Responses to Questions from the Office of the Health Care Advocate
Regarding Northwestern Medical Center's Proposed FY'17 Budget

Question 1. If you included a rebasing in your proposed budget, why do you believe the Green Mountain Care Board should agree to rebase your budget? How do you plan to contain your growth going forward?

Answer: We believe rebasing is an important component of allowing our organization to continue to provide access to the appropriate care locally. As presented as part of our budget hearing with the Green Mountain Care Board ("GMCB"), we have experienced relatively flat growth in hospital net patient revenues over the past five years at 1.1% per year, while over the same time period physician practice net patient revenue growth has averaged 22.3% per year. Going forward, we will continue to grow our net patient revenues within the parameters established by the GMCB, which may include exceptions such as physician transfers.

Question 2. What is your expected All-Payer and/or Medicare case mix index for FY17?

Answer: We only budget case mix for Medicare and that figure is 1.3100.

Question 2a. Please also provide your case mix index for FY14 (actual), FY15 (actual) and FY16 (budget and projected) along with any drivers (e.g. demographic shifts, product line additions, payer mix changes, etc.) that explain increases or decreases over time.

Answer:

- FY14 actual – 1.3805
- FY15 actual – 1.4042
- FY16 budgeted – 1.3200
- FY16 projected – 1.3696

We have not experienced any significant changes in our demographics, product lines, or payer mix that would result in notable increases or decreases from one year to another. As noted above, these case mix index figures are strictly for our Medicare inpatients.

Question 2b. Please explain the basis for anticipated changes to your case mix index going forward from FY16, if any.

Answer: We have consistently budgeted a Medicare case mix between 1.3 and 1.4 based on historical actuals. This figure can be difficult to predict, and can swing largely for a small organization based on the compliment of physicians on staff.

Question 3. Please explain the basis of any anticipated changes in your payer mix for FY17. What are the changes you expect to see going forward?

Answer: We are budgeting payer mix to be consistent with FY16 projected, we do not typically see large swings in payer mix. The only trend we are seeing at the moment is an increase in Medicaid, both due to Medicaid expansion and the addition of our pediatric practice.

Question 4. As a nonprofit with a duty to benefit your community, please explain any policies your hospital has, if any, to put a reasonable cap on executive pay and on the percentage of your overall budget that is made up of administrative costs.

Answer: Setting executive compensation is a very important part of the role of the hospital's board of directors. Each year the board gathers market data to ensure that the executive compensation set is within the range of compensation commensurate with the role and responsibility of the executive and consistent with fair market compensation for the size and scope of the organization. We do not apply a cap or percent of operating budget that gets applied to administrative costs. We consider NMC to be a lean organization from an administrative perspective.

Question 5. If you have varied your commercial rate increases by program or service, how do you determine these increases? Are they based on projected cost increases by program or service or based on something else?

Answer: We have varied our rate increases by program or service in recent years. We have also done across the board increases in the past. We apply commercial rate increases strategically to stay competitive and to ensure we meet the needs of our community partners. If we implement a commercial rate increase in FY17, we plan to apply it to hospital services only. We would not apply it to physician services as they are paid on a fee schedule and increasing the rate would not impact net patient revenue.

Question 6. What is your margin target, and how was it determined?

Answer: This has been addressed as part of the budget narrative and presentation (question #4).

Question 6a. Is this a long-range target for your hospital?

Answer: Yes – a 3% operating margin per year is a long-range target for our hospital and was addressed as part of the budget narrative and presentation (GMCB Question 4).

Question 7. Please describe how your budget process would differ if a 3- or 5- year net patient revenue cap were used rather than a yearly cap.

Answer: We do not see any significant differences at this time. We would operate within the guidelines established by the GMCB.

Question 8. What is your budgeted amount for Medicaid underpayment for FY17?

Answer: The Medicaid underpayment is not calculated as part of the budget process. Per Schedule H of our FY15 Form 990, our total Medicaid underpayment was $7,232,693. We anticipate that the amounts

for FY16 and FY17 will be similar. However, DVHA is currently in the process of implementing significant reimbursement changes for FY17. These changes may result in decreased reimbursement to our organization of approximately $972,000.

Question 9. What is the extent of your Choosing Wisely initiative(s), if any?

Answer: While we haven't formally adopted Choosing Wisely as a hospital program, our organization is very focused on reducing waste and improving quality patient outcomes. We invested in LEAN as a methodology and have identified numerous projects that are focused on cost savings, which is built into our strategic plan.

Question 9a. Please describe the initiative(s) and how you have chosen which departments participate.

Answer: Several examples include: Antibiotic Stewardship (reducing un-necessary use of antibiotics and following best practice guidelines) as outlined by the Center for Disease Control; being championed by our Medical Director of our Hospitalist Service. In addition, we have worked with our Emergency Department physicians to identify their ordering/utilization patterns for ancillary services such as Diagnostic imaging (CT scans, MRI) as well as Laboratory tests. We do comparative analysis and share data transparently to discuss opportunities to make change without compromising care outcomes. We have been able to better align our care protocols and reduce variation in practice in the ED as a result. We have also identified our top DRG's and are performing detailed cost analysis, by physician/provider to better understand the cost of inpatient care. We are working with our Hospitalists to align care protocols and reduce variation in practice that can be costly. In our OR's we are identifying areas of cost saving opportunity and have re-negotiated our orthopaedic implant contracts for a total of $340k. We understand the importance of reducing costs without impacting the quality of care and ultimately, these savings are passed on to our patients and community. We will continue to focus on these efforts in our FY17 operating plan.

Question 9b. Which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement?

Answer: The OR projects have reduced waste and reduced costs. We identified $340k in implant savings and have identified another $45k of supply cost reductions by adjusting preference cards and bundling tray contents, and reducing the number of trays/supplies opened during specific surgical cases.

Question 10. Please explain how the federal regulations on nonprofit hospital financial assistance policies and billing practices that go into effect on October 1, 2016 affect your budget proposal for FY17 as compared to FY16.

Answer: Our existing financial assistance policies are compliant with the practices that go into effect on 10/1/16 so we anticipate no budget impact to FY17 as a result.

Question 10a. Include how you anticipate the regulations affecting your bad debt and charity care.

Answer: N/A (see above)

Question 10b. Which charges did you base your financial assistance discounts upon in FY16?

Answer: Total gross charges

Question 11. *For all community benefits that you listed on your Form 990 Schedule H, what is the dollar amount you are budgeting for each benefit by year (FY14 Actual, FY15 Actual, FY16 Budget, FY16 Projection, and FY17 Budget)?

Answer: We do not explicitly budget for community benefits that get listed on Form 990 Schedule H. Please see below for historical results.

FY14 Actual – $7,883,556

FY15 Actual – $10,087,338

FY16 Budget – N/A

FY16 Projection – Not available at this time

FY17 Budget – N/A

Question 12. *What is your current level of community benefit as a percentage of revenues?

Answer: IRS Form 990 calculates community benefit as a % of expense. Our FY15 community benefit as a % of expense was 10.46%. It would be 11.11% if calculated on net patient revenues.

Question 12a. *What percentage level are you willing to commit to on an ongoing basis?

Answer: As discussed at the GMCB budget hearing, we believe our future percentage will be similar to that in recent years.

Question 12b. *Please provide a detailed breakdown of the programs and other components you include in your community benefit calculation.

Answer: The major program and components are as follows:

- Financial assistance at cost
- Medicaid underpayments
- Other subsidized health services
- Cash and in-kind contributions

Question 13. How does the money you plan to spend on community benefit align with the top five issues identified in your most recent Community Health Needs Assessment (CHNA)? If your assessment of your top five issues has changed since your last Community Health Needs Assessment, please explain the change as part of your answer.

Answer: As discussed as part of our GMCB budget presentation, we use our Community Health Needs Assessment ("CHNA") to guide our daily work and our future strategic planning. While we do not attempt to specifically assign community benefit dollars to CHNA priorities, we do feel that they are aligned. For example, one of the top five issues identified in our most recent CHNA is mental health and substance abuse. We address this issue through our substance abuse and chronic pain practice, Northwestern Comprehensive Pain. Our FY17 budget includes investments to grow this practice, which will result in additional Medicaid underpayments that will appear on Schedule H of the Form 990 as a community benefit. In addition, as we look at our investments in our community, which may or may not be formally reported in our 990 summary of community benefit to date, we have invested significantly in primary prevention efforts and secondary prevention (RiseVT, etc) that tie directly to obesity and indirectly to other priorities as it seeks to improve health, enhance the quality of life, and reduce long-term healthcare costs in our community.

Question 13a. Are there needs identified in your CHNA that you would like to address, but feel that additional cooperation by outside entities is required for an effective solution?

Answer: Absolutely, as every one of our top priorities are truly community priorities and it will take all of us: the hospital, the municipalities, social agencies, schools, law enforcement, churches, civic groups, etc., to truly change our culture around each of these and the resulting healthcare manifestations. Fortunately, northwestern Vermont is a collaborative community by nature and we are part of numerous formal and informal collaborations at varying levels working towards improvements. For example, we look forward to collaborating with the operators of the new HUB in Franklin County. We look forward to engaging the entire community in alignment with the socio-ecological model for behavior change and the EPODE methodology to make a long-term reduction in childhood obesity. We are currently working, through a grant from Susan G. Komen, with local employers to strengthen participation in mammography to boost the early detection of breast cancer and are excited to expand these efforts.

Question 14. Do you anticipate needing to replace your electronic health records system in the next five years?

Answer: No, we are currently in the process of a major upgrade to our electronic health records system that will go live in March of 2017. We will also be converging multiple EMRs into one system in our ambulatory care (physician practices) settings. This process will take us from supporting three EMRs to one that will provide better coordination of care at a lower cost with fewer interfaces and systems to support. (Joel update 8/22/16)

Question 15. Do you use any of the services offered by VITL (Vermont Information Technology Leaders)?

Answer: Yes

Question 15a. If so, which services?

Answer: We use the following services:

- HL7 routing service
- VITL Direct: CCD exchange service (including HISP Medicity)
- VITL Access: Provider portal
- Meaningful Use reporting and preparation assistance

Question 15b. To what extent are VITL's services integrated into the hospital's care delivery?

Answer: VITL's services are highly integrated into our hospital's care delivery. All outbound results for Lab, Blood Bank, and Microbiology currently flow through VITL's system. We are currently testing outbound results for Pathology, Radiology, and Transcription as well. NMC's Care Management Team, Hospitalists and Emergency Department providers have been trained and use VITL Access to review medical record information for patients that have been treated at other facilities.

Question 15c. Has the hospital experienced any cost savings or quality improvement from VITL's services?

Answer: Yes, direct results have reduced paper and time and increase satisfaction. We did not have to purchase our own HISP subscription because we are able to use VITL's.

Question 15d. Do VITL's services compliment your other health information technology initiatives? If so, how?

Answer: NMC was recently named one of the American Hospital Associations "Most Wired" Hospitals based on the strength and direction of our technology program. In our completed survey for this recognition we highlighted how we use and partner with VITL. We used VITL's services to qualify for Meaningful Use certifications through planning services as well as to meet criteria for care coordination with VITL Direct.

Question 16. *What percent of your employed primary care providers are participating in the Hub and Spoke program?

Answer: 3 out of 4 – 75% of our employed primary care physicians are participating. NMC recently lost two primary care providers who both seeing suboxone patients. At this time, 83% of our primary care physicians were participating.

Question 16a. *What is the average number of substance abuse patients that those providers treat?

Answer: Our full time primary care physician at Northwestern Primary Care (NPC) has approximately 41 patients with a limit of 100. Given the current primary care vacancies at NPC, he is unable to take new suboxone patients. Our two physicians at our Georgia Health Center (GHC) location are part time and unable to take full 100 patient panels. One provider is currently seeing 23 patients and the second provider is currently prescribing for 17 patients. Both provide coverage for each other when out of office to ensure sufficient coverage for each open prescription.

Question 16b. *How many additional providers would be required to fully meet your community's needs in a reasonable amount of time? Please take into consideration any waitlists for treatment.

Answer: NMC's Comprehensive Pain Clinic is staffed with 2 full time addiction medicine providers. In addition, we have 3 primary care providers prescribing to a limited number of suboxone patients based on their primary care panels and demand for primary care. NMC recently lost two primary care providers who were seeing suboxone patients. We've requested approval for emergency limit increases. We are awaiting a decision; however, the process is extremely delayed. We have entered into a letter of intent with an additional addiction medicine physician with an estimated start date of August, 2017. We believe 3 full time addiction medicine providers at our Comprehensive Pain Clinic will meet current demand in our area, but we are challenged to forecast exact long term needs. Our numbers indicate an upward trend of new patients. We have felt the restriction of being able to see more patients due to the panel cap at 100. Our panels are currently closed due to vacancies and our challenge to recruit the clinical staff needed to support physician panels. We are recruiting for MAT RN Coordinators and MAT Licensed Counselors.

Question 16c. *If your hospital is involved in any medication assisted treatment programs, do you have any information on your costs for these programs versus savings to your hospital?

Answer: As described above we dedicate significant resources to assisting suboxone patients with their treatment programs. The significant resources that are dedicated, in part, to this service are identified in the previous questions. The benefit that these programs provide to the hospital, in theory, is to help reduce and or prevent these patients from ending up in either or Emergency Department or ultimately being admitted. It is difficult to estimate how many patients may end up seeking out other services if the medication assisted treatment options were not available.

Question 17. *Please explain to what extent mental health patients presenting at your Emergency Department impacts your budget?

Answer: Our Emergency Department (ED) as many others within the state ends up being the easiest path for those with behavioral health needs to seek out care. Often we have these patients using valuable resources within our ED and in many cases they end up being admitted to our inpatient unit until appropriate alternatives are made to serve them. These patients require 1:1 nursing for the duration of their stays including 1:1 security, which implicates additional hours outside of budgeted staffing grid and overtime in most cases. We estimate that we dedicate approximately 2 full time equivalents over the course of the year to serve this population. This includes licensed nursing assistants as well as security guards that provide this 1:1 supervision. The annual cost of this is estimated at $90,000.

Question 17a. *Please explain how mental health patients are handled when they present to your Emergency Department or other triage location, including a description of any holding or isolation areas that you use, and how often you expect to use this type of area in FY17.

Answer: Our Emergency Department triages and holds an average of 2-4 mental health/substance abuse/overdose patients per week. On average half of these patients are admitted; similar to the examples we cited above in Question 17. We expect this trend will increase in FY17 as we see our community mental health and substance abuse issues escalating, which were highlighted in our Community Needs Assessment. We triage every patient and consult with our community partner, Northwest Counseling and Support Services (NCSS) to provide us with crisis and /or psychiatric team support in the ED and the inpatient units. For every patient that is boarded in our ED, we offer the patient a private room and depending on the severity of their mental illness or level of violent behaviors, we will provide one on one security. We also make every attempt to provide primary nursing care which creates a consistent approach for those patients needing structured care environments . We have budgeted to embark on ED renovations in FY18, which will include a safe room for patients in crisis. If the patient is admitted to our inpatient medical surgical unit, we offer them a private room close to the nursing station and ensure there is primary nursing and security watches as warranted. In the past six months, we have provided over 2000 hours (1FTE) of one to one 'sitter ' and/or security coverage for our mental health/substance abuse patients or gero psych patients. We expect this to annualize to 2 FTE's of support by the end of the FY, consistent with last year's data.

Question 17b. *How do you train your security staff, contracted or in-house, on handling situations involving people experiencing mental health crisis? If some security staff members have been trained but not all, please explain which ones and why.

Answer: All of our ED and Security staff have had MOAB and MANDT training. MOAB training presents principles, techniques, and skills for recognizing, reducing, and managing violent and aggressive behavior. MANDT training is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. We require these trainings to be updated annually by staff. Our inpatient staff has received MOAB training and are in process with MANDT training.