NORTHEASTERN VERMONT REGIONAL HOSPITAL

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FY 2017 BUDGET NARRATIVE

On June 29, 2016 the Northeastern Vermont Regional Hospital (NVRH) Board of Trustees approved the operating and capital budgets for fiscal year 2017. The approved budgets have been submitted to the Green Mountain Care Board in their prescribed worksheets. This narrative describes our Health Reform Programs and Services and provides information on key elements of the FY 2017 with an emphasis on factors are driving net patient revenue changes from FY 2016 to FY 2017.

EXECUTIVE SUMMARY:

The following summary highlights key elements of the FY 2017 operating and capital budgets:

- Operating margin of 1.9%
- Average charge increase of 3.75%
- Budget to budget volume increase of 3%
- Budget to budget net revenue growth of 4.8%
- FY2016 projected to FY 2017 budget net revenue growth of 3.1%
- New positions to improve access to essential services
- Funding for both new and ongoing health care reform related activities
- Capital budget of $2,726,000, excluding potential Certificate of Need project

HEALTH CARE REFORM PROGRAMS AND SERVICES INCLUDED IN FY 2017 BUDGET

Health care reform continues to evolve rapidly in the state of Vermont. And NVRH continues to be at the forefront of reforming health care in our service area. Our most recent effort, which was two years in development, is the Cal-Essex Accountable Health Care Community (CAHC.) The FY 2017 operating budget includes funding for CAHC as well as funding for these health reform programs and services:

- Emergency Department Care Manager
- Emergency Department Mental Health Specialist
- Community Connections Team
- Low Income Prescription Drug Program
- Ambulatory Pharmacist
- Palliative Care Services
- Community Health projects that address Community Health Needs Assessment priorities

The following section provides additional information on each of the above services.

Cal-Essex Accountable Health Care Community:

The CAL-ESSEX Accountable Health Community (CAHC) was organized nearly two years ago, with a goal of using the collective impact model to drive community-wide outcomes in the NEK. It was founded and is led by the CEO of the Northeastern Vermont Regional Hospital (NVRH). The CAHC leadership group includes NVRH; Northern Counties Health Care (NCHC), the area's federally qualified health center and home health and hospice provider; Rural Edge, the regional

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low-income housing provider and developer; Northeast Kingdom Community Action (NEKCA); the Northeast Kingdom Council on Aging; Northeast Kingdom Human Services (NKHS), the regional nonprofit mental health agency; and the Vermont Foodbank. There are also strong connections with and monthly participation from the Vermont's Agency of Human Services through the Agency's regional directors, programs of the Department of Children and Families, the Vermont Department of Health, Green Mountain United Way, and many others – including school district leaders and regional planning and economic development agencies.

An aspirational model, an Accountable Health Community (AHC) is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An AHC supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

CAHC covers Caledonia County and the southern portion of Essex County, essentially the NVRH service area. This region is currently supported and served by existing Vermont Blueprint for Health Patient-Centered Medical Homes and Community Health Teams. Many of the members of the CAHC are members of one of the current Vermont ACO's.

Over the past year, the CAHC team has developed the groundwork for collaboration, identifying the necessary components to building a holistic strategy for addressing the significant problems in the region. The CAHC provides the structure for plan development and implementation leading to change in the dynamics of care provision throughout the region by moving from separated and disconnected tactics to unified and fully connected approaches to meeting the region's chronically unmet needs.

Regional leaders agree that, at this time, mental health needs, challenges related to misuse of substances, and the plague of obesity are the top health priorities in the CAHC community. Project collaborators fully understand that none of these problems arise in isolation from others such as a severe shortage of affordable housing, significant food insecurity, and lack of sufficient transportation to needed services. In addition, all of these challenges are exacerbated and made substantially more difficult to address in an environment of pervasive poverty.

A core element of this work is to "work smart" by breaking down the multiple organizational silos at work between and sometimes within the agencies trying to solve some of the more prevalent community needs. Through our collective and as yet primarily individual efforts, there is an evolving foundation for beginning discussion on how best to deploy scarce resources most effectively regardless of the location of those resources.

To our knowledge, nowhere have executive leaders of the major providers of health and social services been more prepared to accept the challenge of true complete service integration by breaking these silos apart than currently exists in the Northeast Kingdom. If, through the formation of CAHC, we can collectively establish an organizational foundation that will promote and facilitate the evolution of continuous dissipation of possessive action on behalf of service integration, we will have developed a "game plan" that is both profound in impact and replicable in other rural

communities throughout the country.

A goal of this initiative is to ensure that the CAHC's results make a real difference in the NEK and help inform work that will happen in other parts of the state and country. The Center for Rural Studies (UVM) has been contracted as data partners to look at the compatibility of our data plan, but also to provide us with ideas and options that may be less costly and less complex.

Mission Statement

Our Accountable Health Community is committed to our shared goal to improve the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services with an emphasis on reducing poverty in our region.

Priorities/Outcomes

We want our population to be

- Financially secure
- Physically healthy
- Mentally healthy
- Well-nourished
- Well-housed

Emergency Department Care Manager:

The latest in our continuous efforts to reduce avoidable use of the Emergency Department involves placing a full-time care manager to work in the emergency room. One of this person's roles is to identify emergency department patients who do not have a primary care provider, find an opening in a provider's schedule and make an appointment for those patients. This position was created in October, 2015. To date there has been an average of 400-500 contacts monthly. She has identified 1,400 patients who did not have a primary care provider and found a provider for 1,000 of those patients. The Emergency Department Care Manager performs several other functions to help community members maintain good health at the correct level of care by providing essential support thereby decreasing the need for patients to seek care emergently at the location with the highest cost. Some of the other functions performed include:

- Referrals to community agencies – 1,200
- Palliative Care and Hospice referrals - 100
- Follow up appointments with a PCP after being seen in the ED - 700
- Call back program – 2,800 contacts
- Work with attending MDs at DHMC to set up initial appointments with local PCP as part of the discharge plan for patients returning home to our service area
- Nursing Home Placements – 35
- Dental Referrals – 280
- Transportation assistance - 150
- Advance Directives – 85
- Medication Assistance for the uninsured – 60

Community Mental Health Specialist:

NVRH's service area lacks a sufficient number of mental health workers providing outpatient mental health services. This is an identified funding gap for designated mental health agencies in the State. As a result patients needing mental health services present in our emergency department

(ED). Through our CAHC, NVRH is partnering with other local agencies to fund and hire a mental health specialist to help address the community's need for outpatient mental health services. This person will be housed in the NVRH ED, as well as sharing consultation space with our Community Connections team. The desired outcome is to more pro-actively identify patients in need of mental health services, thereby breaking the cycle of ED use and reducing repeat visits to the emergency room and inpatient admissions.

Community Connections Team:
The Community Connections Team is staffed by four Community Health Workers (CHW). Patients may access the Community Connections Team from a variety of entry points from within the Blueprint for Health Community Health Team (CHT), medical offices. or through any community partner. Some clients learn about Community Connections via word of mouth and seek services without a referral. Forty-seven percent of clients were referred to Community Connections by someone in their patient-centered medical home.

A recently completed evaluation by the Centers for Disease Control and Prevention of the Community Connections team showed that across subjects there was statistically significant improvement between clients' first encounters and most recent encounters in the areas of accessing health insurance, . In summary, the evaluation team observed the following themes from interviews with Community Connections Team clients:

- The Community Connections Team is easy to access
- CHWs are empathetic and provide a welcoming environment
- Clients experience immediate results and had regular follow-up from Community Connections Team members.
- Clients felt that they got a two-for-one experience in getting help from the Community Connections Team
- Clients felt less stressed after working with the Community Connections Team
- Meeting their basic needs went a long way in improving quality of life
- Community Connections does not "cure" people but clients have more awareness of their health issues

Prescription Medication Support for Low Income Patients
NVRH partners with a local pharmacy, Gauthier's Pharmacy in St. Johnsbury, to provide free prescription medications to patients who cannot afford them. This program is administered through Community Connections. When a patient needs a medication and cannot afford it, the staff at Community Connections makes the connection with Gauthier's Pharmacy. The patient fills the prescription at Gauthier's and Gauthier's bills the hospital with no charge to the patient.

Palliative Care Services
Palliative Care provides care coordination with healthcare providers, support for family members and caregivers, pain and symptom management, patient-centered decision making, referrals to complimentary therapies (massage, Reiki), and connections to community resources.

NVRH takes a team approach to providing palliative care services to patients with a life limiting illness. Team members include two board certified palliative medicine physicians, the patient and family, primary care and specialty providers, hospital care managers, home health, Community Connections, pharmacists, and spiritual advisors or clergy.

Referrals to Palliative Care are made by primary care or specialists, and hospitalists. The discussion about Palliative Care can also start with a Community Health Team member.

To meet the community's increasing need for Palliative Care Services, NVRH recently added provider time to expand the availability of the service.

Ambulatory Pharmacist

NVRH recently hired an ambulatory care pharmacist to become part of the inter-professional patient care teams in NVRH's existing patient-centered medical homes. Working with providers the ambulatory pharmacist focuses on medication management for ambulatory patients, coordination of care, patient advocacy, wellness and health promotion, triage and referral, patient education and self-management. The pharmacist also works to ensure safe medication use and optimize medication therapy for patients with chronic conditions including diabetes, asthma, cardiovascular disease, and renal disease. As noted by the American Society of Health-System Pharmacists briefing paper on the use of ambulatory pharmacists:

> "By assertively advancing ambulatory care practice, pharmacy will help achieve the national priorities of improving patient care, patient health, and affordability of care."

This person is another example of our commitment to achieve the triple aim goals.

Community Health Initiatives FY17

NVRH is funding a variety of community health initiatives to address our 3 identified health priorities: obesity and obesity-related chronic conditions; poverty related issues; mental health and substance abuse. These include, but are not limited to:

- Providing Bridges Out of Poverty training for community based agency staff
- Working with the St Johnsbury School District on preventing adverse childhood events through their Promise grant initiatives
- Working with community leaders to address poverty issues such as housing and living wage jobs
- Supporting training programs on mental health issues for area professionals
- Providing meeting and office space for the Kingdom Recovery Center
- Providing non-motorized user amenities for the newly created rail trail running from St Johnsbury to W. Danville
- Expanding our No Sugar Added campaign to reduce consumption of sugary drinks to a teen Audience

Health Reform Investment Request

NVRH is requesting a Health Care Reform Investment allowance of $272,000 to cover costs of new and expanding programs, which were described above. In summary these projects are:

- Cal-Essex Accountable Health Care Community
- Emergency Department Care Manager
- Community Mental Health Specialist
- Expansion of Palliative Care Program

REVIEW OF FISCAL YEAR 2017 BUDGET AND YEAR TO YEAR CHANGES

NET PATIENT REVENUE:

On a budget to budget basis net patient revenues will increase by 4.8% from 2016 to 2017. The following table summarizes the key elements that contribute to the year to year increase.

Description	Amount	Percent
FY 2016 Approved Net Revenue	$68,095,300	
Increase Utilization	2,065,900	3.0%
Increase Uncompensated Care	(165,600)	(.2)
Increase DSH Revenue	258,000	.4
Decrease Medicaid OPPS	(186,000)	(.3)
From Rate Increase	1,000,000	1.5
New Health Care Reform Programs	272,000	.4
FY 2017 Budget Net Revenue	$71,339,600	4.8%

Rates charged for services will increase by an average of 3.75%. This increase will be accomplished by raising charges for hospital services by an average of 4% and minimally increasing rates for hospital owned physician practices.

A summary of key assumptions for each of insurance category follows:

Medicare Reimbursement Assumptions

No changes to Medicare reimbursement formulas for Critical Access Hospitals are anticipated.

Medicaid Reimbursement Assumptions

The Department of Vermont Health Access implemented a new Outpatient Prospective Payment System on July 1, 2016. As a result of this change Medicaid payments to NVRH will decrease by $186,000 annually.

Commercial Insurance/Self Pay Reimbursement Assumptions

Reimbursement from commercial or private payers is budgeted based on discount rates established through contracts with these payers. No significant changes to existing negotiated contracts are anticipated.

Uncompensated Care

As a percentage of gross revenue Uncompensated Care will decline slightly.

Disproportionate Share Revenues

The Department of Vermont Health Access has determined NVRH's Disproportionate Share Revenue (DSH) for fiscal year 2017 will be $1,730,400. This represents an increase of $258,000 from fiscal year 2016.

Other Operating Revenues

Other Operating Revenues total $1,585,100. A majority of other operating revenue, $1,515,000, is for the 340B Retail Pharmacy Program.

Justification for the Net Revenue Growth
In early May, 2016 during a telephone conversation with GMCB staff NVRH provided a "heads-up" that on a budget to budget basis our net patient revenue growth would exceed the 3.4% cap. During that discussion it was also noted that NVRH would exceed its allowed FY 2016 net patient revenue amount. We followed up that conversation with a letter dated June 14, 2016 to Al Gobeille, with copies to all GMCB Board members and GMCB staff. In that letter, and below, we provide justification for the 4.8% net revenue growth and "excess" revenue for FY 2016.

A majority of the net patient revenue growth will be generated by having a third orthopedic surgeon in the group. The availability of three (3) orthopedic surgeons has greatly improved the community's access to this essential service. During the FY 2016 budget process we predicted improved access to NVRH orthopedic providers would reduce the need for patients to go to NH facilities to receive services within a reasonable period of time. Conservatively, we estimated the third orthopedic surgeon would increase FY 2016 net patient revenue by $2.9 million. During the budget review process the GMCB reduced that estimate from $2.9 million to $2.5 million. Based on year to date results the actual net revenue increase will be approximately $3.7 million. Based on discussions with members of the community, and our internal information, the revenue is not a result of increased utilization but rather from patients now spending VT health care dollars at NVRH rather than at NH hospitals. Our internal data supports what the community is telling us. Data through May, 2016 shows that referrals to NH orthopedic providers have dropped significantly since NVRH added the third provider. VHCures data to support community feedback and our internal data is not yet available (VHCures data is only available through December 31, 2014.) However, we did receive a report from GMCB staff that, using VHCures data, shows the magnitude of VT dollars that were leaving the state during the 5 year period 2010 through 2014 (for commercially-insured patients only.) During the that 5 year period over $10 million dollars was spent for orthopedic services at NH hospitals by commercially-insured patients living in NVRH's service area. Approximately 65% of the $10 million was spent at a NH Critical Access Hospital and the remaining 35% went to a NH tertiary hospital.

Our FY16 budget also included $1.5 million from additional primary care providers and the expansion of urology and pain management services. Based on our year to date results the actual additional net revenue they will generate is close to our estimate. Another factor contributing to the additional net revenue is higher inpatient and observation days. There is no discernable trend to explain the additional volume. One possible factor is the lack of available beds at DHMC. The majority (90 – 95%) of patients requiring tertiary level of care are transferred to DHMC. When beds aren't available, many of the patients remain at NVRH. However, we are unable to quantify the additional patient days that may have resulted from this situation.

Request for Net Patient Revenue Rebasing
As part of the FY 2017 budget review process we are requesting a rebasing of FY 2016 net patient revenue to the actual amount for the year rather than the amount approved by the GMCB. Currently, we are projecting the FY 2016 actual net patient revenue will be $69,210,200 or

$1,110,000 higher than the amount GMCB approved for NVRH.

This request is made to recognize that a significant increase in net patient revenue has occurred due to NVRH recapturing millions of dollars per year of lost orthopedic services revenue. This is a permanent increase in net patient revenue that should be recognized as FY 2016 will become the base year for 2017 and beyond. Assuming our request to rebase is approved, the FY 2016 to FY 2017 net patient revenue growth will be only 3.1% as shown below.

Description	Amount
FY 2017 Budgeted Net Patient Revenue	$71,339,600
FY 2016 Projected Net Patient Revenue	69,210,200
$$ Increase	2,129,400
% Increase	3.1%

OPERATING EXPENSES:

Total operating expenses are budgeted to increase by $xxxx or xxx%. The factors contributing to this increase are summarized in the table below.

Description	Amount	% Change
FY 2016 Approved Expenses	$68,696,400	
Inflation/Cost of Living Increases/Other	1,463,100	2.2%
New positions	550,000	.8
Provider Tax Increase	300,000	.4
Volume Increases	500,000	.7
FY 2017 Budgeted Expenses	$71,509,500	4.0%

The inflation/cost of living increase includes general inflation and employee wage increase of approximately 3.25%, which includes an overall increase and a mid-year market-based increase given to hospital-based registered nurses. Through our membership in the New England Alliance for Health NVRH is able to minimize inflation-related cost increases.

A nurse practitioner or physician assistant has, or will be, added to our general surgery, orthopedic, neurology and pediatric practices to support existing providers. Patients are experiencing exceedingly long wait times to access each of these four essential services. Adding the nurse practitioner or physician assistant will reduce those wait times to acceptable levels.

The Provider Tax increase is based on the most recent estimate from DVHA

Most of the volume related cost increase is related to additional orthopedic volume and occurs in the operating room and pharmacy cost centers.

REQUESTED RATE INCREASE

NVRH is requesting a rate increase of 3.75%. This increase will be accomplished by raising charges for hospital services by an average of 4% and minimally increasing rates for hospital owned physician practices.

A REVIEW OF CAPITAL INVESTMENTS FY 2016 to FY 2018:

FY 2017 Capital Budget

The FY 2016 capital budget totals $2,700,000, excluding CON projects. A new portable C-Arm at a cost of $130,000 is only capital budget item with a cost in excess of $100,000.
During fiscal year 2016 NVRH will submit a certificate of need application to replace our 12 year old fixed-trailer MRI machine, with a new in-house machine.

FY 2018 – FY 2020 Capital Budget

The FY 2018 to FY 2020 capital budget includes the following projects:

- Meditech software upgrade $768,200
- Birth Center renovations $2,000,000
- Operating Room renovation/expansion $1,750,000
- Master Facility Plan Project (TBD) $1,400,000

DEFINITION OF ALL OUPATIENT VISITS

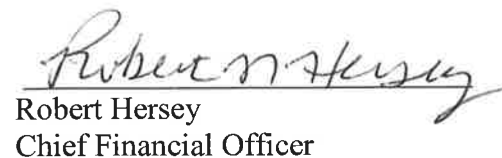
NVRH includes the following under All Outpatient Visits. Patient visits in the emergency room, outpatient surgery, diagnostic imaging, laboratory, infusion therapy unit, two physical therapy sites and respiratory care.

UPDATE TO COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENATION PLAN

NVRH completed a Community Health Needs Assessment during fiscal year 2015. The corresponding Community Needs Assessment Implementation Plan has been resubmitted.

TECHNICAL CONCERNS:

At this time, NVRH does not have any technical concerns with the Green Mountain Care Board's processes for the fiscal year 2017 budget submission.



Robert Hersey
Chief Financial Officer

CC: Paul Bengtson, CEO