) and cost per adjusted discharge (admission) is presented in the following table:

Fiscal Year	FY 2014A	FY 2015A	FY 2016A	FY 2017B	FY2017P	FY 2018B
Acute Admissions	1,199	1,233	1,367	1,329	1,315	1,340
Adjusted Acute Admissions	5,463	5,331	6,561	6,559	6,442	6,506
Cost Per Admission	11,900	12,263	10,947	10,903	11,794	12,217