TESTIMONY OF DANA KRAUS, MD
Senate HELP Subcommittee on Primary Care & Aging
"Diverting Non-urgent Emergency Room Use:
Can It Provide Better Care and Lower Cost"
May 11, 2011

I would first like to thank Chairman Sanders, Senator Paul, and members of the subcommittee for inviting me to come and give testimony about how we in my community have begun to lower ER visits, decrease healthcare costs, and improve the health of our patients.

My name is Dana Kraus. I am a board certified family physician working at the St Johnsbury Family Health Center in Vermont. The clinic is one of six Federally Qualified Health Centers run by Northern Counties Health Care (NCHC). NCHC has been operating Federally Qualified Health Centers since 1976. NCHC provides care for over 18,000 patients in three hospital catchment areas in rural northern Vermont, and also runs two dental clinics and a Home Health and Hospice Agency. As a Federally Qualified Health Center we offer a sliding scale fee program so that no one is denied care, and also a low cost prescription drug program.

Four of the six clinics are in and around the town of St Johnsbury, with a service area of 30,000 people. NCHC provides 40-50% of the primary care for this catchment region. Another 40-50% is provided by a clinic owned and run by the local hospital, a twenty-five-bed critical access hospital. Our ER currently sees on average 45 patients per day.

Chronic Care Model:
The four NCHC St Johnsbury based clinics, in collaboration with the local hospital, have been participating as a pilot site in the Vermont Blueprint for Health since 2005 (SEE ATTACHMENT 1). This initial pilot brought the Chronic Care Model (SEE ATTACHMENT 2) of care to our area, transforming our care delivery system from a reactive model designed for acute care, to a proactive model designed to improve the care of patients with chronic conditions. We have made some fundamental changes in the way that we see patients with chronic illness. All these patients are given regular follow up visits. Labs and tests are scheduled prior to the follow up visit so that they are available for review at the time of the visit. We use templates and charts embedded within our Electronic Medical Record (EMR) to remind providers of guideline-recognized goals for each chronic condition. We are able to identify those patients who are overdue for a visit, and are proactive in contacting them and bringing them back up to date with routine care. We set self-management goals with patients, and provide written care plans.

It is known that a large proportion of our health care expenditure is spent on patients with chronic conditions. Since implementing the Chronic Care Model, we have seen significant improvements in short term outcome measures of our patients with chronic illnesses. For example, our diabetics have better control of their sugars

and blood pressure, have more frequent preventive eye and foot exams, and are taking medications known to decrease complications more regularly. Under this program greater proportion or our hypertensive patients have well-controlled blood pressure, and more of them are taking aspirin, known to decrease the risk of heart attacks and strokes.

NCQA Medical Home Certification:

Late in 2008 we became one of the first two Vermont Medical Home pilot sites. All participating clinics underwent National Committee for Quality Assurance (NCQA) certification for Medical Home status and all four NCHC clinics, as well as the hospital run rural health center, qualified at the highest level (level 3). This certification indicates among other things that a clinic provides enhanced access to and continuity with a primary care provider, and has a robust electronic medical record that can be used for population management and performance feedback. A medical home also emphasizes and promotes patient self-care and referrals to community resources, and can track and coordinate care. (SEE ATTACHMENT 3). The Medical Home expands upon the concept of the Chronic Care Model by addressing preventative health maintenance, improved access, and continuous quality improvement.

The Community Health Team:

Key to our success as a high functioning Medical Home is our Community Health Team (CHT). Our CHT is made up of a hospital-based program called Community Connections, and Chronic Care Coordinators and Behavioral Health Providers that are imbedded within the clinics.

Community Connections, One-Stop Services:

The Community Connections piece has its origins back in 2002 with a grant from the Health and Human Services Bureau of Women's Health. A group of primary care providers and community resource representatives sat down to discuss how to improve the health of women in the community. What we found was that we had many existing services, but there was poor coordination and communication between the various agencies, and health care providers had trouble referring to and patients had trouble accessing the existing resources. Thus began the Women's Resource Center, which in 2006 was expanded to include men and children, and was renamed Community Connections. Care coordinators and community health workers staff Community Connections. They work to connect patients with whatever services they need. Our director loves to say that they "wrap services around the patients".

The key to Community Connections is that it provides "one stop services", so that providers and patients do not have to negotiate the complexities of existing disparate agencies. Community Connections staff work very closely with all of the existing state and private agencies so as not to duplicate resources. For example, they help patients get insurance coverage and access to affordable medications. They help patients get childcare, transportation, and respite care for elderly family members. They help patients to connect with local health education programs, such

as diabetes or asthma education, or local exercise programs. They help patients do their grocery shopping, or go with patients to their provider visits to be sure that the patient understands instructions.

Chronic Care Coordinators:
The Chronic Care Coordinator works closely with providers to identify and manage high-needs patients with chronic illness. These are the patients for example with poor control of their diabetes, asthma, or heart failure who are at high risk for expensive ER visits and hospitalizations. They meet with patients during scheduled provider visits, or separately, and do a lot of phone outreach. They help with the handoff of patients to Community Connections. They do panel management using reports pulled from the EMR to identify patients overdue for health maintenance, such as mammograms, or pneumonia vaccines, or those patients with diabetes or asthma or hypertension who are poorly controlled, at high risk of complications, or overdue for a visit.

Behavioral Health Providers:
Our Behavioral Health Specialists are counselors who work within the primary care clinics. They focus on crisis intervention, or short term counseling, in order to keep their schedules open at all times for new patients. For those patients who need long term counseling, they help them find a "good match" with a community-based counselor. Depression is known to frequently co-exist with chronic illness, and treatment of depression has been shown to improve outcomes. Now that we have easy access to a counselor, we are screening all patients for depression. Patients with depression often present to their primary care provider as well as to the ER with multiple complaints, and these complaints typically decrease significantly once the underlying depression is treated.

Behavioral Health Providers help patients with true mental illness and substance abuse, and also those patients who are having trouble motivating to care for themselves and their chronic illness. For example they help patients start exercising, begin a weight loss program, or more reliably take their medications. Such interventions lead to better disease control, which eventually means fewer complications, fewer ER visits and hospitalizations, and decreased costs.

Funding for the Community Healthy Teams (CHTs):
An important point about our CHT is that Vermont's major private insurers and Vermont Medicaid fund it as a shared resource. This is an obligation that is mandated by state law. The state has also been paying for the share of the CHT belonging to Medicare as well as for the per-patient-per-month payments to the practices for Medicare beneficiaries. Vermont was recently chosen as one of 8 states to participate in the CMS Multi-payer Advanced Primary Care Demonstration, enabling Medicare to be a part of the payment reform in the same manner. The CHT and Medical Home Clinics provide care for all patients, regardless of their insurance status.

Under the current payment system, all insurers have their own separate chronic care management programs, which often provide care via the phone from distant sites. It is our vision that the local CHTs will eventually take over much of this redundant and expensive care. We feel strongly that providing face-to-face care, by people who work in conjunction with Primacy care providers and who are intimately familiar with the local resources, culture and climate will provide more effective care. For example, rather than recommending an outdoor walking program during a typical Northern winter, our Care Coordinators know that there is a daily walking group at the Mall, several Strong Living classes for seniors, and a diabetic exercise class through the local hospital.

Evidence of Success/Data:

Recent data gathered from hospital statistics have shown a significant downward trend in both ER visits and hospitalizations in the last two years compared to the two years prior to the Medical Home Pilot. It was anticipated that the ER visit rate would be 60 visits per 1000 patients, and instead it was 40 visits per 1000 patients, a 33% decrease. Similarly, for inpatient hospital admissions, it was expected to be just below 10 admissions per 1000 patients, and instead was only 7.5 admissions per 1000 patients, a 24% decrease. (See attachment 4) The decrease in ER visits is due to both avoiding illness exacerbations that would have lead to necessary ER visits, and to decreasing non-urgent ER visits. Just in a one year period between 2008 and 2009, there was a 11.5% decrease in per member per month (PMPM) expenditures in our pilot population, based on private insurance claims data.

Evidence of Success: examples:

We have endless stories of how the chronic care team has helped our patients. Daily there are patients who get better care because they have help applying for health insurance so that they can afford preventive services, help finding a more affordable medication, help accessing a counselor for their longstanding depression, or help getting transportation to a their appointments. We anticipated that many of these interventions would improve the outcomes of patients with chronic illness and provide cost savings many years down the line. I think that even we here in our community are surprised and thrilled to see how quickly our interventions have lead to more immediate cost savings, with decreased ER visits and hospitalizations.

For example, among my patients is a 30-year-old single mother of 3 who has asthma and chronic pelvic pain, which lead to frequent ER visits. She is functionally impaired, and had great trouble affording and taking her medications. She met regularly with the CHT. She now has her medications "blister packed" at the pharmacy, and has successfully been taking birth control pills, which have taken care of her pelvic pain, and now that she is regularly taking her asthma medications she has had neither ER visits nor even acute clinic visits for her asthma. Another provider had a gentleman who visited the ER 18 times in 2010 for chest pain. Since being connected with the CHT, it was discovered that he was not able to afford his medications, and that depression was contributing to his symptoms. He now has regular care with his primary care provider, a counselor, and his cardiologist. He

also has insurance to pay for his medications, and has had only one ER visit in the last 6 months.

Addressing Non-Urgent ER visits:
There are several components of the Medical Home and Community Health Team that specifically target reduction of non-urgent ER visits. These involve 1) assigning primary care providers to those without one, 2) helping patients access existing insurance options 3) following up with ER patients to ensure that they are improving and have proper follow up 4) improving access to primary care providers 5) educating patients about appropriate ER use.

1.) Efforts to increase patients with access to a primary care provider.
A member of the CCT looks at the ER roster daily. Initially there were multiple patients each day that did not identify a primary care provider. These patients were contacted, and whenever possible they were connected with a primary care provider at one of our Medical Home Clinics. The Medical Home Clinics have worked very hard to accommodate new patients. We have had aggressive recruitment of new physicians and mid level providers in our community. Two years ago most practices had very limited new patient appointments. At my clinic alone in the last 12 months we saw over 650 new patients. Just this week I saw a gentleman who spends 6 months in Vermont and 6 months in Florida. He and his wife are well educated, and have health insurance. His wife had several ER visits last year for what turned out to be giardia. I saw him as a new patient with similar GI complaints, and he was so thankful. "Last year we tried and tried to get in to see a primary care doctor, and were told there were none available, so we had to use the ER any time that we needed care".

2.) Efforts to increase insurance coverage.
The number of patients without a Primary Care provider has decreased to such an extent that the CHT now has the time and resources available to also contact those ER patients without insurance, to work with them to obtain insurance. Patients with insurance are more likely to access primary care and preventive services, rather than using the ER for their care.

3.) Follow-up:
At the Medical Home Clinics our Chronic Care Coordinators provide phone follow-up with most patients who have been to the ER, or have been discharged from the hospital. They insure that the patient understands and is following the instructions that they were given. They also ensure that they have the medications they were prescribed, that they are improving, and that they have appropriate follow-up.

4.) Extended hours and acute slots:
We have extended hours at our sites, opening several mornings per week at 7:30, and staying open until 7:00 PM some evenings. We try to keep "acute time" open slots daily at each site. We have a policy at my clinic that the

support staff or triage nurse can refer no pediatric patient to the ER without consulting a provider. Often these visits are appropriate for the clinic, and usually we can find a spot in even a "full" schedule, or assess the situation and determine that having the child seen the next day would be appropriate. We are hoping to extend this policy to adults. We have recently implemented a system whereby if one of our local health centers is full, an appointment is found at one of the other clinics, instead of sending the patient to the ER.

5.) Education:
During ER follow up phone calls, in the case of non-urgent ER visits, the Chronic Care Coordinators remind patients that we are available to see patients on a same day basis. They also remind patients that there is always an after-hour physician on call to help determine if ER care is required. They stress the importance of using the Medical Home Clinic rather than the ER whenever possible. As part of our nursing intake, every patient is asked about recent ER visits, and those reports are brought to the provider to review. This gives the provider a chance to discuss the appropriate use of the ER when the visit was not urgent.

Benefits of seeing primary care provider:
We believe very strongly that patients get the best care for most semi-urgent conditions when they receive care consistently at their own health center, and preferably by heir own primary care provider. That is where their chronic conditions and current medications that may impact the acute illness are known. There is no need to repeat labs or studies that have been done recently, as that information is typically available at the health center. We screen every patient regularly for depression and substance abuse. And every visit with a primary health provider is an opportunity to be sure that all health maintenance and preventive measures are taken care of. Many a patient comes in with a "cold" or a "sore shoulder" and leaves with a referral to a smoking cessation program, an updated tetanus vaccine, or a lab slip to check fasting cholesterol and blood sugar levels.

Using the Medical Home Model, and with the unique help of our Chronic Health Team, we feel that we have made a significant change in the way we provide care in our community. We believe it is through a combination of improved access and improved care management, along with ongoing patient education, that we have begun to significantly decrease ER use. We expect that in the years to come we will see further significant decreases in the expenses for chronic illness complications as we continually assist our patients in improving their health.

ATTACHMENT 1

From the Vermont Blueprint for Health 2010 Annual Report, January 2011

Full Report available at:

http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

BACKGROUND AND HISTORY

Legislation

The Douglas Administration formally launched the Vermont Blueprint in 2003. The goal at the time was to address the increasing costs of caring for people with chronic illnesses, with an early emphasis on diabetes management in response to the overwhelming projected burden of morbidity and resource utilization. The transition to a more broadly defined Health Reform agent of change has occurred over time. Throughout the Blueprint's history, the Legislative and Executive branches have been critical in its support and development as follows:

- **2006** – The Blueprint officially became law when the Vermont Legislature passed Act 191, sweeping Health Care Reform that also created Catamount Health to provide coverage to uninsured Vermonters. The Act included language that officially endorsed the Blueprint and expanded its scope and scale.
- **2007** -- The Legislature further defined the infrastructure for administering the Blueprint with Act 71 and mandated "integrated" pilot projects to test the best methods for delivering chronic care to patients -- based on the Patient Centered Medical Home model and multi-disciplinary locally-based care coordination teams (Community Health Teams). The original pilot sites were chosen through competitive request for proposals processes in 2007 and 2008 from communities that had been actively involved in Blueprint quality improvement initiatives. Voluntary payment reform to support these innovations in health care delivery was introduced. This transition ultimately led to the Advanced Primary Care Practice model now being implemented statewide.
- **2008** -- Act 204 further defined the Integrated Pilots and officially required insurer participation in their financial support, which covered approximately 10 percent of the state population.

2009 – Launch of the Vermont Accountable Care Organization Pilot (ACO) -- A project led by the Vermont Health Care Reform Commission (HCRC) to investigate how ACOs might be incorporated into the state's comprehensive health reform program.

- **2010** – Act 128 updates the definition of the Blueprint for Health as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management." It also requires the Commissioner of the Department of Vermont Health Access to expand the Blueprint for Health to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013, to primary care practices statewide that wish to participate.

Advanced Primary Care Practice Model and Blueprint Integrated Health Service Program

The Advanced Primary Care Practice model (the basis for the original Blueprint Integrated Pilots and subsequent expansion to the Integrated Health Service program) is characterized by seamless coordination of care. It stresses the importance of preventive health – engaging people when they are well, as well as giving patients the tools to keep existing conditions

from worsening. Patients are encouraged to become active partners in their own care, and practices become effective and efficient teams.

As one of the requirements of recognition as a Blueprint IHS APCP, practices must meet a set of criteria for Patient Centered Medical Homes, established by the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to improving health care quality. Using the NCQA Physician Practice Connection – Patient Centered Medical Home (PPC-PCMH) recognition rubric, practices are scored on their compliance meeting standards related to areas such as access and communication, patient tracking and registry functions and advanced electronic communications. These evolved practices create internal teams, maximizing the effectiveness of their staff and expanding the definition of their roles within the site and beyond.

Another key IHS requirement is to form Community Health Teams (CHTs) – locally based groups of multi-disciplinary practitioners that support patients who receive care in the associated APCPs. The teams are designed at the local level, informed by community-wide assessments of local resources and gaps, to help patients with and without chronic conditions adhere to preventive health guidelines.

Payment Reform Figure 1.

Vermont's Integrated Health System APCP model includes two components of payment reform, which are applied consistently to all participating public and commercial insurers. Currently, fee-for-service methodology remains intact, with the reforms below in addition.

1. Enhanced Payments to Advanced Primary Care Practices

All insurers pay each recognized APCP an enhanced provider payment above the existing fee-for-service payments – calculated on a per patient per month (PPPM) basis – and based on the quality of the health care they provide as defined by the NCQA PPC-PCMH standards. In order to calculate payment, each insurer must count the number of their beneficiaries that are attributed to a practice, and multiply that by the PPPM amount.

2. Community Health Team Payments

The Vermont Blueprint emphasizes that the excellent and challenging work of an APCP must be supported by more than just the NCQA PPC-PCMH-triggered payments. A dedicated Community Health Team (CHT) provides this essential range of services. Insurers currently share the costs of CHTs equally. This support allows the services of a CHT to be offered free of charge to patients and practices, with no co-pay or prior authorization. Insurers provide a total of $350,000 per full CHT annually, which serves a general population of 20,000, with shares paid to a single existing administrative entity in each HSA. This combined funding covers the salaries of the core team, allowing for barrier-free access to the essential services provided. While this "core" CHT often works one-on-one with patients to meet a wide range of needs, the "functional" team may be much larger, including members of other local individuals and organizations who work in partnership with the CHT and the APCP. Planning and refining these elements are achieved through consensus in the Blueprint Expansion Design and Evaluation Committee, and the details of implementation at the Blueprint Payment Implementation Work Group. Both groups are well represented by a wide variety of stakeholders and serve to advise the Blueprint Executive Director. (See Appendix II for Blueprint advisory committee membership.)

Community Health Teams

The Blueprint's cutting edge payment reforms allow for the innovative Community Health Teams (CHTs) to provide services free of charge to the APCP patients. The multidisciplinary CHT partners with primary care offices, the hospital, and existing health and social service organizations. The goal is to provide Vermonters with the support they need for well-

coordinated preventive health services, and coordinated linkages to available social and economic support services. The CHT is flexible in staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHTs function as extenders of the practices they support, and their services are available to all patients (no eligibility requirements, prior authorizations or co-pays).

To ascertain the local Health Service Area's specific needs, the local IHS workgroup identifies current health services and existing gaps for patients and providers in participating primary care practices and the surrounding community. Based on the information obtained, the group will build the foundation of the CHT by working together to determine how existing services can be reorganized and what new services are required.

The overall design of the Blueprint Integrated Health Services model provides patients with seamless and well-coordinated health and human services. This includes transitioning patients from patterns of acute episodic care to preventive health services. Well structured follow up and coordination of services after hospital based care has been shown to improve health outcomes and reduce the rate of future hospital based care for a variety of patient groups and chronic health conditions (e.g. reduce emergency department visits, hospital inpatient admissions, re- admissions). CHT members, hospital staff, and other community service providers work closely together to implement transitional care strategies that keep patients engaged in preventive health practices and improved self-management. A goal of the Blueprint model is seamless coordination across the broad range of health and human services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population.

The Community Health Team serves as the central locus of coordination and support for patients.

Self-Management

A central part of the Blueprint's self-management efforts has been the Healthier Living Workshop (HLW), Vermont's version of the evidence-based Stanford Chronic Disease Self Management program, offered throughout the state since 2007. The original workshops are not specific to any chronic disease, but rather teach patients self-management skills and provide a peer-support network for individuals with chronic conditions. HLWs empower individuals as self-managers through education, support and skill-building exercises, notably, goal-setting and problem-solving.

This year, the workshops have been expanded to more specifically target common problems including diabetes and chronic pain. Successful pilots have paved the way for broader spread statewide. Plans are also underway to pilot an online Healthier Living Workshop program in partnership with the Stanford program and the National Council on Aging.

The Blueprint also helps provide clinical practices with the skills and resources needed to create a self-management infrastructure – and in conjunction with the Jeffords Center for Quality at Fletcher Allen Health Care, offers educational sessions that train coaches and practice facilitators to assist individual practices with self-management support. This educational effort has successfully trained clinic-based practice coaches ("local talent") to complement the EQuIP personnel.

Health Information Architecture

The Blueprint works closely with the Vermont Information Technology Leaders (VITL) – the state-sponsored Health Information Exchange (HIE) – to develop infrastructure that supports the meaningful use of health information. The core of this infrastructure is the Blueprint's

centralized registry and web-based clinical tracking system: DocSite-Covisint. The registry is used to produce visit planners that guide individual patient care, and to produce reports that support population management, quality improvement, program evaluation and comparative benchmarking.

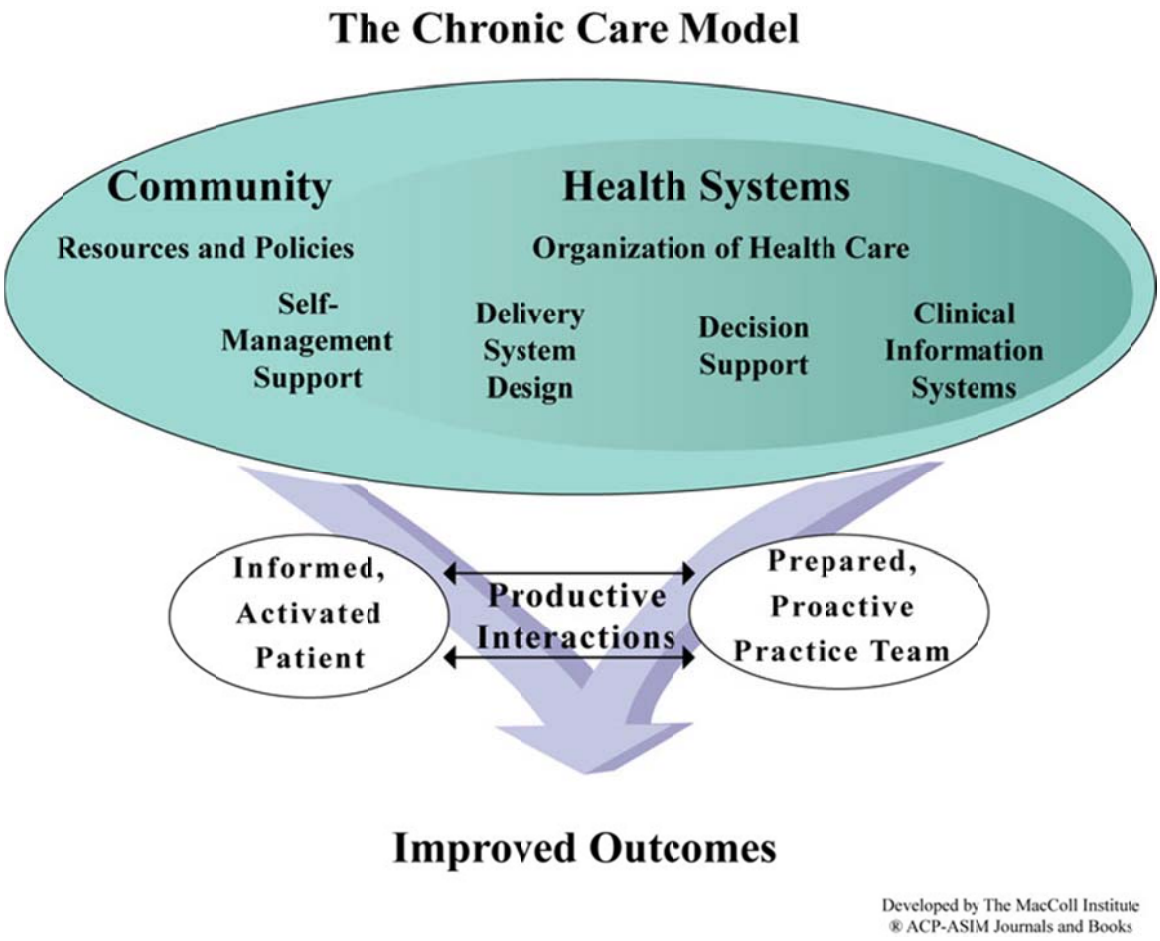
Data from the IHS APCP sites are sent to DocSite from the point of care, either entered manually into the web-based portal or via interfaces and direct feeds. It is a major goal to facilitate the entry of data at the point of care while minimizing any disruptions to the work flow of the practice. This is a major improvement process at the practice level, facilitated by the EQuIP and internal practice teams.

All aspects of the Blueprint's information architecture are designed to meet strict guidelines concerning data access and privacy protections.

ATTACHMENT 2

The Chronic Care Model

From the Improving Chronic Illness Care Web site:
www.improvingchroniccare.org



Delivery System Design

Assure the delivery of effective, efficient clinical care and self-management support

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients *(2003 update)*
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background *(2003 update)*

Improving the health of people with chronic illness requires transforming a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible. That requires not only determining what care is needed, but spelling out roles and tasks for ensuring the patient gets care using structured, planned interactions. And it requires making follow-up a part of standard procedure, so patients aren't left on their own once they leave the doctor's office. More complex patients may need more intensive management (care or case management) for a period of time to optimize clinic care and self-management. Health literacy and cultural sensitivity are two important emerging concepts in health care. Providers are increasingly being called upon to respond effectively to the diverse cultural and linguistic needs of patients.

Decision Support

Promote clinical care that is consistent with scientific evidence and patient preferences

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

Treatment decisions need to be based on explicit, proven guidelines supported by clinical research. Guidelines should also be discussed with patients, so they can understand the principles behind their care. Those who make treatment decisions need ongoing training to stay up-to-date on the latest evidence, using new models of provider education that improve upon traditional continuing medical education. To change practice, guidelines must be integrated through timely reminders, feedback, standing orders and other methods that increase their visibility at the time that clinical decisions are made. The involvement of supportive specialists in the primary care of more complex patients is an important educational modality.

Clinical Information Systems

Organize patient and population data to facilitate efficient and effective care

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care *(2003 update)*
- Monitor performance of practice team and care system

Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders for needed services, with the summarized data helping to track and plan care. At the practice population level, an information system can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts.

Self-Management Support

Empower and prepare patients to manage their health and health care

- Emphasize the patient's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management.

Effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. Self-management support can't begin and end with a class. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

ATTACHMENT 3

From The NCQA Web Site, at http://www.ncqa.org

NCQA's initial Physician Practice Connections®- Patient-Centered Medical Home™ (PPC-PCMH) program reflects the input of the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association and others in the revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

NCQA's Patient-Centered Medical Home (PCMH) 2011 is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams and coordinating and tracking care over time. The NCQA Patient-Centered Medical Home standards strengthen and add to the issues addressed by NCQA's original program.

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

There are six PCMH 2011 standards, including six must pass elements, which can result in one of three levels of recognition. Practices seeking PCMH complete a Web-based data collection tool and provide documentation that validates responses.

NCQA PCMH 2011

6 Standards, 27 Elements, 149 Factors

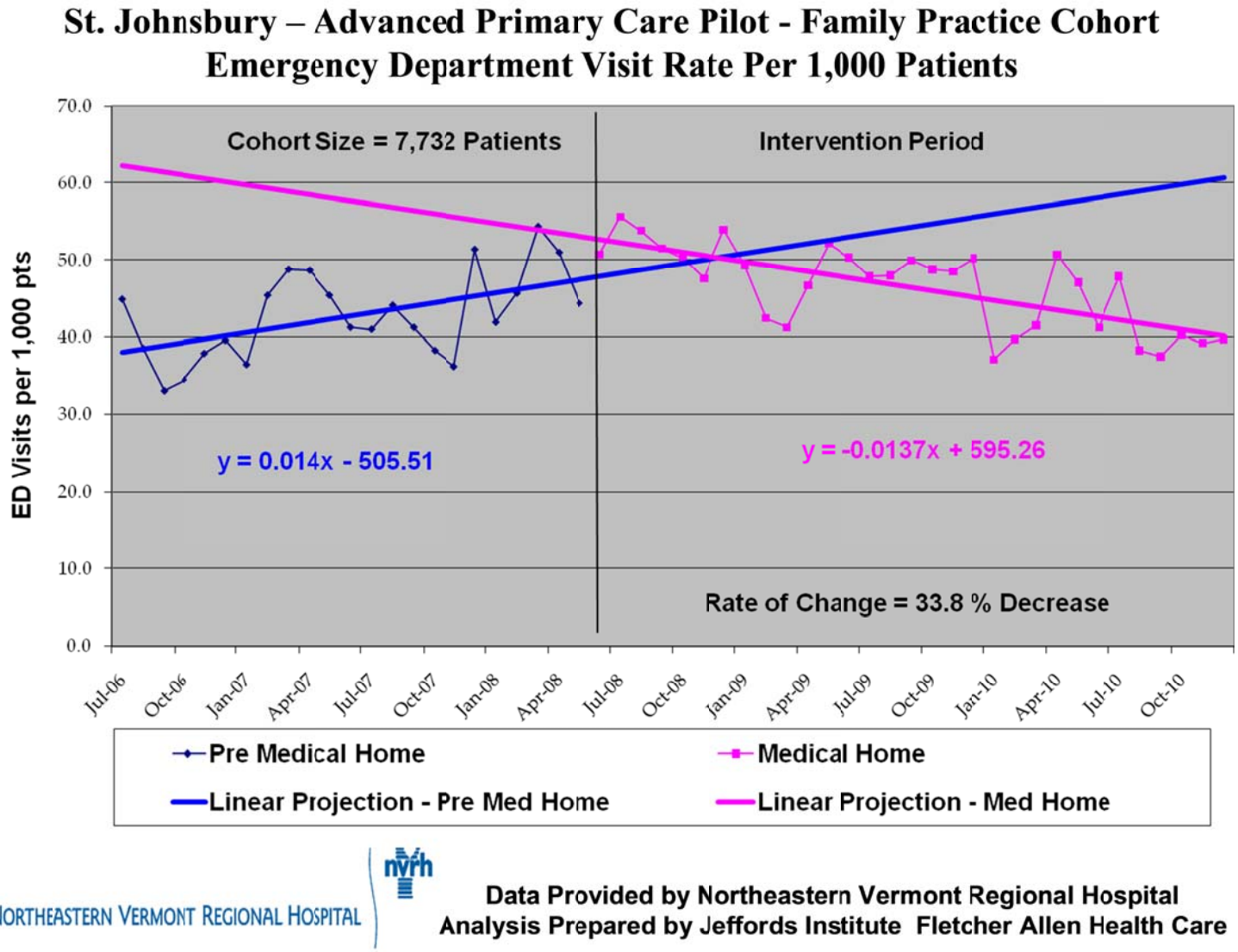
Points	Standard and Element	No. Factors	Must Pass 50% score
20	**1 Enhance Access and Continuity**	34	
4	A Access During Office Hours	4	X
4	B Access After Hours	5	
2	C Electronic Access	6	
2	D Continuity	3	
2	E Medical Home Responsibilities	4	
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	
4	G Practice Organization	8	
17	**2 Identify and Manage Patient Populations**	35	
3	A Patient Information	12	
4	B Clinical Data	9	
4	C Comprehensive Health Assessment	10	
5	D Using Data for Population Management	4	X
17	**3 Plan and Manage Care**	23	
4	A Implement Evidence-Based Guidelines	3	
3	B Identify High-Risk Patients	2	
4	C Manage Care	7	X
3	D Manage Medications	5	
3	E Electronic Prescribing	6	
9	**4 Provide Self-Care and Community Support**	10	
6	A Self-Care Process	6	X
3	B Referrals to Community Resources	4	
18	**5 Track and Coordinate Care**	25	
6	A Test Tracking and Follow-up	10	
6	B Referral Tracking and Follow-up	7	X
6	C Coordinate with Facilities/Care Transitions	8	
20	**6 Measure and Improve Performance**	22	
4	A Measures of Performance	4	
4	B Patient/Family Feedback	4	
4	C Implements Continuous Quality Improvement	4	X
3	D Demonstrates Continuous Quality Improvement	4	
3	E Performance Reporting	3	
2	F Report Data Externally	3	
100 Points		**149 Factors**	**6 MP Elements**

ATTACHMENT 4

From the Vermont Blueprint for Health 2010 Annual Report, January 2011

Full Report available at:

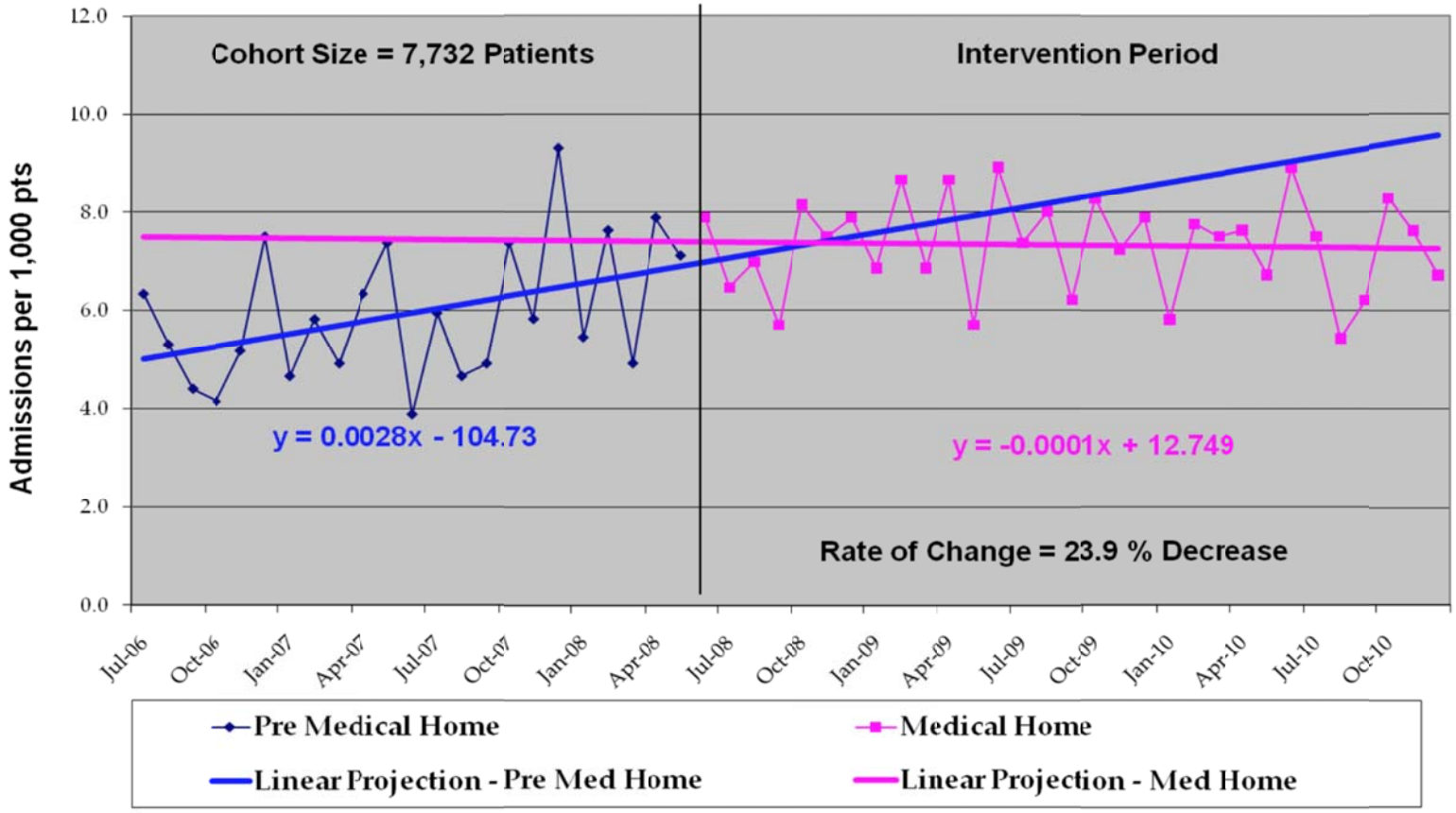
http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf



NORTHEASTERN VERMONT REGIONAL HOSPITAL

Data Provided by Northeastern Vermont Regional Hospital
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care

St. Johnsbury – Advanced Primary Care Pilot - Family Practice Cohort
Inpatient Admission Rate Per 1,000 Patients



NORTHEASTERN VERMONT REGIONAL HOSPITAL

Data Provided by Northeastern Vermont Regional Hospital
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care