

**DIVERTING NON-URGENT EMERGENCY ROOM USE:
CAN IT PROVIDE BETTER CARE AND LOWER
COSTS?**

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING
OF THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING DIVERTING NON-URGENT EMERGENCY ROOM USE, FOCUS-
ING ON IF IT CAN PROVIDE BETTER CARE AND LOWER COSTS, AND
HEALTH CENTER STRATEGIES THAT MAY HELP REDUCE THEIR USE

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MAY 11, 2011
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DIVERTING NON-URGENT EMERGENCY ROOM USE: CAN IT PROVIDE BETTER CARE AND LOWER COSTS?

WEDNESDAY, MAY 11, 2011

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in Room 430, Dirksen Office Building, Hon. Bernard Sanders, chairman of the subcommittee, presiding.

Present: Senators Sanders, Bingaman, Merkley, Whitehouse, and Paul.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Let me open the very first meeting of the U.S. Senate Subcommittee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging.

Today we have a very important hearing. Senator Paul is here as well and we expect other members as the hearing proceeds.

We have some excellent panelists and in a bit we will be hearing from James Macrae who is the associate administrator for the Bureau of Primary Health Care, Health Resources and Services Administration. Our second panel will include Deborah Draper, the director of Health Care, Government Accountability Office; Peter Cunningham, senior fellow, Center for Studying Health Systems Change; Alieta Eck, M.D., founder and co-director Zarephath Health Center in New Jersey; Dana Kraus, M.D., Family Practice Physician, Northern Counties Health Care in St. Johnsbury, VT. We are pleased that you are all here.

Let me begin with an opening statement and say that I think most of us would agree that our health care system today has many very, very serious problems. In America today we have some 50 million fellow Americans who lack any health insurance, we have many more who are under-insured with large copayments and deductibles and many more even with insurance who are finding it very hard to locate a primary health care physician who will treat them and their family.

The United States today is the only Nation in the industrialized world that does not guarantee health care to all of its people as a right. Meanwhile, despite 50 million Americans without any health insurance, we end up spending—and this will be an important part of what this hearing is about—we end up spending almost twice as

much per person on health care as any other industrialized Nation. I think it is important to understand why that is so and how we can go forward in providing quality health care to all of our people in a cost-effective way.

Here are just a few facts that should concern every American. According to a study from Harvard University, some 45,000 Americans will die this year because they do not get to a doctor on time. They are sick, their sicknesses fester and by the time they walk into the doctor's office it is often too late. Further, in terms of cost, we spend an unsustainable 17.6 percent of our GDP on health care in 2009 and that is projected to go up to 20 percent by 2020. So this is not just an issue of people who cannot afford health insurance, it is not just an issue of employers who are forced to pay 10, 20, 30 percent more a year for health insurance, it is an issue for our entire economy. This health care cost soaring is just not sustainable.

Yet, despite all of that, we rank approximately 26th among major developed nations on life expectancy and 31st on infant mortality. It just seems to me that with those problems facing us we have to take a hard look at why these problems occur.

One of the major focuses of today's hearing is the use of emergency rooms in a way that is not appropriate. While there are differences of opinion, and certainly the figures will vary in different parts of the country, nobody denies that many, many hospitals see large numbers of people who are coming into their emergency rooms, not for emergency care. It is terribly important, I think we all agree, that our emergency rooms are there for people who have heart attacks, strokes, accidents, etc, but there is no debate that many people use the emergency room as a source of primary health care because there are not other primary health care facilities available.

The testimony that we will hear today, and that I think everyone agrees on, is that an emergency room is, in fact, the most expensive form of primary health care. That, for example, if one were to go to a federally qualified community health center or other primary health care facilities, the cost is substantially lower. So it seems to me one of our goals is to increase access for primary health care, get people who don't need the emergency room out of the emergency room and provide good quality primary health care to those people at a cost that will be substantially lower than the cost of an emergency room.

Obviously in different parts of the country the figures are different, but in some cases at least, a visit to an emergency room for primary health care may be as much as 10 times more than a visit to a community health center. So my hope is that we can begin to understand, and we are going to hear some interesting testimony today, how we can do that. How we can keep unnecessary visits to the emergency room lower and get people the quality primary health care that we need.

I very much look forward to hearing the testimony that we will be hearing in a few minutes.

Senator SANDERS. Senator Paul.

STATEMENT OF SENATOR PAUL

Senator PAUL. Thank you, Senator Sanders.

I do agree, as a physician I have seen it first hand, that ER visits are much more expensive than primary care visits and that the emphasis should be trying to figure out how we can get patients to go to primary care as opposed to clogging up the emergency rooms.

I would also say though, that private clinics and charitable clinics are much more efficient than government clinics. This is true throughout all of the economy, that private enterprise is always more efficient than government, just as a matter of fact.

I wholeheartedly agree with Dr. Eck, who will testify later, that charity should be voluntary. In fact, charity is, by definition, voluntary. The nobleness of giving is only real if giving is voluntary. Many on the left wish to experience the reward of giving by giving other people's money, but it doesn't work that way. When you use force to transfer money from those who work to those who don't, that is not charity, that is redistribution of wealth. When you use government to try to perform good works, not only is the accolade of charity undeserved but the effect of the good works is always less than satisfactory because government rarely does anything well.

I often ask an audience, if you had a hundred dollars to give who would you rather give it to, the Federal Government or the Salvation Army. I've yet to meet a thinking adult who would choose the Federal Government. Government, particularly government that is distant from the people is inefficient and wasteful. Our job should not be to expand wasteful government programs but to get government out of the way of true charity.

Not only is true charity good for the heart, but it is good for the recipient. It warms the heart to hear of those who receive charity, giving back with their time and effort to the charity itself. In fact, many charities that work well require the recipient to work at the charity. Many charities have come to the conclusion that cash payments to recipients is counterproductive and so the charity only pays bills directly.

Charity encourages help in times of need, but does not encourage the perception of lifelong entitlement. Those who receive charity typically understand that charity is a temporary hand-up and not a permanent hand-out.

As a physician, I have seen the difference firsthand. Time and again patients who I treated through the Lions Eye Clinic, a charity that I helped set up, were appreciative and courteous while others who felt entitled to free care were often disruptive and rude.

Obamacare expands entitlements at a time when entitlements are already stretched beyond solvency. Because we are living longer and because of the population boom after World War II, entitlements are all short of money. Social Security is \$6 trillion short. Medicare is short over \$30 trillion over the next several decades. Social Security, for the first time, last year pays out more than it brings in. Even without Obamacare, the entitlements are on a collision course to consume the entire budget within little

more than a decade. We have serious problems, just adding on more programs isn't the answer.

What we should be discussing today is, is it fiscally responsible to increase funding to taxpayer financed health centers by 68 percent over the next 5 years? Where will the money come from? Are we willing to borrow from China to pay for Obamacare? Are we willing to raise taxes to pay for the expansion of entitlements? Are we willing to ask the Federal Reserve to simply print more money to pay for the entitlements? Will we expand government welfare to such a degree that we bankrupt the entire system and no entitlements are paid?

I know advocates of increased welfare mean well, but in the end good intentions must also be paired with fiscal responsibility and that is the discussion that we as a country should now be engaged in. Thank you.

Senator SANDERS. Thank you, Senator Paul.
Senator Bingaman.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Mr. Chairman, I am here to hear the witnesses and focus on this issue. I do think that diverting folks from emergency rooms to other opportunities to get health care is a great opportunity for us to save money in the health care system, both in the public health care system and in the private health care system.

So I commend you for having the hearing.

Senator SANDERS. Thank you very much.

Let's begin with Mr. Macrae. James Macrae is the associate administrator for the Bureau of Primary Health Care, Health Resources and Services Administration, usually referred to as HRSA, the U.S. Department of Health and Human Services.

Mr. Macrae, thanks very much for being with us.

STATEMENT OF JAMES MACRAE, ASSOCIATE ADMINISTRATOR, BUREAU OF PRIMARY HEALTH CARE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Mr. MACRAE. Thank you very much Mr. Chairman, members of the committee and subcommittee. Thank you for the opportunity to testify today.

I am Jim Macrae, the associate administrator of the Bureau of Primary Health Care in the Health Resources and Services Administration. I am very pleased to join my other colleagues today in appearing before you.

Our agency, HRSA, helps the most vulnerable Americans receive quality primary health care, without regard to their ability to pay. Our agency works to expand access to health care for millions of Americans, the uninsured, the underserved and the vulnerable. HRSA recognizes that people need to have access primary care and through its programs and activities the agency seeks to meet these needs.

HRSA's vision for the Nation is healthy communities and healthy people. Our mission is to improve health and achieve health equity through access to quality services, a skilled workforce and innova-

tive programs. At HRSA we also believe that primary care is more than having a place to go when you are sick. We view primary care as an institute of what medicine does, providing integrated, accessible health care services like clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community.

Now I would like to talk more specifically about the health center program. For more than 40 years health centers have developed comprehensive, high quality, cost-effective primary care to patients regardless of their ability to pay. During that time health centers have become an essential primary care provider for America's most vulnerable populations, people living in poverty, the uninsured, the homeless, ethnic and racial minorities, public housing residents and people who are geographically isolated. Health centers advance the preventive, coordinated, comprehensive and patient-centered care model coordinating a wide range of medical, dental, behavioral and social services. Today more than 11,000 health centers operate over 8,000 delivery sites that provide care, in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Basin.

More importantly health centers offer care that is affordable and accessible. The health center program requirements include: The provision of care to all patients regardless of their ability to pay; offering discounts to patients on a sliding fee scale for all patients at or below 200 percent of the poverty level and the provision of services at times and locations that assure accessibility and meet the needs of the populations. Health centers frequently offer evening and weekend hours and are located in areas convenient to where the target population lives, including schools, homeless shelters and through mobile vans.

Health centers are also required to provide professional coverage for medical emergencies during hours when the center is closed. This coverage must be clearly defined and include telephone access to a clinician who can access the patient's needs and recommend appropriate followup care. This includes advising the patient of whether a visit to the ER is appropriate.

The impact of health centers can be seen in other ways as well. Health centers provide high quality care to rural and urban populations by focusing attention on improving the community's health through preventive care and providing direct patient care.

The health center model also reduces the use of costlier providers of care such as emergency rooms and hospitals. Research has shown that Medicaid beneficiaries receiving care from a health center were less likely to be inappropriately hospitalized and less likely to visit the emergency room inappropriately. Rural counties with a community health center site had fewer than 33 percent emergency room visits than those without a health center.

Health centers also improve access to care, health outcomes and reduce health disparities and reduce costs. For example, studies have demonstrated that uninsured people living within close proximity to a health center are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care and more likely to have had a general medical visit. Health center

uninsured patients are more likely to have a usual source of care than the uninsured nationally. Likewise, Medicaid beneficiaries receiving care from health centers are more likely to report having access to care.

The reach of health centers is not limited to just what we do in HRSA. In the past several years we have been working with our counterparts in the Center for Medicaid and Medicare Services on emergency room diversion programs. In 2008 CMS awarded grants to 20 States with the goal of reducing hospital emergency rooms by Medicaid beneficiaries, with many health centers playing a key role in highlighting that health centers are well positioned to adopt and showcase innovations in care delivery, their experience with quality improvement and the use of evidence-based models like the Chronic Care Model.

Finally, I would like to highlight an important finding referenced in the GAO report, that health centers reduce the use of hospital emergency rooms for non-urgent care because health centers have the attributes of the medical home. Several studies have shown that medical homes reduce emergency room use significantly, not only for healthy patients but for those who are sicker and have greater health care needs. HRSA is dedicated to helping health centers move toward the medical home model and to date more than 125 health centers have enrolled in HRSA's recently announced Patient-Centered Medical Home Initiative.

In closing, we recognize the key role that health centers do and can play in the reduction of inappropriate emergency room use and I appreciate the opportunity to testify today. Thank you.

[The prepared statement of Mr. Macrae follows:]

PREPARED STATEMENT OF JAMES MACRAE

Mr. Chairman, Ranking Member, and members of the committee, thank you for the opportunity to testify. I am Jim Macrae, associate administrator of the Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA). I am pleased to join my other colleagues in appearing before you today.

HRSA OVERVIEW

The Health Resources and Services Administration helps the most vulnerable Americans receive quality primary health care, without regard to their ability to pay. HRSA works to expand access to health care for millions of Americans—the uninsured, the underserved and the vulnerable. HRSA recognizes that people need to have access to primary health care and, through its programs and activities; the Agency seeks to meet these needs.

HRSA delivers on its obligation to address primary care access through the 6 Bureaus and 13 Offices that comprise the Agency. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations and non-profit foundations, to seek solutions to primary health care challenges. HRSA provides leadership and financial support to health care providers in every State and U.S. territory.

HRSA'S VISION, MISSION AND GOALS

HRSA's vision for the Nation is healthy communities and healthy people. Our mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.

The Agency seeks to further our vision and carry out our mission through four major goals:

- Improve Access to Quality Care and Services;
- Strengthen the Health Workforce;
- Build Healthy Communities; and
- Improve Health Equity.

At HRSA we also believe that primary care is more than having a place to go when you are sick. We view primary care as the Institute of Medicine (IOM) does¹: providing integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

HEALTH CENTER PROGRAM OVERVIEW

For more than 40 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for America's most vulnerable populations: people living in poverty, uninsured, or homeless; minorities; farm workers; public housing residents; people who are geographically isolated; and people with limited English proficiency.

Health centers advance preventive, coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,100 health centers operate over 8,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In fiscal year 2009, these non-profit and public, community-based and patient-directed health centers served 18.8 million patients, providing almost 74 million patient visits, at an average cost of \$600 per patient. Patient services are supported through a variety of revenue sources, including but not limited to Medicaid, Medicare, and State and local grants. The Health Center Program grant funds from HRSA account on average for 20 percent of total revenues for health centers.

HEALTH CENTER RESEARCH

Research continues to highlight health centers' success in increasing access to care, improving health outcomes for patients, reducing health disparities, and containing health care costs.

Health centers increase access to health care through an innovative model of community-based, comprehensive primary health care that focuses on outreach, disease prevention, and patient education activities. For example, studies found:

- Uninsured people living within close proximity to a health center are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care, and more likely to have had a general medical visit.²
- Health center uninsured patients are more likely to have a usual source of care than the uninsured nationally (98 percent versus 75 percent).³
- Medicaid beneficiaries receiving care from health centers are more likely to report having access to care.⁴

Despite serving sicker and more at-risk patients than seen nationally, health centers continue to demonstrate a strong track record in delivering high quality care and reducing health disparities. For example, studies found:

- Health center patient rates of blood pressure control were better than rates in hospital-affiliated clinics or in commercial-managed care populations, and racial/ethnic disparities in quality of care were eliminated after adjusting for insurance status.⁵
- Health center low-birth weight rates continue to be below the national averages for all infants. In particular, the health center low-birth weight for African-American patients is below the rate observed among African-Americans nationally (10.7 percent versus 14.9 percent respectively).⁶
- Health centers play a critical role in providing health care services to rural residents who tend to have higher rates of chronic diseases, such as the 27 percent of

¹Donaldson M, Yordy K, Vanselow N, eds. Institute of Medicine. *Defining Primary Care: an Interim Report*. Washington, DC: National Academy Press, 1994:16.

²Hadley J and Cunningham P. Availability of Safety Net Providers and Access to Care of Uninsured Persons. *Health Services Research* 2004;39(5):1527–46.

³Carlson, BL, et al., "Primary Care of Patients without Health Insurance by Community Health Centers." April 2001 *Journal of Ambulatory Care Management* 24(2):47–59.

⁴Shi L, Stevens GD, and Politzer RM. "Access to care for U.S. Health center patients and patients nationally: how do the most vulnerable populations fare?" 2007 *Med Care* 45(3):206–13.

⁵Hicks LS, et al. The Quality of Chronic Disease Care in U.S. Community Health Centers. *Health Affairs* 2006;25(6):1713–23.

⁶Shi, L., et al. America's health centers: Reducing racial and ethnic disparities in perinatal care and birth outcomes. *Health Services Research*, 2004; 39(6):1881–1901.

rural residents suffering from obesity⁷ and nearly 10 percent diagnosed with diabetes.⁸

Health centers provide high-quality care to rural and urban populations alike by focusing attention on improving public health through preventive care in addition to direct patient care. The health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals. For example, studies found:

- Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized.⁹
- Medicaid beneficiaries receiving care from a health center were less likely to be inappropriately hospitalized and less likely to visit the emergency room inappropriately.¹⁰
- Rural counties with a community health center site had 33 percent fewer uninsured emergency room/department visits per 10,000 uninsured population than those without a health center.¹¹

EMERGENCY ROOM DIVERSION PROGRAM

In the past several years, HRSA has worked with our counterparts in the Centers for Medicare & Medicaid Services (CMS) on Emergency Room Diversion programs. In 2008, CMS awarded grants to 20 States with the goal of reducing the use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. One community health center project in Colorado focused on three goals: (1) to educate the Medicaid population about alternative nonemergency care options; (2) to offer real time referrals to alternative non-emergency care through the use of Outreach Case Managers; and (3) to promote the concept of a medical home for Medicaid patients so that they will have a better understanding of their healthcare options and appropriately use health care services. Additionally, Connecticut proposed to utilize a Web-based application to connect providers in federally qualified health centers (FQHCs) and hospitals in designated communities throughout the State to create a common platform to search and schedule appointments for Medicaid enrollees. This approach was designed to facilitate access to primary care and enhance linkages between emergency departments and community-based primary care providers.

PATIENT-CENTERED MEDICAL HOME INITIATIVE

As highlighted by GAO, one reason health centers reduce the use of hospital emergency departments for non-urgent care is because they have attributes of the medical home model. Studies have shown that having a “medical care home” reduces emergency department use significantly, not only among healthy patients but also among those who are sicker and have greater health care needs. Patient-centered medical homes (PCMHs) utilize interdisciplinary teams that re-distribute care responsibilities to those most capable and most accessible. A PCMH then coordinates care within this interdisciplinary team and with others in the community including hospitals and specialists.

HRSA is dedicated to assisting health centers move toward the medical home model, and health centers are well-positioned to adopt and showcase innovations in care delivery because they are experienced with quality improvement that uses evidence-based models like the Chronic Care Model. To date, more than 125 health centers have enrolled in HRSA’s recently announced Patient Centered Medical/Health Home Initiative. Additionally, through the CMS Center for Medicare and Medicaid Innovation, a Medicare FQHC Advanced Primary Care Practice Demonstration project will be implemented soon to engage up to 500 FQHC sites and up to 195,000 fee-for-service Medicare beneficiaries in a medical home demonstration. One of the key expected outcomes of this demonstration is a decrease in ED utilization by those that participate.

⁷Bennett, KJ, Olatosi, B., & Probst, JC. (2008). “Health Disparities: A Rural—Urban Chartbook.” South Carolina Rural Health Research Center.

⁸Pleis JR, Lethbridge-Cejku M. Summary health statistics for U.S. adults: National Health Interview Survey, 2006. National Center for Health Statistics. Vital Health Stat 10(235). 2007.

⁹Falik M., et al. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. *Medical Care* 2001;39(6):551–61.

¹⁰Falik M., et al. Comparative Effectiveness of Health Centers as Regular Source of Care. *Journal of Ambulatory Care Management* 2006;29(1):24–35.

¹¹Rust George, et al. “Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties.” *Journal of Rural Health* Winter 2009 25(1):8–16.

HEALTH CENTER SUPPORT SERVICES

Another core component of the comprehensive model of primary care provided by health centers is the non-clinical services that aim to increase access, improve health care quality and reduce emergency use. The provision of these enabling services is a distinguishing feature of health centers, which recognize that barriers to care take various forms. Health centers offer a variety of supportive and enabling services to their patients including:

- Case management for chronic conditions, reducing the need for emergency services;
- Eligibility and enrollment assistance for health and social services;
- Outreach and transportation services; and
- Education of patients and the community regarding the availability and appropriate use of health services, including emergency rooms.

HEALTH CENTER CARE IS AFFORDABLE, ACCESSIBLE AND REDUCES THE NEED FOR EMERGENCY ROOM CARE

Health centers offer affordable care to people in need. Health centers are required to provide care to all patients regardless of ability to pay, and to offer discounts based on a sliding fee scale for all patients at or below 200 percent of the Federal poverty level. This requirement helps ensure that financial concerns do not prevent patients from accessing the health center's primary and preventive services offered in a timely manner.

Health Centers offer care that is accessible. Health centers are required to provide services at times and locations that assure accessibility and meet the needs of the population to be served. For example, health centers frequently offer evening and weekend hours to ensure they are accessible to working adults. They are located in areas convenient to where the target population lives or works, including schools, homeless shelters, and/or through mobile van services.

Health centers are also required to provide professional coverage for medical emergencies during hours when the center is closed. This coverage must be clearly defined, and include telephone access to a clinician who can assess the patient's needs and recommend appropriate followup care. This includes advising the patient on whether a visit to an ED is appropriate.

CONCLUSION

In closing, we recognize the key role that health centers do and can play in the reduction of inappropriate emergency room use. I appreciate the opportunity to testify today, and I would be pleased to answer any questions at this time.

Senator SANDERS. Thank you very much.

Let me begin. Mr. Macrae, as you know, we recently increased funding for community health centers and the word went out that more money was available. What kind of response did you get? In your judgment, is there a need for more community health centers around this country?

Mr. MACRAE. Senator, in terms of our recent announcement, we had an announcement for what we call community health center new access points, which is applications for both new community health centers as well as satellite sites for existing health centers, to establish. We put out our application guidance saying that we could fund approximately 350, we received applications from over 800 applicants all across the country for those resources. So there is clearly demand for these services.

Senator SANDERS. All right. I want you to elaborate on a point that you just made. Common sense would suggest that if there was good quality primary health care available to people on a sliding scale basis, that welcomed Medicaid and Medicare, took private insurance as well, that people were welcomed to walk in the door, they would go there and they would find a medical home which could treat them in a general sense. What has been the experience, and I know we will hear more about this this morning, about com-

munity health centers keeping people from using an emergency room, what kind of experiences have we seen?

Mr. MACRAE. There have been several studies, as I mentioned in my testimony, about the impact of even having a health center in a particular community. The study that was done most recently looked at rural communities and the impact of having a health center in that community actually reduced the level of inappropriate emergency room use by almost a third. In addition, by expanding the access in terms of evening hours and weekends and making sure that care is available through a sliding fee scale, enables people to be able to use the services of a health center as opposed to going to the emergency room.

In fact, one of the big initiatives that we have been working on with our health centers is to actually coordinate and work with hospitals on working with the triage group there to educate folks about the appropriate use of the emergency room and actually create opportunities for followup visits from emergency room visits, to actually hook them up with the health center. About 65 percent of ER discharges actually result in a referral to a clinic or a primary care provider and we are trying to foster that kind of connection to make sure that folks are aware that health centers are available.

Senator SANDERS. In your judgment, what kind of potential savings are out there if we can provide quality primary health care in areas where people are now over-using the emergency room? Do you see this as an opportunity for both government and the private sector to be saving significant sums of money?

Mr. MACRAE. It is definitely an opportunity and I think you will definitely hear more from our colleagues in GAO about this. They estimate that about 8 percent of emergency room use currently is for non-urgent, nonemergency types of situations. If we can encourage the use of primary care, in particular through health centers and other safety net providers or other primary care providers, that will definitely have an impact in cost. It has been estimated that the cost at a health center is roughly six to seven times less than what we would receive in an emergency room.

Senator SANDERS. In general, if one walks into an emergency room, one gets the care for the problem that one has. That is a different care than one would get if one had a medical home and an ongoing primary health care physician. Would you agree that it makes a lot more sense to try to find a medical home for people so that physicians can know the family history, be treating people on an ongoing basis, rather than just episodic care at an emergency room?

Mr. MACRAE. Yes. That is definitely something that we are promoting at the Health Resources and Services Administration through our medical home model, to really encourage the opportunity for folks to have a place to go, a regular source of care for their primary care needs. And through that actually preventing illness, preventing emergencies and making sure that they know they have a place to go or even a person to call when they are in an emergency situation and determine whether it makes sense to go to the emergency room or to actually followup with a visit at the health center.

Senator SANDERS. It appears that in many parts of this country there is a shortage of primary health care physicians. We increased funding for the National Health Service Corps to encourage medical school students to work in primary care in underserved areas. How are we doing in that regard? Are we finding medical school students interested in moving into primary health care in underserved areas?

Mr. MACRAE. We very much are. As you know, the National Service Corps has seen an increase in its funding and through that we have put out application guidance for both what we call our scholarship program as well as loan repayment program. The program has received thousands of requests for applications and we have been able to fulfill many of those. Actually, many of those providers are providing service in health centers as well as other clinics all across the country.

Senator SANDERS. All right. Say a word about that, because I am not sure everybody knows what the National Health Service Corps does.

Mr. MACRAE. The National Health Service Corps provides loan forgiveness, either through a scholarship mechanism to encourage folks to practice in medically underserved areas and for medically underserved populations. So in exchange for either a scholarship encouraging folks to enter medical school or once they have completed medical school to pay back their loans, there will be loan forgiveness, depending on the amount of time that you provide service in that particular community.

Senator SANDERS. OK. Thank you very much.

Senator Paul.

Senator PAUL. Thank you, Mr. Macrae and thank you for coming this morning.

Mr. MACRAE. Yes.

Senator PAUL. At your taxpayer-funded health centers do you provide screening for sexually transmitted disease?

Mr. MACRAE. Yes, we do.

Senator PAUL. Birth control?

Mr. MACRAE. Yes.

Senator PAUL. Family planning and pregnancy testing?

Mr. MACRAE. Yes.

Senator PAUL. It sounds a lot like some of the things that Planned Parenthood does. Would you say that maybe you duplicate or they duplicate some of the things you do?

Mr. MACRAE. I can't comment specifically on Planned Parenthood, but the health center program is required to provide preventive and primary care services to their population.

Senator PAUL. It sounds to me like you exactly duplicate what they are doing.

I guess my question here is, as you have heard, we are a little bit short of money, you are asking for a lot more money and I think what responsible legislators should do and what responsible government officials should do should be to own up and say, "Look if I think this is good and the government needs to provide for it, why are we providing for it with three different entities?"

I see no reason whatsoever, if you are wanting 68 percent increase in your budget, that you can't own up, stand up and tell us,

“Yes, we are doing the same thing Planned Parenthood does. It is a very emotional, political football, but we are doing the same darn thing they are doing and we should just eliminate one or the other.” Are you willing to give up the money that Planned Parenthood does or do you want them to give it up? That is the choices, the difficult choices that should be made and what we should be talking about here.

Do you have a comment on that?

Mr. MACRAE. I can't comment specifically on the family planning piece, but I can say in terms of health centers that the investment is cost-effective in the sense that, as I think you will hear from some of the witnesses, that investing in primary care and in prevention actually reduces overall cost for patients. There have been many studies that have demonstrated that the overall reduction in cost for health center patients is significant, especially for Medicaid beneficiaries as well as for other patients.

So the investment is actually cost-effective in the sense of investing on the front end through prevention and primary care actually results in less hospitalization and less cost to the system overall.

Senator SANDERS. Senator Bingaman.

Senator BINGAMAN. Thank you very much for being here. One of the points you made in your testimony is that health centers frequently offer evening and weekend hours to ensure they are accessible to working adults. When does the inappropriate use of emergency rooms occur; how much of that inappropriate use occurs during the evenings or the weekends because people really don't have a choice, as they see it?

Mr. MACRAE. I think my colleagues will speak to this more clearly, but clearly that is a huge impact in terms of people being able to access care. Both what we have heard from emergency room physicians as well as different studies that our counterparts in the Centers for Disease Control and Prevention have indicated is that a significant number of visits are evenings or on weekends. And that is one of the things that we have been working with our community health centers—to extend and expand the number of evening hours as well as hours on the weekend.

In addition, making sure that there are people that folks can call and contact before they make that decision to go to the ER. There are many reasons why it absolutely makes sense for people to go directly to the ER. But in a lot of circumstances, as you said, it is the only place that people feel like they can go.

Senator BINGAMAN. Yes. My impression is, and this is just anecdotal, that a lot of the health centers and sites in my State of New Mexico do not provide services regularly on weekends and even some evenings. That could substantially increase access to these community health centers and reduce cost in the emergency room, by expanding hours of operation. So I hope you can give that a real priority and as you expand the services or the delivery system that you folks are in charge of, I hope you can give priority to expanding the hours of service in areas where that is justified.

Mr. MACRAE. Absolutely. In fact, with the expansion it is not just, for us, about creating new sites and even expanded service, it is about redesigning how the care is provided. One of the key pieces of that actually is expanding the number of hours that are

available on evenings and weekends. Most recently, through the Recovery Act, we actually provided additional resources to health centers to expand their capacity to provide those evening and weekend hours.

Through the Medical Home Initiative we are actually really working with our health centers to look at how they even provide care in the clinic today. The whole idea of creating more open access, same day appointments so that there aren't wait times for appointments and other things, so that people can have ready access, whether that is during the day, in the evening or on the weekends.

Senator BINGAMAN. Senator Sanders was talking about the importance of this—of having patients able to go to their so-called medical home when they need medical care instead of just episodic visits at emergency rooms. I would think that anything that could be done to expand the availability of those services in the evenings and weekends would be a big factor.

My recollection is, when we were raising our son, that he only got sick on weekends.

[Laughter.]

At times when it was very difficult to find a physician other than taking him to some emergency room, which clearly was not the ideal case. I commend you on what you are trying to do with expanding these services. They are extremely valuable to my State and they are really a lifeline for a lot of folks.

I agree with the points you made that this is a cost-effective way to spend taxpayer dollars. I mean if we are going to have taxpayer dollars spent to try to assist people in getting health care, one of the most cost-effective expenditures we make is through these community health centers.

I will stop with that, Mr. Chairman.

Senator SANDERS. Thank you. If I might just open it up to all of the Senators here, to respond a little bit to Senator Paul's statement.

Of course there is quote/unquote duplication of services. In my view Planned Parenthood does an excellent job and I strongly support it. Obviously some of the services that Planned Parenthood provides are also provided in community health centers and probably provided at almost every primary health care office in the United States of America.

The issue is, it seems to me, is there a need for more primary health care access in the United States of America? The question also is, if we provide that access, do we, (a) not only keep people healthier, because the doors are now opened to walk into a primary health care physician when you are sick, but equally important, do we save money.

Now you may be familiar, Mr. Macrae, with the study done by George Washington University, and they said, in fact, that if we expand community health centers and enable people to walk in the door, so that they don't have to go to the emergency room as much as 10 times the cost per visit, so that they don't get sicker and then when they walk in the doctor's office they end up in the hospital at what could be more than 50 times the cost of what it might have been to treat them initially, then in fact investing in primary health care access and community health centers saves substantial

sums of money, both for the government, in terms of Medicaid and Medicare and for the private sector as well. Is that your understanding?

Mr. MACRAE. Yes. I would say there are several studies that point out that by investing on the front end, in terms of preventive and primary care, the services that health centers provide, it does, again, reduce the use of emergency rooms, hospitalizations and overall reduces the costs for the patients and for the government, in terms of care.

Senator SANDERS. Senator Paul.

Senator PAUL. So one followup on this, on the idea of whether Planned Parenthood is duplicate service, as obviously it is, and I know you don't want to comment because it is very emotional, political football, but they obviously do. You duplicate every one of their services. The real difference between you and Planned Parenthood is you are a civil servant, correct?

Mr. MACRAE. Yes.

Senator PAUL. You can be fired by the taxpayers, someone in the executive branch can replace you, if you don't do your job. Planned Parenthood is not responsive to the taxpayer or to the government and we give them money.

The other question is, and this is in the scheme of the large picture, we are nearly \$2 trillion short every year. Should we not, at the very least, even if I accept all of your arguments that the government should be doing this, if we stick our head in the sand and just say every program is going to always get money, we have 42 different programs doing Federal workplace training; we have 82 different programs judging teachers. Every year we just add on one more program.

You are here and Obamacare is going to give you 68 percent increase in funding. We are throwing tons of money at community health centers and yet we are still throwing at it because Planned Parenthood is supported by the left, they give contributions, they lobby and they are a big organ for the other side. But the thing is, why don't we try to—I don't see you as a partisan, you are trying very hard not to be a partisan, but Planned Parenthood is a partisan, politically and otherwise. You are not. At the very least, if you want government to do it, if you want taxpayers to fund it, let's do it through a government agency and not be giving it to a private agency. Thank you.

Senator SANDERS. Let me just say I wasn't quite aware, maybe at some point we can do a hearing on Planned Parenthood. I am strongly supportive of what they do.

Does the government have a serious deficit problem? It sure does. You are absolutely right. But some of us think maybe the cause of that are two wars that were unpaid for, huge tax breaks for the rich and a Wall Street bailout, we could talk about that also, Senator Paul, at some point.

But, Mr. Macrae, that is probably not your area of involvement. [Laughter.]

So why don't we thank you, if that is OK with Senator Paul, thank you very much for being here and thank you very much for the excellent work you and your agency do.

Now let us bring up all of our other panelists.

Mr. MACRAE. Thank you.

Senator SANDERS. Thank you.

Mr. MACRAE. Thank you very much.

Senator SANDERS. We have a great panel and I want to, on behalf of the committee, thank you all very much for being with us today to discuss this very important issue. My request is that you limit your initial remarks to 5 minutes. Senator Paul and I and any others, we are going to ask you questions and we can go on from there in a kind of an informal way.

Let's begin with Debra Draper. Am I pronouncing your name, last name correct?

Ms. DRAPER. It is Draper.

Senator SANDERS. Draper. Sorry. All right.

Dr. Draper is a director on the health care team at the U.S. Government Accountability Office. She received her doctorate in health services organizations and research from the Medical College of Virginia, Virginia Commonwealth University.

Dr. Draper, thanks very much for being with us.

STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. DRAPER. Chairman Sanders, Ranking Member Paul, thank you for the opportunity to be here today as you discuss the diversion of non-urgent use of hospital emergency departments in the implications for care and costs.

Hospital emergency departments are a major component of the Nation's health care safety net. They are open 24 hours a day, 7 days a week and generally are required to medically screen all individuals, regardless of their ability to pay. Emergency department use has increased over time and in 2007 there were approximately 117 million visits, of which 8 percent were classified as non-urgent.

Like hospital emergency departments, the national network of health centers, which includes approximately 8,000 delivery sites, is an important component of the health care safety net, particularly for those who may have difficulty obtaining access to health care because of financial or other limitations. Health centers are funded, in part, through Section 330 grants and provide comprehensive health care services without regard to a patient's ability to pay. They also provide enabling services, such as case management and transportation which help patients to access care.

Some emergency department visits, include those for non-urgent conditions, may be treated in other, more cost-effective settings such as health centers. According to 2008 national survey data, the average amount paid for a nonemergency visit to the emergency department was seven times more than that for a health center visit. Individual's decisions to go to the emergency department vary, but often include the lack of timely access to care in other settings.

In my statement today I will discuss key findings from a report that we are publicly releasing today that describe strategies that health centers have implemented that may reduce emergency department use. I will also highlight challenges that health centers may face in implementing and evaluating these strategies.

Health center officials that we spoke with described three types of strategies they have implemented that may reduce emergency

department use. One type of strategy focus on emergency department diversion, which is often implemented in collaboration with the hospital, and includes educating emergency department patients on appropriate use. Diversion strategies often target patients whose visits are non-urgent, lack a regular source of care, are uninsured or have Medicaid or are frequent users.

The second type of strategy that health centers have implemented focuses on care coordination. Health center officials describe two types of care coordination strategies, the first is the medical home model, which uses a physician-led team to provide ongoing and comprehensive care to patients to improve outcomes. The second is chronic care management which aims to reduce, if not prevent, disease-related emergencies. It emphasizes the monitoring and management of conditions such as diabetes, asthma and heart disease through preventative care, screening and patient education on healthy lifestyles.

The third type of strategy that health centers have implemented focuses on increasing awareness of and access to services and includes expanding health center hours to include evenings and weekends, making available same day or walk-in appointments and locating service delivery sites in or near hospitals, schools and homeless shelters. Health center officials also discuss the use of strategies that reach out to patients, including tele-medicine, home visits and mobile clinics.

Health center officials identified a number of challenges implementing the strategies that I have discussed today. For example, they talked about the difficulty of changing the care seeking behaviors of some patients who are frequent emergency department users, including those who are homeless or have substance abuse and mental health issues. Health center officials also told us that they have mostly anecdotal evidence on the effectiveness of the strategies they have implemented. However, one health center that had participated in a diversion program with a formal evaluation reported a 63 percent decrease in emergency department visits 1 year after patients enrolled in the program.

To conclude, as more people obtain health care coverage through the Affordable Care Act, the demands on hospital emergency departments are likely to increase. Health centers may provide a more effective alternative for some emergency department visits, including those for non-urgent conditions. The Affordable Care Act provides health centers with an additional \$11 billion in funding over the next 5 years, which is expected to increase capacity, positioning these providers to serve more people, including those who may have sought care from hospital emergency departments.

Mr. Chairman, this concludes my opening remarks. I am happy to answer any questions.

[The prepared statement of Dr. Draper follows:]

PREPARED STATEMENT OF DEBRA A. DRAPER

SUMMARY

Our work found that health centers have implemented three types of strategies that may help reduce emergency department use. These strategies focus on (1) emergency department diversion, (2) care coordination, and (3) accessibility of services. For example, some health centers have collaborated with hospitals to divert emergency department patients by educating them on the appropriate use of the

emergency department and the services offered at the health center. Additionally, by improving care coordination for their patients, health centers may help reduce emergency department visits by encouraging patients to first seek care at the health center and by reducing, if not preventing, disease-related emergencies from occurring. Finally, health centers employed various strategies to increase the accessibility of their services, such as offering evening and weekend hours and providing same-day or walk-in appointments—which help position the health center as a convenient and viable alternative to the emergency department. Health center officials told us that they have limited data about the effectiveness of these strategies, but some officials provided anecdotal reports that the strategies have reduced emergency department use. These officials also described several challenges in implementing strategies that may help reduce emergency department use. For example, health center officials indicated that some services, such as those provided by case managers who may help coordinate care, are generally not reimbursed by third-party payers. Additionally, some officials noted that it is difficult to change the behaviors of patients who frequent the emergency department and some noted challenges with recruiting the necessary health providers to serve their patients.

Chairman Sanders, Ranking Member Paul, and members of the subcommittee, I am pleased to be here today to discuss strategies that health centers—facilities that provide primary care and other services to individuals in communities they serve regardless of ability to pay—employ that may help reduce hospital emergency department use. Hospital emergency departments are a major component of the Nation's health care safety net as they are open 24 hours a day, 7 days a week, and generally are required to medically screen all people regardless of ability to pay.¹ From 1997 through 2007, U.S. emergency department per capita use increased 11 percent.² In 2007, there were approximately 117 million visits to emergency departments; of these visits, approximately 8 percent were classified as nonurgent.³ The use of emergency departments, including use for nonurgent conditions, may increase as more people obtain health insurance coverage as the provisions of the Patient Protection and Affordable Care Act (PPACA) are implemented.⁴

Some nonurgent visits are for conditions that likely could be treated in other, more cost-effective settings, such as health centers. In 2008, the average amount paid for a nonemergency visit to the emergency department was seven times more than that for a health center visit, according to national survey data.⁵ While there are many reasons individuals may go to the emergency department for conditions that could also be treated elsewhere, one reason may be the lack of timely access

¹In order to participate in Medicare, hospitals are required to provide a medical screening examination to any person who comes to the emergency department and requests an examination or treatment for a medical condition, regardless of the individual's ability to pay. Social Security Act §§1866(a)(1)(I), 1867 (codified at 42 U.S.C §§1395cc(a)(1)(I), 1395dd). Medicare is the Federal health program that covers seniors aged 65 and older, certain disabled persons, and individuals with end-stage renal disease.

²In 1997, there were an estimated 35.6 emergency department visits per 100 people compared to 39.4 visits in 2007. See P. Nourjah, "National Hospital Ambulatory Medical Care Survey: 1997 Emergency Department Summary," *Advance Data*, no. 304 (1999), and R. Niska, F. Bhuiya, and J. Xu, "National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary," *National Health Statistics Reports*, no. 26 (2010).

³The National Center for Health Statistics developed time-based acuity levels based on a five-level emergency severity index recommended by the Emergency Nurses Association. The acuity levels describe the recommended timeframe for being seen by a physician. The recommended timeframes to be seen by a physician are less than 1 minute for immediate patients, between 1 and 14 minutes for emergent patients, between 15 minutes and 1 hour for urgent patients, greater than 1 hour to 2 hours for semiurgent patients, and greater than 2 hours to 24 hours for nonurgent patients.

⁴We refer to the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat 1029, as PPACA. According to estimates from the Congressional Budget Office (CBO), an additional 32 million individuals are projected to obtain health insurance coverage by 2019; CBO also estimates that gaining insurance increases an individual's demand for health care services by about 40 percent. See D. Elmendorf, Director, CBO, "Economic Effects of the March Health Legislation" (presentation at the Leonard D. Schaeffer Center for Health Policy and Economics, University of Southern California, Los Angeles, CA, Oct. 22, 2010).

⁵According to estimates from 2008 Medical Expenditures Panel Survey (MEPS), the average amount paid for a nonemergency visit to an emergency department was \$792, while the average amount paid for a health center visit was \$108. Similarly, the average charge for a non-emergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—\$2,101 compared to \$203. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States.

to care in other settings, possibly due to the shortage of primary care providers in some areas of the country.

Like emergency departments, the nationwide network of health centers is an important component of the health care safety net for vulnerable populations, including those who may have difficulty obtaining access to health care because of financial limitations or other factors. Health centers, funded in part through grants from the Department of Health and Human Services' Health Resources and Services Administration (HRSA), provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services, as well as referrals to specialty care—without regard to a patient's ability to pay. They also provide enabling services, such as case management and transportation, which help patients access care. In 2009, more than 1,100 health center grantees operated more than 7,900 delivery sites and served nearly 19 million people. With funding from PPACA—projected to be \$11 billion over 5 years for the operation, expansion, and construction of health centers⁶—health center capacity is expected to expand.

My statement will highlight key findings from a report we are publicly releasing today that describes strategies that health centers have implemented that may help reduce the use of hospital emergency departments.⁷ For that report, we interviewed officials from nine health centers, and conducted group interviews with officials from multiple health centers operating in three States, about strategies they have implemented that may help reduce emergency department use. We selected these health centers and States, based on our review of relevant literature and interviews with HRSA officials and experts, to provide geographic variation and to ensure that health centers serving rural and urban areas were represented. We also e-mailed all State and regional primary care associations—private, nonprofit membership organizations of health centers and other providers—to identify specific health centers in their jurisdictions that had implemented strategies that may have reduced emergency department use.⁸ In addition, we collected information about health centers' strategies from the literature and our interviews with agency officials and experts. Our work was performed from November 2010 through April 2011 in accordance with generally accepted government auditing standards.

In brief, our work found that health centers have implemented three types of strategies that may help reduce emergency department use. These strategies focus on (1) emergency department diversion, (2) care coordination, and (3) accessibility of services. For example, some health centers have collaborated with hospitals to divert emergency department patients by educating them on the appropriate use of the emergency department and the services offered at the health center. Additionally, by improving care coordination for their patients, health centers may help reduce emergency department visits by encouraging patients to first seek care at the health center and by reducing, if not preventing, disease-related emergencies from occurring. Finally, health centers employed various strategies to increase the accessibility of their services, such as offering evening and weekend hours and providing same-day or walk-in appointments—which help position the health center as a convenient and viable alternative to the emergency department. Health center officials told us that they have limited data about the effectiveness of these strategies, but some officials provided anecdotal reports that the strategies have reduced emergency department use. These officials also described several challenges in implementing strategies that may help reduce emergency department use. For example, health center officials indicated that some services, such as those provided by case managers who may help coordinate care, are generally not reimbursed by third-party payers. Additionally, some officials noted that it is difficult to change the behaviors of patients who frequent the emergency department and some noted challenges with recruiting the necessary health providers to serve their patients.

Chairman Sanders, Ranking Member Paul, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the subcommittee may have at this time.

Senator SANDERS. Thank you very much, Dr. Draper.

⁶Specifically, PPACA appropriated \$9.5 billion for fiscal years 2011 through 2015 to a new Community Health Centers Fund to enhance funding for HRSA's community health center program. It also provided \$1.5 billion over that same time period for the construction and renovation of community health centers. Pub. L. No. 111-148, §10503, 124 Stat. 119, 1004 (2010); Pub. L. No. 111-152, §2303, 124 Stat. 1029, 1083.

⁷GAO, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, GAO-11-414R (Washington, DC: Apr. 11, 2011).

⁸We received responses from 21 of 52 regional and State primary care associations we contacted.

Our next panelist is Dr. Peter Cunningham who is a senior fellow and director of quantitative research at the Center for Studying Health System Change here in Washington. His research focuses on a number of crucial health care topics that have long been of interest to policymakers, including trends in health care access, utilization and expenditures.

Dr. Cunningham, thanks very much for being with us.

**STATEMENT OF PETER CUNNINGHAM, Ph.D., SENIOR FELLOW,
CENTER FOR STUDYING HEALTH SYSTEMS CHANGE, WASHINGTON, DC**

Mr. CUNNINGHAM. Chairman Sanders, Senator Paul and members of the subcommittee, thank you for the invitation to testify about the use of hospital emergency departments for non-urgent health problems.

My name is Peter Cunningham and I am a researcher and director of quantitative research at the Center for Studying Health System Change here in Washington. We are an independent, non-partisan health policy research organization. Our goal is to inform policymakers with objective and timely research on developments in the health care system and the impact on people. We do not make specific policy recommendations.

Since 1996 we have been following trends in the use of hospital emergency departments and how it is related to other developments in the health care system through analyses of survey data as well as intensive study of the health systems in 12 communities.

My written testimony concurs with many of the points made in the GAO report in that there has been a substantial increase in the use of hospital emergency departments over the past 15 to 20 years. This has certainly contributed to crowding at many emergency departments which has generated concern about the impact on the quality of patient care, the costs of care and the ability of hospitals to respond to mass casualty events and public health emergencies.

To alleviate crowding and to improve the quality of primary care for patients, we have seen a number of efforts across the country to shift some of the excess demand for emergency department care, especially for non-urgent health problems, to other primary care providers in the community, including community challenge centers.

My written testimony also notes that it is important that efforts to shift care out of the emergency department take the following into account. First, people with private insurance account for most of the increase in emergency department use. It is true that the uninsured depend on emergency departments for their care a lot more than people with insurance coverage. But the uninsured are generally not responsible for the problem of crowding, at least at a national level. There is compelling evidence that insufficient capacity with the primary care system is resulting in some spillover into hospital emergency departments.

But it is not just a lack of primary care providers but also the lack of after hours care at other primary care providers in the availability of 24/7 at the emergency department that leads many people to go there for minor ailments.

Also, identifying visits that should be moved out of the emergency department must be done very carefully and with consideration of other primary care resources in the community. It is not just the acuity level of the health problem or the immediacy in which the patient should be seen, but also the availability of after hours care, other facilities such as freestanding urgent care centers and community health centers and how easy it is for patients to get same day appointments at other providers in the community. This differs across communities as well as by patient characteristics, especially their insurance coverage.

Despite concerns about crowding at the emergency department, hospitals are not always onboard with efforts to shift care out of their emergency departments or at least they want to do so selectively by shifting their uninsured patients to community health centers but retaining their paying patients. We have observed that lack of cooperation by hospitals can severely limit the effectiveness of any program to shift care out of the emergency department.

I do agree that visits to emergency departments are more expensive than at other primary care providers. I am a little bit more skeptical about the overall amount of cost savings to the health care system that could be generating by shifting more of these visits outside, but I think probably more notable is that it would reduce the financial burden of medical care for the uninsured and I think it would generate a higher level of cost savings for the Medicaid program.

Whatever the issue of cost, there is widespread agreement among medical care providers that shifting non-urgent care out of the emergency department and into primary care settings has important benefits for the quality of patient care, the continuity of care and reducing unnecessary or redundant utilization. It is also consistent with recent developments in health care that emphasize a more integrated health care delivery system and having a medical home where all of the patient's care, including care by specialists and pharmaceuticals is coordinated and managed.

That concludes my testimony. Thank you.

[The prepared statement of Dr. Cunningham follows:]

PREPARED STATEMENT OF PETER CUNNINGHAM, PH.D.

SUMMARY

There has been much concern over the past decade about crowded and overloaded hospital emergency departments (EDs). Contributing to the problem of ED crowding is a substantial increase in emergency department utilization among the U.S. population—often attributed to growing use for nonurgent health problems. As a result, many policymakers and health care providers believe it is essential to shift some of this use to community-based primary care providers to relieve crowded EDs, lower the costs of care to both the health system and patients, and improve the quality of care. The following points are key:

- Emergency department use has increased substantially over the past 15 years, but most of this is the result of increased use by people with private insurance and other health insurance coverage. The uninsured account for only a small share of the overall increase in emergency ED volumes. Thus, the problem of ED crowding will not be resolved by reducing utilization among the uninsured.
- Few emergency department visits are truly nonurgent, but a much larger number could potentially be treated in primary care settings depending on the circumstances of the visit, such as the time of day and day of the week when care is needed, the availability of other providers in the community such as freestanding

urgent care centers, and the ability to get same-day appointments with primary care physicians.

- Capacity constraints in the ambulatory medical care system have likely contributed to an increase in ED use for nonurgent health problems, and at the same time, these capacity constraints inhibit the ability to shift patients from EDs to primary care settings.

- Some patients prefer going to the ED—even when they have a primary care physician—in large part because of the greater convenience of emergency departments, which are open 24 hours a day, 7 days a week. Thus, increasing the availability of after-hours care and same-day appointments is critical to shifting care from EDs to primary care settings.

- Many hospital EDs are expanding capacity to accommodate the increased demand as well as to increase revenues from resulting inpatient admissions and procedures. Most hospitals have little financial incentive to discourage ED use, except for uninsured patients. Gaining cooperation of some hospitals to shift nonurgent ED visits to primary care settings could be a major obstacle to the success of any such program.

- Reducing the use of EDs for nonurgent health problems may generate much lower cost savings to the health care system than is commonly assumed. However, shifting more of this care to community health centers is likely to generate more substantial cost savings for both uninsured patients as well as State Medicaid programs.

Chairman Sanders, Senator Paul and members of the subcommittee, thank you for the invitation to testify about use of hospital emergency departments for nonurgent health problems. My name is Peter Cunningham, and I am a researcher and director of Quantitative Research at the Center for Studying Health System Change (HSC).

HSC is an independent, nonpartisan health policy research organization affiliated with Mathematica Policy Research. HSC also is the research arm of the nonpartisan, nonprofit National Institute for Health Care Reform, a 501(c)(3) organization established by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors to conduct health policy research and analysis to improve the organization, financing and delivery of health care in the United States (NIHCR.org).

I and other HSC researchers have conducted a number of studies documenting the increase in the use of hospital emergency departments, including for nonurgent health problems, and the problems of crowding at some emergency departments (EDs). We have examined how these trends affect and are affected by larger developments in the health care system, the reasons why people use emergency departments for minor ailments, and the potential for hospitals to shift some of their emergency department visits to primary care providers in the community.

Our goal at HSC is to inform policymakers with objective and timely research on developments in the health care system and the impact on people. We do not make specific policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

There has been much concern over the past decade about what many believe is a national crisis of crowded and overloaded hospital emergency departments and the consequences for patient care and the ability of EDs to respond to both individual and mass-casualty emergencies. Contributing to the problem of ED crowding is a substantial increase in emergency department utilization among the U.S. population, which is often attributed to growing use of emergency departments for nonurgent health problems. As a result, many policymakers and health care providers believe that it is essential to shift emergency department use for nonurgent health problems to primary care providers in the community to relieve crowded emergency departments, lower the costs of care and improve the quality of care.

My testimony today will make the following key points:

- Emergency department use has increased substantially over the past 15 years, mostly because of increased use by people with private insurance and other health coverage. While emergency department crowding is often attributed to the uninsured, their use of emergency departments is considerably less than privately insured people. Increases in emergency department visits by the uninsured account for only a small share of the overall increase in emergency department volumes.

- Few emergency department visits are truly nonurgent, according to the most credible national data. Most ED visits are neither clearly nonurgent nor truly emergencies. Determining whether these visits could be shifted to primary care settings in the community is difficult because the appropriate use of the emergency depart-

ment for health problems often depends on factors other than their urgency, including the time of day and day of the week when care is needed, the availability of other providers in the community such as freestanding urgent care centers, and the ability to get same-day appointments with primary care physicians.

- Increases in emergency department visits reflect a more general increase in the demand for ambulatory care, and it should be emphasized that physician office visits have increased at an even higher rate than emergency department visits. As office-based physicians struggle with growing practice capacity constraints, some of the excess demand is spilling over into hospital EDs. For their part, some patients prefer going to the emergency department—even when they have a primary care physician—because emergency departments are open 24 hours a day, 7 days a week.

- Many hospital emergency departments are expanding capacity to accommodate the increased demand, as well as to increase revenues from resulting inpatient admissions and procedures, particularly for privately insured and Medicare patients. Far from perceiving emergency departments as money losers, most hospitals have little financial incentive to discourage emergency department use by privately insured and Medicare patients—including for nonurgent health problems—which could complicate efforts to shift some nonurgent visits to more-appropriate community settings.

- Despite recent increases in utilization, hospital emergency departments represent a relatively small part of the U.S. health care system in terms of both utilization and costs. Reducing the use of EDs for nonurgent health problems may generate much lower cost savings than is commonly assumed. However, because Medicaid enrollees have by far the highest per person use of hospital emergency departments, the potential cost savings to the Medicaid program could be more substantial.

THE EVOLVING ROLE OF HOSPITAL EMERGENCY DEPARTMENTS

Hospital emergency departments are a critical and indispensable component of the U.S. health care system. While their traditional mission is to provide trauma and emergency services for people in imminent danger of losing their life or suffering permanent damage to their health, the role of emergency departments has evolved over the past several decades. EDs are on the front lines of communities' preparedness efforts and responses to natural disasters, other mass-casualty events, and public health emergencies arising from outbreaks of influenza and other communicable diseases.

Emergency departments have become the true provider of "last resort" for uninsured people and other patients who are unable to afford other medical providers in the community, largely as a result of the 1986 Federal Emergency Medical Treatment and Labor Act (EMTALA) that requires hospitals to provide emergency screening and stabilization services regardless of patients' ability to pay. Along with the fact that emergency departments are often the only medical facilities in a community that are open 24 hours a day, 7 days a week, true emergencies comprise only a relatively small share of visits to emergency departments. Today, hospital emergency departments are a major source of primary health care in the community, treating a broad range of health problems that include many visits for minor ailments and other "nonurgent" conditions.

USE OF EMERGENCY DEPARTMENTS STILL RELATIVELY RARE

Americans made a total of 124 million visits to hospital emergency departments in 2008, the latest year for which data are available from the National Hospital Ambulatory Medical Care Survey (NHAMCS)—the most authoritative and cited source of information on emergency department utilization (see Table 1).¹ Compared with other forms of ambulatory care use, however, use of hospital emergency departments is relatively rare, accounting for only 10 percent of all ambulatory care visits to medical providers. By contrast, Americans made 956 million visits to physician offices in 2008—representing 80 percent of all ambulatory care visits—and 110 million visits to hospital outpatient departments.

Emergency department use is also much less frequent than physician office visits on a per capita basis. There were 41 emergency department visits for every 100 Americans in 2008, compared to 320 physician office visits for every 100 Americans. About 84 percent of Americans visited a physician's office in 2007, compared to 23 percent who visited a hospital emergency department.

¹National Center for Health Statistics. Health, United States: With Special Feature on Death and Dying. Hyattsville, MD (2011).

Table 1.—Use of Ambulatory Medical Care Services by the U.S. population, 1995–2008

	1995	2000	2008	Percent change 1995– 2008
Number of visits in thousands:				
Emergency departments	96,545	108,017	123,761	28
Physician offices	697,082	823,542	955,969	37
Hospital outpatient departments	67,232	83,289	109,889	63
Number of visits per 100 persons:				
Emergency departments	37	40	42	14
Physician offices	271	304	315	16
Hospital outpatient departments	26	31	36	38

Source: CDC/NCHS, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey, as reported in Health, United States, 2010.

BUT INCREASES IN UTILIZATION CONTRIBUTE TO CROWDING

Concern about the use of hospital emergency departments increased substantially over the past decade because of widespread reports of growing demand by patients and crowding at many emergency departments. Indeed, in a 2007 report, the Institute of Medicine described a growing national crisis of crowded emergency departments leading to delays in care for patients, ambulance diversions to other hospitals, and inadequate capacity to handle a large influx of patients from a public health crisis or mass-casualty event.²

Increased crowding at emergency departments has a number of causes, and a 2003 U.S. Government Accountability Office report concluded that insufficient inpatient capacity—the inability of hospitals to move patients from the emergency department into inpatient beds—was a major factor.³ As a result of problems with “throughput,” emergency department patients are (1) waiting longer to be seen in the emergency department; (2) waiting longer to be admitted as an inpatient if necessary, and; (3) increasingly leaving the emergency department without being seen. Also, there has been an increase in hospitals diverting ambulances to other hospitals because of emergency department crowding.

Increased demand for emergency departments has exacerbated these problems. Between 1995 and 2008, visits to hospital emergency departments increased 28 percent, with much of the increase because of increased per person use—from 37 visits per 100 persons in 1995 to 41 visits in 2008 (see Table 1). However, physician office visits increased by an even greater amount between 1995 and 2008—37 percent—with per person use increasing from 266 visits per 100 persons in 1995 to 320 visits in 2008. Thus, increases in emergency department use over the past decade and a half reflect a more general increase in the demand for ambulatory care and must be understood in the broader context of changes in the health care system. As physician practices have become busier and patients have greater difficulty getting timely appointments with their physicians, some of the excess demand for ambulatory care is no doubt spilling over into emergency departments.⁴

PRIVATELY INSURED PATIENTS ACCOUNT FOR MOST OF THE INCREASE IN ED VOLUME

Also, while there is a common perception that emergency department crowding is driven primarily by increases in utilization by the uninsured, most of the growth in emergency department volume during this period was driven by insured people. For example, the share of emergency department visits classified as “self-pay” or “no charge”—mostly uninsured patients—actually decreased from 17 percent of visits in 1995 to 15 percent in 2008, despite the fact that the number of uninsured increased by 23 percent during this period.^{5 6 7} In contrast, the share of emergency department visits made by privately insured people increased from 37 percent of all visits in

² Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, The National Academies Press, Washington, DC (2007).

³ U.S. Government Accountability Office, *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities*, No. GAO-03-460. Washington, DC (March 2003).

⁴ Cunningham, Peter, and Jessica May, *Insured Americans Drive Surge in Emergency Department Visits*, Issue Brief No. 70, Center for Studying Health System Change, Washington, DC (October 2003).

⁵ National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables, Hyattsville, MD. (2011).

1995 to 42 percent of visits in 2008. Privately insured people accounted for about 60 percent of the overall increase in ED use between 1995 and 2008, while the uninsured accounted for only 9 percent of the increase.

The perception that the uninsured are responsible for the problems of emergency department crowding may be because uninsured people depend more on emergency departments for access to care. For example, more than one-fourth of all ambulatory care visits by the uninsured are in emergency departments, compared to only 7 percent for the privately insured and 17 percent for Medicaid enrollees.⁸ Even more striking is that uninsured people's dependence on EDs for care has grown dramatically since 1995 when 16 percent of ambulatory care visits by the uninsured were in hospital emergency departments.

The increasing dependence on hospital emergency departments by the uninsured reflects an erosion in access to office-based physicians, as evidenced by declines in the percent of physicians providing any charity care during this period.⁹ Some physicians believe they are no longer able to afford to provide charity care because of financial pressures from payers, while others have much less time for charitable and volunteer activities because of the increased demand for care by privately insured patients.

WHAT ARE "NONURGENT" HEALTH PROBLEMS?

Many observers have attributed increases in "nonurgent" use of emergency departments as a key driver of crowding at some EDs. However, defining a "nonurgent" ED visit is not straightforward and has been the subject of much debate and controversy. Estimates of the percent of emergency department visits that are for nonurgent health problems vary widely, from about half of all visits to less than 10 percent.¹⁰ The wide differences in estimates largely reflect differences in the assumptions made about the feasibility of shifting certain types of visits to a primary care physician's office or clinic without harm to the patient.

One major problem is that it is difficult to determine the "urgency" of a visit based solely on a physician's diagnosis after examination of a patient, which may be quite different from the patient's perception of symptoms when deciding to seek emergency care. An example often used to highlight the difficulty is a patient arriving at an emergency department complaining of chest pains and concerns of a possible heart attack, only to learn after a medical examination, the problem is severe indigestion.

Thus, from the patient's perspective, the visit is certainly urgent or emergent, but it is unlikely to be classified as such based only on the physician's diagnosis.

For this reason, the "urgency" of a hospital emergency department visit is best determined by the level of immediacy (in minutes) assigned upon arrival at the emergency department by triage staff. The National Hospital Ambulatory Medical Care Survey uses this information to determine the urgency of a visit, which includes five categories: (1) Immediate (patient needs to be seen immediately); (2) emergent (needs to be seen within 15 minutes upon arrival); (3) urgent (between 15–60 minutes); (4) semiurgent (1–2 hours) and nonurgent (2–24 hours). It is important to note that the immediacy with which a patient should be seen is unknown for about 16 percent of emergency department visits in the NHAMCS data for 2008, in part because some emergency departments either do not triage patients in this way or do not keep records of their triage decisions.

Based on this classification system, 4 percent of emergency department visits in 2008 (a total of 4.6 million visits) were visits in which the patient needed to be seen immediately; 12 percent were considered emergent; 39 percent were considered urgent; and 21 percent were semi-urgent (see Table 2). Only 8 percent of visits—a total of 9.9 million—were classified as nonurgent. Trends in the relative number of nonurgent visits have actually decreased slightly since 2000, when 10.7 percent of

⁶Stussman, Barbara J., "National Hospital Ambulatory Medical Care Survey: 1995 Emergency Department Summary," National Center for Health Statistics Advance Data From Vital and Health Statistics; No. 285, Hyattsville, MD (1997).

⁷Fronstin, Paul, *The Impact of the 2007–09 Recession on Workers' Health Coverage*, Employee Benefit Research Institute Issue Brief No. 356, Washington, DC (April 2011).

⁸The estimates in this paragraph are computed from published reports by the National Center for Health Statistics based on the 1995 and 2008 National Hospital Ambulatory Medical Care Survey and the 1995 and 2008 National Ambulatory Medical Survey.

⁹Cunningham, Peter, and Jessica May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again*, Tracking Report No. 13, Center for Studying Health System Change, Washington, DC (March 2006).

¹⁰Simonet, Daniel, "Cost Reduction Strategies for Emergency Services: Insurance Role, Practice Changes and Patient Accountability," *Health Care Analysis*, Vol. 17, pp. 1–19 (February 2009).

visits were classified as nonurgent.¹¹ In sum, most visits to hospital emergency departments are neither true emergencies requiring that patients be seen almost immediately nor are they clearly nonurgent problems that could be addressed in other primary care settings.

The majority of visits that are considered urgent or semi-urgent reside in a gray area as to whether they could potentially be shifted to other primary care settings, such as freestanding urgent care centers or through same-day appointments with private practice physicians. While many conditions associated with these visits could likely be treated in other outpatient settings, it is not necessarily inappropriate for the patient to use the emergency department depending on the circumstances, such as the availability of other health care providers in the area, the time of day and day of the week when services are needed, and the affordability of these other providers based on a patient's insurance status and ability to pay.

Two-thirds of all emergency department visits occur outside normal business hours—8 a.m. to 5 p.m., Monday through Friday, compared to only 5 percent of visits to office-based physicians and 11 percent of visits to hospital outpatient departments.¹² Thus, increasing the number of primary care providers in the community who are available after normal business hours (i.e., in the evenings and on weekends) is essential for any effort to shift visits from the ED to other primary care providers in the community.

Table 2.—Triage Status of Emergency Department Visits, by Expected Source of Payment, 2008

	Percent distribution of visits					
	Number of visits in thousands	Immediate/Emergent	Urgent	Semiurgent	Nonurgent	Unknown
All visits	123,761	16	39	21	8	16
Expected Source of Payment:						
Private insurance	51,887	17	41	21	6	15
Medicaid/SCHIP	29,701	14	40	22	10	15
Medicare	22,827	25	41	14	6	14
Uninsured	19,094	12	34	24	12	19
Worker's compensation	1,561	8	32	37	8	13
Other	5,706	17	43	22	8	11
Unknown	7,492	11	33	19	7	30

Triage status is based on the following classification:

Immediate/emergent—Patient should be seen immediately or within 15 minutes.

Urgent—Patient should be seen within 15–60 minutes.

Semiurgent—Patient should be seen within 61–120 minutes.

Nonurgent—Patient should be seen between 121 minutes and 24 hours.

Unknown—No mention of immediacy in the medical record; hospital does not perform triage; or the patient was dead on arrival.

Source: CDC/NCHS. National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables (Table 7).

MOST NONURGENT VISITS MADE BY PERSONS WITH INSURANCE COVERAGE

As with emergency department visits overall, people with insurance coverage account for most nonurgent ED visits, with privately insured persons alone accounting for about one-third of nonurgent visits (computed from Table 2). Uninsured persons account for slightly less than one-fourth of all nonurgent emergency department visits, while Medicaid enrollees account for 29 percent. Nevertheless, the uninsured are more likely to use emergency departments for nonurgent health problems compared to the privately insured: visits for nonurgent health problems account for 12 percent of ED visits by the uninsured compared to 6 percent for the privately insured. Similarly, the uninsured are less likely to use emergency departments for true emergencies compared to privately insured persons: emergencies accounted for 12 percent of visits for uninsured persons compared to 17 percent for privately insured persons (see Table 2).

IMMIGRANTS INFREQUENT USERS OF EMERGENCY DEPARTMENTS

Another common perception is that immigrants—particularly undocumented immigrants—are responsible for much of the crowding in emergency departments. Al-

¹¹ McCaig, Linda F., and Nghi, Ly, "National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary," National Center for Health Statistics Advance Data From Vital and Health Statistics, No. 326, Hyattsville, MD (April 2002).

¹² Pitts, Stephen R., et al., "Where Americans Get Acute Care: Increasingly, It's Not at Their Doctor's Office," *Health Affairs*, Vol. 9, No. 1, pp. 1–10 (September 2010).

though the National Hospital Ambulatory Medical Care Survey has limited information on race/ethnicity and immigration status, other studies call into question the extent of the problem that emergency departments have treating undocumented immigrants. Recent immigrants—in the United States for 5 years or less—are less likely to use emergency departments (9 percent), compared both to immigrants who have been in the United States for 20 years or more (19 percent), as well as native-born Americans (22 percent).¹³ In addition, an analysis of variation in emergency department use across communities showed that communities with high levels of emergency department use had fewer Hispanic noncitizens compared to communities with low levels of emergency department use.¹⁴

Low ED use by recent immigrants reflects the fact that they are much less likely to use health care of any type, including physician office visits, primarily as a result of high uninsured rates and a lack of access to care.¹⁵ As with the uninsured, recent immigrants tend to *rely* on emergency departments to a much greater extent when they do use health care compared to native-born Americans, which may contribute to the perception that they are “flooding” local hospital emergency departments. Crowding of emergency departments by immigrants may occur in some isolated circumstances, such as in communities along the border with Mexico or areas that have seen a recent surge in immigration, but it is not a major contributor to hospital emergency department crowding nationally.

LACK OF PRIMARY CARE ACCESS NOT THE REASON FOR EMERGENCY DEPARTMENT USE

It is not the case that people who use emergency departments for nonurgent health problems have no source of primary care they could use instead. One study found that among all people visiting the emergency department for nonurgent health problems, two-thirds reported they had a regular source of medical care at a physician’s office.¹⁶ Only 3 percent reported that the ED was their usual source of care, while 15 percent reported they did not have any usual source of care. In addition, people who use the ED for nonurgent health problems tend to have greater use of physicians in other ambulatory care settings over a 1-year period. This strongly suggests that use of emergency departments for nonurgent problems does not reflect lack of access to other primary care providers for most patients, although it is a much more important reason for uninsured patients.

CAPACITY CONSTRAINTS CONTRIBUTE TO HIGHER EMERGENCY DEPARTMENT USE

As noted previously, it is possible that greater capacity constraints in the ambulatory care system are shifting some of the excess demand for ambulatory care from physician offices to emergency departments. Many experts and policymakers have been concerned about physician shortages—particularly of primary care physicians—resulting in some patients having greater difficulty finding physicians that are close to their home or work, scheduling same-day appointments with their primary care physician, and physicians being able to spend adequate time with patients.¹⁷

In examining differences between communities with low levels of ED use and communities with high levels of ED use, I have observed that communities with high levels of ED use tend to have greater capacity constraints among office-based physicians, as reflected in longer average appointment waiting times for patients and a greater number of visits per physician in the community.¹⁸ This suggests that as demand for medical care increases over time and the capacity of office-based physicians is squeezed, some of the excess demand for ambulatory care will spill over to hospital emergency departments.

At the same time, many patients prefer to use hospital emergency departments even if they believe that their health problem could have been handled by a primary

¹³ Cunningham, Peter, and Samantha Artiga, “*How Does Health Coverage and Access to Care for Immigrants Vary by Length of Time in the U.S.*,” Kaiser Commission on Medicaid and the Uninsured, Washington, DC (June 2009).

¹⁴ Cunningham, Peter, “What Accounts For Differences In The Use Of Hospital Emergency Departments Across U.S. Communities?” *Health Affairs*, Web Exclusive (July 2006).

¹⁵ Cunningham and Artiga (June 2009).

¹⁶ Cunningham, Peter, “The Use of Hospital Emergency Departments for Nonurgent Health Problems: A National Perspective,” *Medical Care Research and Review*, Vol. 52, No. 4, pp. 453–74 (1995).

¹⁷ O’Malley, Ann S., et al., *Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System*, Issue Brief No. 101, Center for Studying Health System Change, Washington, DC (November 2005).

¹⁸ Cunningham (July 2006).

care physician outside of the emergency department.¹⁹ The greater convenience of hospital emergency departments relative to primary care providers is among the most important reasons for using EDs, especially the fact that they are open 24 hours a day and 7 days a week, and that they can “walk-in” to the emergency department at their own convenience rather than scheduling an appointment. The greater convenience of emergency departments is especially important for people who are unable or unwilling to take time off from work to see a physician.

What is less clear is whether patient preferences for the emergency department will continue given the increased crowding at many facilities and the longer wait times. The total amount of time that patients spend in the emergency department—including time spent waiting as well as for examination and treatment—has increased from 45 percent of visits lasting 2 or more hours in 2001 to 60 percent of visits in 2008.²⁰ Other research has shown that patients’ satisfaction with their visit to an emergency department decreases rapidly the longer they wait to be seen. For example, two-thirds of patients who waited 15 minutes or less to be seen by a medical provider in the emergency department reported that the thoroughness of their exam was very good or excellent.²¹ However, positive ratings of their visit dropped to 46 percent for patients who waited between 30 and 60 minutes, and 28 percent for patients who waited more than an hour.

HOSPITALS EXPANDING EMERGENCY DEPARTMENT CAPACITY

At the same time, many emergency departments have been expanding capacity to meet increased demand. More than one-fourth of emergency departments in 2008 had expanded their capacity in the previous 2 years, and 28 percent had plans to expand their capacity in the next 2 years.²² Emergency departments serving a large volume of patients (50,000 or more per year) were much more likely to be expanding capacity compared to emergency departments serving smaller volumes of patients.

Expanding the capacity of hospital emergency departments appears to conflict with a widely held view that emergency departments are money losers for hospitals—i.e., they generate insufficient revenue from billings to cover the costs. In this view, hospitals should be reluctant to expand emergency department capacity and be eager to look for ways to decrease their volumes by shifting patients to other sources of primary care when appropriate.

However, when the overall financial status of many hospitals is considered, emergency departments generate more revenue for the hospital than they lose, mainly by serving as a conduit for inpatient admissions. Researchers at the University of Southern California estimated that by closing the emergency department, a hospital would lose one-third or more of its inpatient admissions, which would cost the hospital much more than the savings generated by closing the emergency department.²³ Seen in that context, it is not surprising that many hospitals are expanding their emergency departments, not only to relieve crowding because of increased demand, but also as a way to generate more revenue from inpatient admissions.

Efforts to expand emergency department capacity and volume also suggest that many hospitals perceive few incentives or benefits to shift nonurgent care from their emergency department to primary care settings. Even if an emergency department visit does not result in an inpatient admission, nonurgent emergency department patients may require inpatient care or other hospital services in the future, in which case the assumption is that the patient would continue to use the same hospital to receive these more “profitable” services. Hospitals will especially encourage privately insured, Medicare and sometimes even Medicaid patients to use their emergency departments, as these patients generate revenue for the hospital. Many hospitals are likely to be much more selective about the patients they are willing to shift to primary care settings, focusing especially on their uninsured patients to decrease their uncompensated care costs.

COST SAVINGS FROM REDUCING NONURGENT ED USE LIKELY TO BE MODEST

About \$47.3 billion was spent on emergency department visits in 2008, accounting for 4 percent of all health care expenditures received by the U.S. population during

¹⁹ California HealthCare Foundation, *Overuse of Emergency Departments Among Insured Californians*, Oakland, CA (October 2006).

²⁰ National Center for Health Statistics (2011); and McCaig and Ly (April 2002).

²¹ Cunningham and May (October 2003).

²² National Center for Health Statistics (2011).

²³ Melnick, Glenn A., et al., *California Emergency Departments: Do They Contribute to Hospital Profitability?* California HealthCare Foundation, Oakland, CA (July 2003).

that year, according to the Medical Expenditure Panel Survey.²⁴ Total spending on emergency department visits doubled between 2000 and 2008, even after accounting for general inflation, and has been rising at a faster rate than overall health care spending.²⁵ The cost of emergency department use for nonurgent health problems is more difficult to estimate since expenditures are not collected in the National Hospital Ambulatory Medical Survey. Moreover, the wide range of estimates of the number of emergency department visits that could potentially be shifted to primary care settings also means that the potential cost savings from these shifts will also vary widely.

The GAO report, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, included an estimate based on the 2008 MEPS that the average amount for a nonemergency visit to an emergency department was \$792, less than the \$1,265 per visit for all emergency department visits and more than seven times higher than a visit to a community health center.²⁶ However, other research suggests that the potential cost-savings associated with shifting nonurgent emergency department visits to office-based practices may be much lower. An earlier study using data from the 1987 National Medical Expenditure Survey (the predecessor to the MEPS) compared the costs of nonurgent visits to the emergency department with the potential costs of these same visits had they occurred in office-based physician practices.²⁷ The results showed that the cost of nonurgent visits to emergency departments was only three times higher compared to what they would have cost in an office-based practice, which is considerably less than the estimate in the GAO report. Also, a study based on hospitals in Michigan during the early 1990s found that the average cost of an urgent emergency department visit was five to six times higher than for a nonurgent visit, indicating that cost savings to the health care system from shifting nonurgent emergency department visits to primary care settings may be less than is commonly assumed.²⁸

It is possible that shifting nonurgent emergency department visits to community health centers (CHCs) could result in greater savings than comparable visits to private office-based physicians. Research has shown that the availability of CHCs in an area is associated with lower rates of hospital emergency department use, particularly among the uninsured.²⁹ There is some evidence that CHCs provide care more efficiently and at lower cost compared to private physician practices, perhaps because the large volumes of patients CHCs see permit greater economies of scale in the cost of patient care.³⁰ Also, the typically tight budgets and low margins with which they operate may compel CHCs to identify efficiencies and cost savings in their operations. In addition, many CHCs provide after-hours care in the evening and on weekends, an important consideration for those who use emergency departments because of the convenience of after-hours care.³¹

Nevertheless, community health centers comprise only a small share of total ambulatory care volume in the United States—70 million visits to CHCs in 2008 compared to a total of 956 million physician office visits. CHCs are not present or convenient in all areas, and many do not provide after-hours care. Even with the increased funding for CHCs included in the Patient Protection and Affordable Care Act, CHCs would likely be able to accommodate only a relatively small share of the nonurgent emergency department visits that could potentially be shifted to primary care providers, and most of these would likely be people who are uninsured or enrolled in Medicaid who already comprise the majority of CHC patients. Privately in-

²⁴ Agency for Healthcare Quality and Research, "Emergency Room Services—Median and Mean Expense Per Person with Expense and Distribution by Source of Payment, 2008," Summary Data Table From the Medical Expenditure Panel Survey—Household Component.

²⁵ Ibid. and Agency for Healthcare Quality and Research, "Emergency Room Services—Median and Mean Expense Per Person With Expense and Distribution by Source of Payment, 2000," Summary Data Table From the Medical Expenditure Panel Survey—Household Component.

²⁶ U.S. Government Accountability Office, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, No. GAO-11-414R, Washington, DC (May 2011).

²⁷ Baker, Laurence C., and Linda Schuurman Baker, "Excess Cost of Emergency Department Visits for Nonurgent Care," *Health Affairs*, Vol. 13, No. 5, pp. 162–71 (1994).

²⁸ Williams, Robert M., "The Costs of Visits to Emergency Departments," *The New England Journal of Medicine*, Vol. 334, No. 10, pp. 642–46 (March 1996).

²⁹ Rust, George, et al., "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties," *Journal of Rural Health*, Vol. 25, No. 1, pp. 8–16 (2009).

³⁰ McRae, Thomas, and Robert D. Stampfly, *An Evaluation of the Cost-Effectiveness of Federally Qualified Health Centers Operating in Michigan*, Institute for Healthcare Studies at Michigan State University (October 2006).

³¹ Michelle M. Doty, et al., *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings From the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers*, The Commonwealth Fund, New York (May 2010).

sured people with nonurgent visits to emergency departments are unlikely to switch to CHCs both because of negative perceptions that more affluent patients may have of community health centers and because CHCs are generally not located in areas where more affluent privately insured persons tend to live.

COST SAVINGS FOR THE UNINSURED AND MEDICAID LIKELY TO BE GREATER

While the cost savings to the health care system of shifting care out of the emergency department to Community Health Centers may be minimal, the cost savings to uninsured patients could be considerable. The average cost of an emergency department visit for uninsured persons was \$1,203 in 2008, of which half is paid out-of-pocket.³² Nonurgent visits are likely to be less costly for the uninsured—as they are with the general population—but they may still be responsible for a bill of several hundred dollars or more. By contrast, community health centers typically charge patients on a sliding scale—the fee amount increases along with their incomes—and typically ranges from \$20 to \$60 per visit.

It should also be noted that most hospitals have policies that allow their charges to be waived or reduced based on the patient's ability to pay, including for visits to hospital emergency departments. For poor or low-income patients, hospitals often use a sliding-scale method similar to that used by community health centers to determine the patient's responsibility, and charges are often waived for the poorest uninsured patients.³³ Thus, depending on the hospital's charity care policies and the patient's income, an uninsured person could pay little or none of the charge, or they could be responsible for most or all of the charge of the emergency department visit. However, hospitals sometimes limit the effectiveness of their charity care policies by failing to advertise them or making them known to patients, as well as by rigorous eligibility determination process that includes verification of sources of income.

Shifting nonurgent emergency department visits to community health centers and other sources of primary care could generate greater cost savings for the Medicaid program. Medicaid enrollees have the highest rates of emergency department use compared to persons with private insurance, Medicare or who are uninsured, and Medicaid enrollees account for more than one-fourth of nonurgent visits to the emergency department.³⁴ Because Medicaid patients already comprise a large proportion of patients at community health centers—and they tend to live in areas where CHCs are located—programs designed to shift nonurgent care from EDs to CHCs may have greater potential to generate cost savings in the Medicaid program than for private payers, Medicare or even hospital uncompensated care costs from caring for the uninsured.

Finally, improvements in continuity of care, patient satisfaction and care coordination between primary care providers and specialists that can be facilitated by community health centers and other primary care providers can also increase cost savings to the Medicaid program, primarily by reducing redundant and unnecessary use of health services.

GAINS IN QUALITY OF CARE MAY BE GREATER THAN COST SAVINGS

Shifting ED use for nonurgent problems to primary care providers in the community is likely to have even more important implications for the quality of care. ED use for nonurgent health problems is associated with greater fragmentation and discontinuity of care with the patients' primary care physicians and other medical providers they use. Studies have found that communication and coordination of care between EDs and primary care physicians tends to be haphazard and generally poor, which is exacerbated by a lack of shared information systems that could facilitate communication.³⁵ The lack of coordination and continuity between EDs and other providers in the community often leads to duplicative testing and other redun-

³² Agency for Healthcare Quality and Research, "Emergency Room Services—Median and Mean Expense Per Person with Expense and Distribution by Source of Payment, 2008," Summary Data Table From the Medical Expenditure Panel Survey—Household Component.

³³ Staiti, Andrea, et al., *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients*, Issue Brief No. 99, Center for Studying Health System Change, Washington, DC (October, 2005).

³⁴ Cunningham, Peter, "Medicaid/SCHIP Cuts and Hospital Emergency Department Use," *Health Affairs*, Vol. 25, No. 1, pp. 237–47 (January/February 2006).

³⁵ Carrier, Emily, et al., "Coordination Between Emergency and Primary Care Physicians," National Institute for Health Care Reform, Research Brief No. 3, Washington, DC (February 2011).

dant utilization, complicates appropriate followup care, and increases the risk of medical errors.³⁶

Shifting ED use to primary care physicians may also increase patient satisfaction with care. According to one survey, more than three-fourths of patients with scheduled appointments at a doctor's office gave positive ratings about the thoroughness of the exam and the physician's willingness to listen.³⁷ By contrast, only about half of ED patients gave such positive assessments. Thus, patients may be motivated to go to the ED because of greater convenience and the availability of after-hours care but not necessarily because they believe the ED provides better quality of care.

Shifting ED visits for nonurgent health problems to primary care providers in the community is a necessary step for broader efforts in the health care system to create "patient-centered medical homes." This would not only improve the quality of care by ensuring that patients have a primary care physician to see for their nonurgent health problems and coordinating care with specialists and other providers, but it is also likely to generate additional cost savings by reducing unnecessary or redundant utilization.

Senator SANDERS. Thank you very much, Doctor. Yes.

Dr. Alieta Eck, do I have your first name right?

Dr. ECK. Alieta.

Senator SANDERS. Alieta, I am sorry. Dr. Alieta Eck, M.D., graduated from Rutgers College of Pharmacy in New Jersey and the St. Louis School of Medicine in St. Louis. She studied internal medicine at Robert Wood Johnson University Hospital in New Brunswick and has been in private practice with her husband, Dr. John Eck, M.D., in Piscataway, NJ since 1988.

Thanks very much for being with us, Dr. Eck.

**STATEMENT OF ALIETA ECK, M.D., FOUNDER & CO-DIRECTOR,
ZAREPHATH HEALTH CENTER, ZAREPHATH, NJ**

Dr. ECK. Thank you very much. I appreciate being able to come here and tell of my experience. I think I can give some really good advice as to what we could do to reduce the emergency room costs and reduce the overall costs of medicine in the entire United States.

I have been in private practice for 23 years. I was involved in the Medicaid program early on but then got out when I realized that I was losing money with every Medicaid patient. That wouldn't have lasted very long if I kept going.

So my husband and I started a free clinic 10 miles away on a church ground. A little building had been flooded and it got renovated by volunteers, we started, it was debt free. We have volunteer physicians, nurses, support staff, everybody volunteers, nobody gets paid and they love to be there. We see about 3 to 400 people per month, we only are open 12 hours a week. So it is a huge, efficient way to take care of people who just come in. They see smiling faces, everybody is happy to see them. They are there because they are volunteered and we provide good primary care.

I looked at the little script in the beginning where it says that it is a thousand dollars to take care of a patient in an emergency room and it is about \$140 to take care of a patient in a federally qualified clinic, and that is by the testimony of somebody who works in one or who runs one in the next town over. It costs us \$13 to take care of a visitor.

³⁶ Pitts (September 2010).

³⁷ Cunningham and May (October 2003).

With all the volunteers there people come for very, very different reasons. People are poor for very different reasons and a lot of them have made social decisions that are not in their best interest, they have gotten involved with drugs or alcohol, there are single parents, just things are difficult. So to have somebody along side that can come and help them with those type of issues, which is the case in a church environment, is huge. Our church has gone from 150 to 2,000 members in the 7 years since we have had our free clinic, because people really want to be in a community that cares. People want to give in a community that cares, the receivers and the recipients—and the givers of the care ennobled by true charity.

I was looking at the Form 990, I was trying to figure out what it is with these federally qualified clinics that makes them different than us and why it costs so much to take care of people there. It seems like it should be a lot cheaper. I looked at one Form 990, they pay \$113,000 for travel, \$650,000 for provision for bad debts, personnel recruitment, \$265,000 a year. They get money from Medicaid, they get money from the Federal Government, grants, they get uncompensated care payments. Their miscellaneous income is twice the income of our little clinic—which \$58,000 a year is all it costs for us to take care of these people and do a very good job.

All of that got me thinking, and I said, Medicaid is \$10 billion of a \$28 billion budget in New Jersey. I thought, what could we do to reduce the costs? It is really hurting the taxpayers, the taxpayers are reeling at the expense the government is putting on them. So if we could reduce taxes that would help the whole economy. And we came up with the idea, several of us came up with the idea of what we call the Volunteer Physicians Protection Act.

We need more physicians. It is hard to find physicians to volunteer. They are very strapped by decreasing payments from third parties and by increasing regulations. So we thought, why don't we have physicians donate 4 hours a week in a nongovernment free clinic dotted throughout the State. Then the only thing we would ask the State to do is to extend the medical malpractice coverage that they give to the physicians who work in the medical schools, just extend it to those physicians as their only reward for doing that time, for putting in 4 hours a week in a free clinic. The free clinic could be located within the hospital, so the hospital, when they see a patient coming in with a sore throat, they could be going over to this free clinic who should be just a couple rooms down and the physician who is volunteering could be taking care of that physician for free at no cost to anybody, to the taxpayer. That way we could take care of the poor, the taxpayer would not be impoverished by the system and we could balance a budget.

In fact, I ran some of the numbers. We were only open 12 hours a week, I figure about maybe a hundred patients a month we are diverting from the emergency room. They are coming in with their sore throats, with their ear aches. Sore throats are the No. 1 reason Medicaid people go to the ER. We are diverting them. If we were open 72 hours a week, that would be 600 patients. If there were a 100, that would be 60,000 ER visits we could be diverting. I am just doing the math, which might be wild. But \$720 million we could save in New Jersey just by doing something like this

where instead of spending a thousand dollars in the emergency room, we spend zero, zero cost to the taxpayers, a lot less cost to the donors and I think we would solve the problem.

[The prepared statement of Dr. Eck follows:]

PREPARED STATEMENT OF ALIETA ECK, M.D.

SUMMARY

The poor go to the emergency room for non-urgent care because there is no deterrence. They know that a physician will be there at any hour and it is easier to just go rather than wait for an appointment. Patients on Medicaid are twice as likely to go to the emergency room than those without insurance, as they feel entitled and empowered by their card. Some feel victimized by the inability to find a physician's office where the Medicaid card is welcomed, so no amount of teaching and reasoning will change their behavior unless they choose to go elsewhere for urgent care.

Increasing payments to physicians as a way of increasing physician participation in Medicaid is not the answer, as the taxpayers can ill-afford to pay more. Opportunities for fraud and abuse would simply multiply as more taxpayer dollars would be flowing out of the State House. Expanding **Federally Qualified Health Centers (FQHCs)** might seem reasonable, but they are extraordinarily expensive to run, 10–20 times more than **non-government free clinics (NGFCs)**. FQHCs are funded by taxpayers. NGFCs are funded by charitable donations.

We see from 300–400 patients per month in the Zarephath Health Center, a NGFC. We estimate that our small clinic diverts from 100–150 inappropriate ER visits per month. Patients tell us that they would have come to the clinic had we been open. We are only open 12 hours per week. So increasing our hours to 72 hours per week would clearly decrease inappropriate ER use. Greatly increasing the numbers of NGFCs would lead to a reduction in the number of patients who go to the emergency rooms for non-urgent care. One hundred similar facilities, including some located within the walls of the hospitals, could divert 60,000 unnecessary ER visits, saving the taxpayers of New Jersey \$60 million per year.

A proposal, The NJ Volunteer Physicians Protection Act (VPPA) is working its way through the legislature in New Jersey, whereby physicians would agree to volunteer 4 hours per week in a NGFC. Surgeons or OB–GYN's might do two cases per month for patients referred by the free clinic. As the physicians' only reward, we are asking for the State government to provide medical malpractice coverage for their entire practices.

Current systems in place include:

- The Federal Tort Claims Act—provides free Federal malpractice coverage for work done in NGFCs.
- New Jersey currently provides medical malpractice coverage to physicians who teach or study in the medical school hospitals.
- Echoclinics.org is an organization that is facilitating the starting of new NGFCs.

Thus, all of the programs are already in place to realign the way physicians care for the poor. The only legislation required will be to *extend existing medical malpractice programs* to the private practices of all physicians who volunteer for a stated amount of time. Gradually defunding the highly bureaucratic programs that are not providing acceptable care to the poor would lower taxes and provide a great stimulus to the economy. The poor would get continuity of care, and emergency room use for non-urgent illnesses would dramatically decrease.

Goals would be to:

- **Increase access for the poor** to friendly non-bureaucratic care outside of the emergency room.
- **Indirectly compensate the physicians** who provide the free care by lowering their office overhead.
- **Relieve the taxpayers of the current unbearable burden of the Medicaid system.**
- Change the entire culture of the way we help the poor in America.

Good morning. I am a physician specializing in Internal Medicine. I welcome the opportunity to speak in front of this committee, and explain what I have observed in both my 23 years of private medical practice and the 7 years of volunteering in a free clinic. I believe that I can give information that will be valuable in helping

to develop policies that would be effective in deterring the unnecessary use of the emergency room.

Both in the practice where I earn my living, and the free clinic where I see the poorest of the poor, I count it a privilege to be able to make a difference in the lives of my patients.

My husband, Dr. John Eck, M.D., and I dropped out of the Medicaid program a few years after enrolling, realizing that it was causing our practice to lose money, thus jeopardizing our livelihood. The cost of filing the claim was greater than the sum Medicaid would pay us several months later.

THE FOUNDING OF A NON-GOVERNMENT FREE CLINIC

After Hurricane Floyd flooded a small house on the edge of our church campus at Zarephath, NJ, we convinced the church leadership to allow us to renovate it and turn it into a clinic. We had read Marvin Olasky's *Tragedy of American Compassion*, and we determined to do things differently—to see the poor for free, to solicit the help of caring volunteer nurses and support staff, and to work to identify the root causes of the poverty that brought the patients to us, helping in any practical way we could. The clinic began operation in September 2003. It has a 501(c)3 charity status and operates completely by private donations—with no taxpayer dollars. In fact, we would turn down taxpayer dollars, as we firmly believe charity should be voluntary.

Volunteers listen to the stories of each person who comes in, offering kind encouragement. A verse stenciled to the wall in the waiting room reads, "Come unto me, all you who labor and are heavy-laden, and I will give you rest. (Jesus)" Then a nurse and physician see the patient to handle common complaints such as a sore throat, bronchitis, hypertension, diabetes, thyroid disease and sometimes illnesses that are more serious and life threatening. We bind up the wounds of their limbs and their hearts. The church has a food pantry and a clothing thrift shop where some people pay a few dollars for clothes and many can get them for free. It is not one-size-fits-all charity situation, but varied help for very different types of people.

We have never advertised, but the patients come—from as far away as Pennsylvania and New York, an hour and a half away.

- Patients are referred by their friends, other patients or church members.
- Patients are referred by the emergency rooms, after they have been seen there.
- Patients are referred by nurses in the hospitals when poor patients are being discharged and have no primary care physician.
- Patients are referred by local pharmacies.
- Patients are actually referred to us by the *Medicaid office* when patients have complained that they could not find a physician who accepts Medicaid.
- Patients are referred by all the social service agencies in the area.
- We see patients who have just been released from prison, referred by their parole officers.
- We see patients who have been released from psychiatric hospitals, prescriptions in hand and no means to pay for them. They are scheduled to see a psychiatrist 6 weeks hence at a State-run psychiatric facility, but are not given any help in between. We hand them their medicines if they are available in our little pharmacy. We handle them medically until they can get to the proper specialists. A local community food bank has a fund set aside for emergency prescriptions.
- We see unemployed union members who are dejected, wondering how to pay their mortgages and unable to pay for medical care.
- We see single mothers who bring their little ones to play with volunteers in our play area, while we take care of mom's medical needs. We try to have the children leave with smiles on their face and often a donated teddy bear.
- We see children when a pediatrician or family practitioner are there.
- We see people who are, temporarily unemployed and feeling frightened and vulnerable.
- We see patients who are referred to us by the unemployment office.
- We see people who are living in their cars or under bridges, having been evicted from their homes, estranged from their families for many reasons including their own poor behavior.
- We see patients referred to us by judges in family court.

No one pays a penny, but some put a few dollars into a donation box at the front desk. This covers some of the \$13 average cost per patient. Medications are handed out for free—donated by pharmaceutical companies, drug representatives, sample closets of fellow physicians, and some purchased wholesale. Often we will write for the \$4 prescriptions that the free market has made available to all. Every patient leaves with a grateful heart, as they know that people cared for them because they

wanted to, not because it was their job. All are treated with respect, empathy and kindness.

Some people are poor through no fault of their own, but many have made bad choices along the way. They need good advice, role models and people who will patiently encourage them to make changes that will empower them to be lifted out of poverty. Zarephath Christian Church has many programs that fill their social voids—men's breakfasts, women's luncheons, Bible studies, support groups for those who grieve, support groups for battered women, marriage ministries and other groups for all ages.

WHO GETS CARE AT THE ZAREPHATH HEALTH CENTER?

Let me give you some examples of actual patients we have seen:

- A 54-year-old gentleman, a carpenter with no work, came in with severe nasal obstruction from sinus polyps. He was on Medicaid but could not find an ENT surgeon who would operate for the amount Medicaid would pay. Why should a surgeon take on full liability for such a low fee? This man was asking me to fill out disability forms. Instead, I called an ENT friend and asked what he would charge. We agreed upon a fair amount and the surgery was done and we paid out of donations we had received. The very grateful patient came to a men's breakfast at the church where volunteer workers are spending their free time fixing up our new clinic facility. He wants to volunteer as well.

- A 34-year-old woman came in with palpitations and a tender thyroid. With no risk factors for heart disease, we gave her medicine to slow her heart and had her come back the next day where our volunteer retired cardiologist saw her and confirmed the diagnosis. She was 100 percent better. The charity system was saved probably \$10,000, as a visit to the ER would have triggered that much in advanced cardiac testing.

- A 25-year-old gentleman walked in with a vial of an anti-psychotic medication that was to be administered monthly. He had the paperwork, but no one to administer it. We did.

- A 15-year-old girl with no insurance came in with palpitations and shortness of breath. Our retired cardiologist diagnosed a cardiac conduction defect that would require a surgical ablation to cure. He called a colleague who was happy to take care of her for no charge. Her grateful mother comes in and volunteers to do clerical work at the clinic.

- A couple is overwhelmed with two severely autistic children. The church has developed a program whereby these children are given one-on-one supervision in Sunday classes and the parents can attend church services together. The parents are extremely grateful and the father, an air conditioning specialist has offered to maintain our system in our new facility.

- A 48-year-old woman came in showing all the signs of the disfigurement of acromegaly, a disease of the pituitary gland where growth hormone continues unchecked after puberty. This was diagnosed 10 years ago, but she had no means to pay for care. She went to the Medicaid office where she was told that the only way to get Medicaid was to be on welfare. She argued that she wanted to work, but just needed help with medical bills. She was thus turned away and referred to us by the unemployment office.

- A 50-year-old woman with extreme weight loss and a breast mass was being worked up for cancer. When no cancer was found, she was referred to our clinic. It turns out that her very bad teeth were seeding her bloodstream and causing the abscesses. Antibiotics helped her gain weight and a dentist agreed to take care of her teeth for no charge.

- A 54-year-old man who had had a kidney transplant came in with no way to pay for his transplant rejection medicine. This was a true emergency. We called the township and asked if there was some type of charity fund for this type of thing. Fortunately, we were able to get him the medicine he needed.

Today we see 300–400 patients per month and the church has made new space available for us. We will go from 900 to 4,000 square feet, with five exam rooms, three intake and counseling rooms, and a large classroom to teach classes on diabetes and other topics. Our new clinic will have a dental chair for dentists to volunteer. It is being built by builders, plumbers and electricians who are working at a reduced rate and many former patients who are volunteering to do the sheet rock and spackling. The township building inspector, so inspired by the stories, has agreed to put the first coat of paint on all the walls for free. Money is being donated for the work, and we will open in a month or so, completely debt free. The church has gone from an attendance of 150 to 2,000 in the 7 years the clinic has been in existence. A culture of caring attracts people.

WHO GOES TO THE EMERGENCY ROOMS FOR NON-URGENT COMPLAINTS?

- Many patients bring their emergency room reports with descriptions of their ear aches, sore throats or rashes. When we ask why they went to the ER for such minor illnesses, they tell that they would have come to our clinic, but we were not open. Because of lack of physicians who are able to volunteer, our clinic is only open 12 hours a week.

- Patients who are poor and without any assets have absolutely no restraint when it comes to going to the ER. They know that there is a physician there 24/7 so do not bother to call an office or clinic to make an appointment. When I was a resident many years ago I remember one patient showing me her rash at 3 a.m. When I asked why she was coming for such a minor complaint at that hour, she said she figured it would be a good time because we wouldn't be busy. To her, this was a perfectly reasonable answer.

- *Patients on Medicaid are twice as likely to visit the ER for non-urgent conditions than patients with no insurance at all.* Their sense of entitlement, having that Medicaid card combined with their poor management of their own resources makes a warm, clean ER environment a pleasant place to spend an afternoon. Since they are not turned away, they continue to come. They have absolutely nothing to lose, as they will never see a bill. Any attempts to divert them are futile.

THE COST OF PROVIDING CARE FOR THE POOR

I note that on the description of today's hearing you claim that the cost to provide care in the emergency room is \$1,000, which is 7 times the cost of providing care in community health centers. This correlates with the information I have gathered where the costs in these centers are between \$140–\$280 per patient visit. Compare that to the cost of providing care in a non-government free clinic such as ours—**\$13, one-tenth to one-twentieth the cost of a federally qualified clinic.** If there were an adequate number of non-government free clinics, the savings to the taxpayer by keeping people out of the emergency rooms would be 100 percent, and the cost to the charitable donors would be minimal.

A federally qualified health center in the next town has a yearly budget of \$14 million—**all from taxpayer dollars.** (from the IRS Form 990). Ours is \$58,000—**none from the taxpayers.** For the amount it costs to fund one FQHC, we could fund 250 clinics like ours, and I submit that the patients would get better, more personalized care.

I do not like to disparage the work of others, but the following is an eyewitness account of someone who worked in one of those \$14 million FQHCs:

“The bureaucracy was unbelievable. The administrators had no clue how the care of patients worked. Tons of rules. Lack of proper supplies. Poor quality of the staff working there, mostly from the indigent areas. Patients had to wait hours to go through the registration and verification process which was very frustrating for them. A normal visit to the clinic took over 2 hours for a patient. Patients came there not by choice but because they had no place else to go. It was not a caring atmosphere. The administration made everything very difficult.”

This is not really surprising, for when providing charity is a job instead of a voluntary giving of one's services for no compensation, the dynamics change. This is not a new concept. In 1853, Rev. William Ruffner noted that:

“Charity is a work requiring great tenderness and sympathy, and agents who do their work for a price rather than love should not be trusted to execute the wishes of donors. The keepers of poor-houses fall into a business, unfeeling way of doing their duties, which is wounding and often partial and cruel to the objects of their attention.”

THE NJ VOLUNTEER PHYSICIANS PROTECTION ACT

So the question is, “What would it take to have thousands of non-government free clinics scattered throughout the country?”

The Zarephath Health Center is open only 12 hours per week as we have trouble finding physicians to volunteer. Physicians have many stresses and often struggle to meet all their obligations, suffering from ever-decreasing third party payments and ever-increasing administrative burden. Volunteering does not easily fit into their schedules. Even though the Federal Tort Claims Act (FTCA) gives us free Federal medical malpractice coverage for the work we do in the free clinic, it is still hard to find physicians.

So we, in New Jersey, are working on a solution. Physicians and citizens have come together to propose the **NJ Volunteer Physicians Protection Act**, whereby physicians would volunteer to donate 4 hours per week in non-government free clinics. Instead of billing for our services, we are asking that the State extend the same medical malpractice coverage it now provides to the medical school attendings, residents and students, to the *entire practices* of the physicians who volunteer. The State could simply take the same paperwork used by the FTCA to identify those physicians who qualify for coverage.

Medical malpractice coverage would be the physicians' only reward—no claim forms, no CPT codes, no secretaries at either end, no money flowing from the government to care for the poor. Just liability protection. The rest of the clinic work would be done with at least 90 percent volunteers, with minimal key paid staff, all funded by private donors, local fundraisers and corporate donations. From our experience, there would be no shortage of volunteer nurses and support staff. The baby boomers are poised to become a huge pool of volunteers with expertise and experience. There would be no avenue for fraud and abuse, as no money would be coming in from the government.

An organization founded by a philanthropic couple in Texas called Echo Clinics (echoclinics.org) has the mission of facilitating the founding of 10,000 free clinics by the year 2030. We look forward to working with them here in NJ. They facilitate in identifying core directors, choosing a free clinic site, establishing the 501(c)3, and going through the FTCA application.

Senator Bernie Sanders, you hail from the left, where you proclaim a deep concern for the poor and underprivileged. So I would think that our idea would appeal to you. Greater and more satisfactory access for the poor to see physicians of every specialty. *This is universal access.*

Senator Rand Paul, as a member of the Tea Party movement, you hail from the right, which believes in freedom, smaller government and lower taxes. Our plan ought to appeal to you as the free clinics would operate with no tax dollars at all. *This is limited government.*

The NJ State Medicaid budget is \$10 billion in a total State budget of \$28 billion. Half of that is for indigent elderly and half is for acute care. Of the \$5 billion for acute care, \$2 billion goes to Medicaid-managed care and \$800 million goes to federally qualified clinics. (data from statehealthfacts.org) Assuming an average 20 percent administrative cost, that means a total of \$500 million of these two entities is paying administrators of the system—people who do not touch the patients. In the NJ Medicaid budget, \$90 million goes directly to physicians. There is a bit of a disconnect in common sense here.

Since the Medicaid office is currently directing frustrated patients to our free clinic, why do we need the middle man? Why would we need Medicaid managed care if we physicians are willing to manage the care of the patients for free? *Who can argue with free?* Since the State would not be purchasing medical malpractice policies, the only cost to the State taxpayer would be incurred if an actual lawsuit were brought. From the experience of the FTCA, these would be rare. It does not take too much accounting to realize that NJ would quickly save \$2 billion if this program were implemented, and the 50 States could **save \$100 billion per year.**

The Federal Government would be able to lower its Medicaid spending as well. An added benefit would be the reduction of the estimated 20–30 percent cost of defensive medicine by the reduction of unnecessary testing done purely to avert potential lawsuits. This would reduce Medicare spending as well, another **\$200 billion in savings**, according to studies done during the Bush administration.

I am not suggesting that we dismantle the Medicaid program in one fell swoop—but give the patients in need a choice. If someone finds himself ill and with no insurance and no funds, he could go to a Medicaid office and spend time filling out forms where he might be rejected, or he could go to a nearby free clinic. Once the word got out, **a well-staffed free clinic that is open for many hours a day would be a huge deterrent from inappropriate use of the emergency rooms.** Also, each hospital could have several rooms set up where non-urgent cases could be seen by physicians who would donate their time there. The free clinics would not have to be free-standing.

Instead of having an entitlement for what might be a temporary tough time, why not have a place to go for only the time that is needed? After patients have been helped and are back on their feet, we will encourage those who find work to access and pay for care at our practices. Poverty should be a temporary state, not a way of life.

We have a Web site—NJAAPS.org. There physicians and citizens can read all about the NJ Volunteer Physicians Protection Act and sign up to voice their ap-

proval. So far we have 40 physicians who agree with the concept, and I do not believe that staffing these clinics will be difficult.

We have a seminar coming up next month to teach church leaders and concerned citizens how they can organize and establish a free clinic in their area. Sometimes it is good to revisit ideas from the past. Providing medical care for the poor and uninsured is one of them.

Thank you for this opportunity to address this committee.

Senator SANDERS. Thank you very much, Dr. Eck.

Dr. Dana Kraus, and I apologize for mispronouncing your first name a moment ago, is a board certified family physician. She did her residency at Oregon Health Science University, went to medical school at Dartmouth Medical School and has a bachelors in comparative literature from Brown University.

Dr. Kraus, thanks very much for being with us.

STATEMENT OF DANA KRAUS, M.D., FAMILY PRACTICE PHYSICIAN, NORTHERN COUNTIES HEALTH CARE, ST. JOHNSBURY, VT

Dr. KRAUS. I would like to thank everyone for the opportunity to come and speak. What I would like to talk about really is the transformation of the primary health care system that has occurred in my rural community in northern Vermont over the last 5 to 10 years.

What we do now is provide comprehensive, proactive and integrated health care using three things: The Chronic Care Model, the medical home and our own innovative community health team. The Chronic Care Model demonstrated that in order to provide the best chronic care, the best care for patients with the—Chronic Care Model indicated that the way to provide the best care for patients with chronic illness was to have a prepared and proactive team interacting with an informed and activated patient.

So it makes no sense to wait for a diabetic patient to come to the clinic with an infected toe that needs hospitalization and expensive IV antibiotics. So our patients with chronic illness, such as diabetes, are scheduled routine visits. Before they come in my staff knows to order their blood work a week before. My nurse knows to pull up a template for me so at the time of the visit I have all of the information that I need about that patient, their last lab work, their most recent visits with other specialists, so I can have a very efficient and very effective visit with that patient.

Now, to get an informed and activated patient, someone who is really engaged in their care and willing to work to improve their care is much more difficult. Remember that for patients with chronic illness, we are asking them, for example, to take medication when they have absolutely no symptoms of their illness, we are asking them to give up their Ben & Jerry's and go for a walk at lunchtime. So in order to help us to motivate these patients we have developed our community health team.

The community health team is staffed for care coordinators, by community health workers, people with social work backgrounds and by counselors and they become then an extension of the primary care providers. They are the people who connect our patients to services that already exist. They make sure that there is no duplication of services. They can help patients to get affordable medication, transportation to and from their visits to us or to the spe-

cialists. They can help patients get to their visits or to find daycare or respite care for their elderly parents.

What is unique in Vermont is that this payment is mandated by the State and is shared by not just Medicare and Medicaid but also by the private insurers, so all are cooperating to pay for this system.

We have aggressively recruited other primary care doctors who come, partly because of the system of support that we have to help them work. We have expanded our clinic hours. We accommodate many new patients. Our community health team reaches out to patients who are seen in the emergency room and can offer them a primary care provider if they don't have one, can help them get access to insurance if they do not have insurance and they can also provide education at the time of that outreach so that they can make sure that the patient is taking their medications, that the patient is understanding their instructions and that they are improving and can also educate them about the fact that we have same day appointments for which they can be seen and also to let them know that we have 24 hour service. They can always call a physician at any time to find out where the most appropriate time or place is for them to get care.

We feel, very importantly, that patients who come to see us at the clinic get significant benefit over going to the emergency room. We understand their chronic conditions and know what medications they are on. We are less likely to repeat tests or order unnecessary tests. We can do screening for depression and substance abuse and refer to our counselor, if that is necessary, as such illnesses tend to increase the cost of caring for the patient. We can also do preventative health service. So a patient who comes to see us for a sore throat is very likely to go out with an updated tetanus vaccine and a lab slip to have their cholesterol and their blood sugar checked for preventative health.

What have the outcomes been? In our community we have seen a significant decrease in ER visits and in hospitalizations. We have seen an 11 percent decrease in per member/per month costs based on private insurance claims data. We also feel very strongly that by providing improved control of chronic conditions and increased adherence to preventative care, that in the future we will be seeing significant cost savings. Thank you very much.

[The prepared statement of Dr. Kraus follows:]

PREPARED STATEMENT OF DANA KRAUS, M.D.

SUMMARY

I 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.

The Problem:

- Many unnecessary ER visits
- High proportion of medical expenditures to treat complications of chronic illnesses

Some of the Causes:

- Medical system designed for providing acute, reactive care
- Shortage of primary care providers
- Patients lack adequate insurance, thus avoid preventive care
- Poor patient understanding of proper ER use

- Changing behavior is difficult: taking medications, proper diet, exercising

Background Information:

- Northern Counties Health Care is a Federally Qualified Health Center (FQHC)
- Located in rural Northeastern Vermont
- 25-bed critical access hospital serves 30,000 people, 45 ER visits per day

Our Solutions:

- Provide comprehensive, integrated care using:
 - Chronic Care Model, Medical Home, Chronic Care Team
- Increase access to primary care providers
- Improve access to health insurance
- Patient education about proper ER use

Integrating The Chronic Care Model:

- Prepared proactive practice team
 - Scheduled appointments with tests done and available
 - Medical data in organized format
 - Guideline recommendations embedded in the EMR
 - EMR used to identify patients overdue for care
- Informed activated patients
 - Self-management goals set and reviewed with patients
 - Written care plans provided and reviewed with patients

Expansion To The Medical Home:

- National Committee for Quality Assurance (NCQA) Certification
- Preventive health maintenance
- Improved access to primary care provider
- Improved coordination of care
- Continuous quality improvement

The Community Health Team (CHT):

- Key to our success!
- An extension of the primary care providers
- Connects patients to existing local services and coordinates care
- Staffed centrally at the hospital and within the Medical Home clinics
- One-stop services, “wrap services around the patient”
- Sets self management goals with patients
- Helps to identify and manage most high-risk patients
- Provides behavioral health within the medical home clinics
- Funded by all insurers

Increased Access to Primary Care Providers:

- Aggressive provider recruitment
- Expanded clinic hours
- Accommodate new patients
- Increased availability of acute, same day slots
- CHT identifies ER patients without primary care provider, offers one

Increased Access to Insurance:

- CHT works with uninsured patients to access appropriate programs

Patient Education:

- CHT provider post-ER phone calls
- Proper use of ER addressed with patient at next clinic appointment

Additional Benefits of Seeing a Primary Care Provider:

- Chronic conditions/medications known
- Less likelihood of repeating tests or ordering unnecessary tests
- Screening done for depression and substance abuse
- Preventative health issues are addressed and implemented

The Outcomes:

- Decreased ER visits
- Decreased inpatient admissions
- Decreased PMPM costs
- Improved care of chronic conditions should lead to future cost savings
- Improved preventive care should lead to further cost savings

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 com-

munity 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 percent of the primary care for this catchment region. Another 40–50 percent is provided by a clinic owned and run by the local hospital, a 25-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 followup visits. Labs and tests are scheduled prior to the followup 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 of 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 eight 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 primary 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 2 years compared to the 2 years prior to the Medical Home Pilot. It was anticipated that the ER visit rate would be 60 visits per 1,000 patients, and instead it was 40 visits per 1,000 patients, a 33 percent decrease. Similarly, for inpatient hospital admissions, it was expected to be just below 10 admissions per 1,000 patients, and instead was only 7.5 admissions per 1,000 patients, a 24 percent decrease. (See attachment 4) The decrease in ER visits is due to both avoiding illness exacerbations that would have led to necessary ER visits, and to decreasing non-urgent ER visits. Just in a 1-year period between 2008 and 2009, there was a 11.5 percent 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 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 led to more immediate cost savings, with decreased ER visits and hospitalizations.

For example, among my patients is a 30-year-old single mother of three 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 followup (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. Pa-

tients with insurance are more likely to access primary care and preventive services, rather than using the ER for their care.

3. Followup

At the Medical Home Clinics our Chronic Care Coordinators provide phone followup 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 followup.

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 p.m. 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 followup 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 their 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. 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 2011¹

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

¹ Full report available at: http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf.

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 ACP, 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 ACPs. 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 ACP 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 ACP 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 PPM amount.

2. *Community Health Team Payments*

The Vermont Blueprint emphasizes that the excellent and challenging work of an ACP 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 ACP.

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 ACP 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 followup 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.

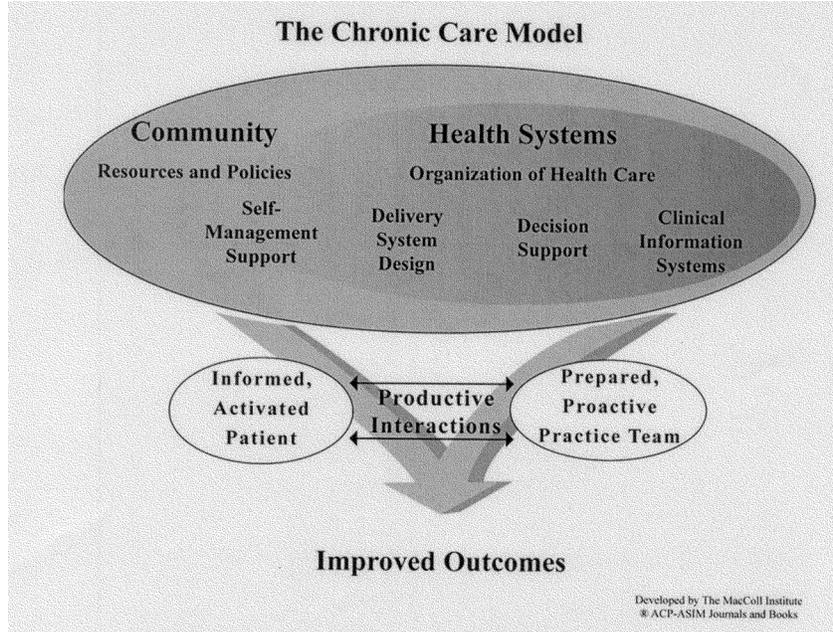
HEALTH INFORMATION ARCHITECTURE

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 ACP 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.—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 followup 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 followup 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 followup.
- 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.

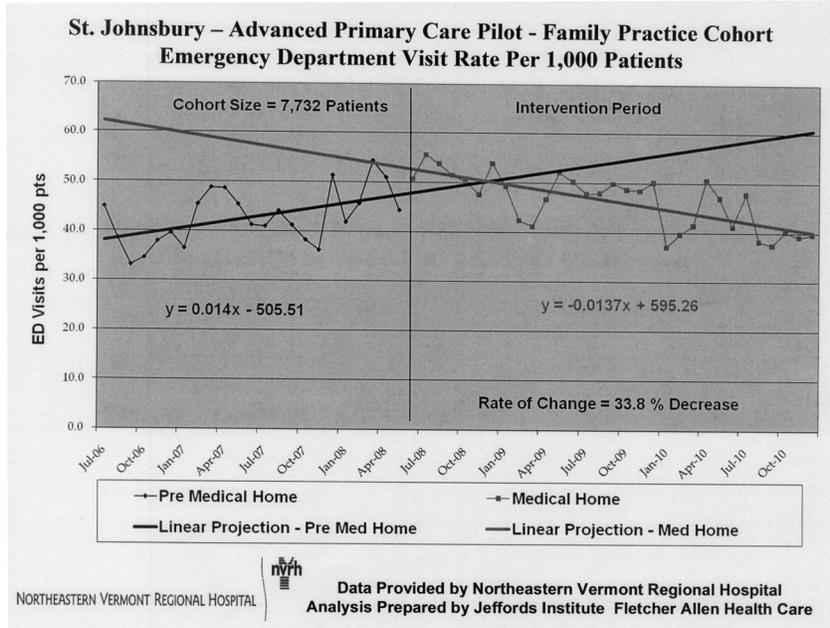
The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure 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.

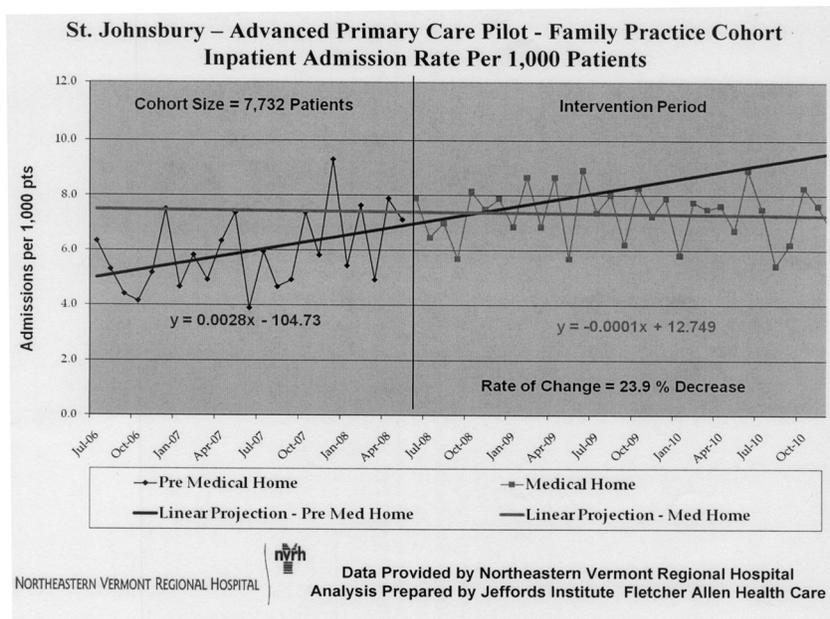
NCQA PCMH 2011
6 Standards, 27 Elements, 149 Factors

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 2011²



² Full Report available at: http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf.



Senator SANDERS. Thank you very much, Dr. Kraus.

If it is OK with Senator Paul, I would like to turn the mic over to Senator Whitehouse to make a comment and ask questions, if you would like.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. I would love to followup a little bit with Dr. Kraus. First of all, I hope you enjoyed your time at Brown University in wonderful Rhode Island.

Senator MERKLEY. And at OHSU.

Senator WHITEHOUSE. I'm sorry?

Senator MERKLEY. And at OHSU.

Senator WHITEHOUSE. I wanted to ask you a little bit more about your experience with electronic health records and integrating them into your practice, how effective have they been, have you been able to integrate your electronic health record with the local pharmacy, the local hospital, and other local specialists. Have you been able to begin to exchange any data? Just sort of give us an update on how that is going.

Rhode Island is doing a pretty good job. We are hoping that we will have an actual health information exchange set up shortly that can do that, we already have a health information exchange operating on a trial basis. But I know Vermont has done a lot of work and as a practitioner who works with it every day I would love to hear your thoughts.

Dr. KRAUS. We, for a small rural town, have a very advanced integrated electronic medical system. All except one private practitioner of our practices use an electronic health record. We have an

electronic record at the hospital and we have data that is automatically downloaded from the hospital labs and x-rays and specialists that come directly into our electronic health medical record.

We are working on and have recently started inputting our data to an entire statewide information center. From that we are now able to pull very helpful patient management reports. So, I send all my lab work, my blood pressures, my foot exams, my eye exams and at the touch of a finger I can immediately get a report of what percentage of my patients who have diabetes are meeting targets; I can run a list of those patients who are overdue for a retinal exam; I can run a list of those patients who are at poorest control so that we can case manage them. So our electronic health record system is working very efficiently at this time.

As I mentioned, using the electronic health record allows us to, at every visit, have the essential information about the patient at our fingertips and also it can take a patient who has multiple medical issues, diabetes and asthma and heart disease, and the system knows that they have all those issues and can highlight to us, this patient is overdue for a eye exam and for a flu shot and for an echocardiogram, all within one system. So it is very efficient and has been very helpful.

Senator WHITEHOUSE. In terms of the finances of your practice, how is this paid for? Did you get support from the Federal Government in the Recovery Act? Does Vermont have a program that supports this? Does your insurance company help with it or did you do this on your own?

Dr. KRAUS. I work for a federally qualified health center, so it has been through the—

Senator WHITEHOUSE. So it goes through the community health center?

Dr. KRAUS. There have been grants in the State to help clinics to improve their use of electronic medical records. We bought the system ourselves but there has been some help to improve the way that we use it and to integrate it with the State information system.

Senator WHITEHOUSE. Do you have a private practice outside or do you practice through the community health center?

Dr. KRAUS. I guess I would like to make clear, I work for a federally qualified health center.

Senator WHITEHOUSE. Yes.

Dr. KRAUS. We provide 40 to 50 percent of care in my community, the other 40—there is another clinic that is a rural health center that is also funded that provides 40 to 50 percent of care in my community. We have about 50 to 60 percent of our patients in our community who have Medicare or Medicaid, about 40 percent of our patients are private. So my private practice is my Federal health center, that is the way—I see patients who are poor and have no insurance, I also see bankers, I see lawyers. I take care of everybody. We are the community health center for everybody.

Senator WHITEHOUSE. Understood. Let me just close, my time is running out. I want to thank Senator Sanders for holding this very important hearing. He has shown a lot of leadership in this area.

I just want to add that in Rhode Island our experience has also been that there has been really considerable leadership shown by

these community health centers in terms of developing an electronic health record system and utilizing the efficiencies that it allows, as well as the improvements in patient care, and the improvements in doctor awareness of medical information. Although it was a chore for them to get through the initial adoption process, if you go to the Thundermist Health Center in Woonsocket which is probably one of our leaders on this, and you tried to take away their health information technology, you would have a war on your hands. They really see the value of it.

Senator SANDERS. You would need emergency care treatment, is what you are saying?

Senator WHITEHOUSE. You would need emergency care treatment, exactly.

[Laughter.]

Senator SANDERS. OK.

Senator WHITEHOUSE. Thank you very much, Doctor.

Senator SANDERS. Thank you very much.

Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you, Mr. Chair. Dr. Kraus, do you have any plans to go to Kentucky?

Dr. KRAUS. I am quite happy in Vermont. Thank you.

Senator MERKLEY. I am just struck by the fact that you have been at Oregon Health Sciences University and then—did I catch that right?

Dr. KRAUS. Yes.

Senator MERKLEY. And then at Brown University, now serving in Vermont, so—

[Laughter.]

Senator MERKLEY [continuing]. Only one stop left for this panel.

When you mentioned the same-day appointments, I thought, that is certainly different than the stories I hear from folks every day about the challenge of getting in the front door of the health care system where they may call with a concern and find that the only appointment they can get is months out, which could drive them to seek care in an emergency room, potentially.

How have you been able to accomplish that kind of flexibility and capacity?

Dr. KRAUS. It can be a dilemma for this, in fact, we are struggling at this point to convince our administration to keep our same day appointments, because what happens is if you leave appointments and they aren't filled, then that is not very good for the bottom line. So there always has to be a very careful balance to book enough patients.

But we, for example, we have a policy in my clinic that no child ever goes to the emergency room without that being run by a provider. So if a triage nurse takes a call or a front staff person takes a call about a kid, they are either offered an appointment today, whether we have space or not, and if the staff feel that there is no space it is run by a provider and we can often make a decision that we know the family, we know the child, they can be seen tomorrow or we will say, just bring them in. It is usually a quick visit, we don't want our kids to go to the emergency room. We are trying to

extend that to adults as well, that we would never say to a patient we cannot see you today.

Senator MERKLEY. I certainly applaud that vision and the fact that you have been able to make it work on the ground.

I also wanted to ask you, on your community health teams, do you have a changing role in terms of the types of responsibility nurses and nurse practitioners carry or any kind of insights there that would be helpful to us?

Dr. KRAUS. Our nurse practitioners have and always have really had an independent practice. I know that in some practices everybody has to have a primary care doctor and then if they have an acute illness or they have a physical and they don't have complicated issues, then they see the nurse practitioner. Our nurse practitioners in our clinic have their own complex panels of patients. If they have a patient that they feel has so many complexities and they are feeling overwhelmed, they will transfer the care to a physician, but they really work equally with us. They certainly ask us questions about our patients.

Senator MERKLEY. When someone calls needing an appointment, how is it determined, internally, whether this person should go to a nurse practitioner or to a doctor, for example?

Dr. KRAUS. We are all primary care providers, that is why I don't use the term primary care physician, I use the term primary care provider. My kids see my nurse practitioner as their primary care provider. The first option is always to have an appointment made with the patient's primary care provider, if possible. If that person is not available, then with one of the others of us.

Senator MERKLEY. So there is a provider assigned to each patient?

Dr. KRAUS. Absolutely. We all have our separate panels but we have access to each other's notes and certainly are able to see each other's patients if the opportunity is needed. But we try and have patients see their own provider as much as possible.

Senator MERKLEY. Thank you.

Now Dr. Cunningham, you noted that sometimes hospitals resist shifting care out of emergency departments, as I gathered because of financial reasons. That suggests that perhaps the high cost at an emergency room is probably related to the structure and the services provided but partly just related to a pricing structure within the institution, in which case shifting folks out of an emergency room we may be overstating the savings. Is that a possibility?

Mr. CUNNINGHAM. I think some of the estimates about the savings on a per visit basis may be a little bit high because it is hard to compare on an apples to apples basis, because the intensity of visits in an emergency room tend to be higher. I think the studies that have really tried to make an apples to apples comparison have shown that it is maybe two to three times higher in an emergency room. But then you also have to consider the downstream cost savings that if you get people into a medical home and you get better continuity of care there could be additional savings down the road, so it is kind of hard to estimate exactly what the total cost is. But, you know, it is difficult even on a per visit basis to do so.

Senator MERKLEY. I want to thank you all for the work you are doing and I am out of time, but Dr. Eck, I will be interested in fol-

lowing up to understand better, if the law was changed, how much expansion of volunteer time you think would occur and the overall impact it might have. Thank you all.

Senator SANDERS. OK. Thank you, Senator Merkley.

Senator Paul.

Senator PAUL. Thank you. Miss Draper, are you familiar with the Hyde amendment?

Ms. DRAPER. No, sir, I am not.

Senator PAUL. The Hyde amendment is an amendment that has been around since the 1970s that prohibits Federal money from being spent on abortions. According to the Alliance Defense Fund, which I would like to insert the comments from them into the record, there is evidence that money for community health centers is actually going to abortion providers.

[The information referred to above can be found in additional material.]

The specific example they bring up is the Institute for Family Health in New York City which gets millions of Federal dollars but also is listed by NARAL as a pro-choice abortion site of recommendation by NARAL in New York City. I think it is illustrated by Dr. Kraus' testimony that there is not really a distinction between community health centers and private practice. Her private practice and her community health center are located in the same venue. I am not saying she does, but it sounds like there are people around the country who are using that money basically to provide for a center that also performs abortion. I think the division between what is private practice and what is community center is very hard to delineate and separate and I find it troubling that I think this goes against the spirit and actually probably the letter of the law with regard to the Hyde amendment.

I was wondering if the GAO has any mechanism for looking into whether Federal funding is being used in community health centers for abortions.

Ms. DRAPER. We have not looked at that, as far as I know. This particular study was looking at strategies that health centers have implemented to really divert the non-urgent use of emergency departments.

Senator PAUL. Can you look into that for me and give me an answer as to whether or not Federal funding is going to pay for abortions at community health centers?

Ms. DRAPER. We can talk about that after the hearing if that works for you.

Senator PAUL. Yes, I would like to have that information and if the GAO could send that to me.

Another question for Miss Draper is that it looks like when you look at the statistics on these community health centers, 72 percent of the patients arriving at them have insurance, Medicare, Medicaid and private insurance. So we are looking at 38 percent that you are helping that have no other venue. My question is, it seems to me that you have a 72 percent duplication rate with other providers who would be providing these services. Many other doctors are taking Medicare, many of them are taking Medicaid, many of them are taking private insurance, so once again, when we look at

a budget that is \$2 trillion over budget, do we really need to be duplicating services that are available in the private sector?

Ms. DRAPER. According to a 2009 UDS—Uniform Data System—data from HRSA, about 80 percent of the patients that are seen in community health centers, overall, are either uninsured or have Medicaid. The remaining 20 percent are Medicare or privately insured.

Senator PAUL. I guess that contradicts data that we have from the government, from the Health and Human Resources that shows 72 percent being Medicaid, Medicare or other private insurance and that only about 38.2 percent are uninsured. The other thing is that a lot of this can be siphoned off, in a sense Dr. Kraus gives a perfect example of what is part of her clinic and what is not part of her clinic. The patients she sees with insurance are not part of the clinic and the ones that are, so it would look like she would have a very high percentage in that case. But, according to the statistics from the Health and Human Resources, 72 percent of these people have insurance of one form or another and it would appear to me that we are duplicating a process where there is also a private sector alternative.

I would like to take the remainder of my time to thank Dr. Eck for coming today. I think her story is incredible. I think that we really have gotten to the point in our society where we do not differentiate between charity of the heart, really giving voluntary, and people who are simply working for the government. Those who would give of their time voluntarily, I think earn a great deal of respect and deserve our respect and admiration. Also really the idea that a lot of this could be done through the private world. We have had government crowding out charity now for decades and the idea that this can be done, I know it from firsthand in my experience with the Lions Eye Clinic in my practice, and I commend Dr. Eck and thank you very much for coming.

Senator SANDERS. Thank you very much, Senator Paul.

Let me just, for the record, pick up on a point that Senator Paul raised. The Hyde amendment simply prohibits abortions being performed by facilities that receive Federal funding. To my understanding there have been a number of studies which suggest that FQHC's, which do receive—community health centers, which do receiving Federal funding, do not perform abortions. Period. That is my understanding.

Let me go to Dr. Kraus, because she comes from the State of Vermont. Why not.

[Laughter.]

I would like to mention to folks that the area that she and her clinic are in is one of the lowest income areas in the State of Vermont, it is the northeastern part of our State, we call it the Northeast Kingdom. A lot of folks there are working at low wage jobs. There is an agency there, an FQHC, one of the very first in the State of Vermont, started by the gentleman behind me, David Reynolds, who now works for me.

One of the interesting things, and Dr. Kraus correct me if I am wrong, is that in one of the poorest parts of a rural State because of the FQHC's there, and I think you have what, six locations now? Six locations in small towns. They have gone a very long way to

solve the crisis of primary health care access which exists in many parts of the country. Is that a fair statement, Dr. Kraus?

Dr. KRAUS When you look at our quality measures compared to other places across the country they are improved. If you look at our ER visits and our hospitalization rates, they are declining whereas in areas of the State that have not instituted the sort of changes that we have made they are raising or staying stable. We have more advanced use of the electronic health record than in most parts of the State and the country.

Senator SANDERS. But what I am getting at, if we were to talk about that region of the State of Vermont, called the Northeast Kingdom, people would tell you there are a lot of problems that exist. Right? We don't have enough jobs, wages are too low, etc. Probably people would not say that access to primary health care is one of the major issues, despite the fact that it is one of the lowest income areas of the State. Is that a fair statement?

Dr. KRAUS. I think we do a wonderful job of trying to get patients in to see their primary care providers.

Senator SANDERS. So the point here is that in a rural area, in a low-income area we have gone a long way through the establishment of six satellite programs to provide quality, cost-effective health care to the people of that area.

I know Senator Paul mentioned before, I think picking up on a point that Dr. Eck made about smiles when somebody walks in the door. I have been to every one of the clinics in the Northeast Kingdom, and you know what, they smile there too. I don't think Dr. Kraus sees herself as a government worker. I think she is working very hard along with the other physicians and nurses and medical personnel there who have great spirit. I have been to all of the clinics and they do a great, great job.

Dr. Kraus, I want to ask you one brief question. I want to get to Dr. Eck in a second. Talk a little bit, because in a sense the thrust of the hearing today is how we provide quality care and try to save money, both for taxpayers as well as the overall system, in terms of keeping people out of the hospital. I know the hospital up there, my son was born there 42 years ago, so I know the hospital in St. Johnsbury. How are you doing that and is it working?

Dr. KRAUS. When you look at the outcomes, the numbers—for example, there was a study looking at Medicaid patients specifically and in our community, as well as in the other pilot community that has had a medical home and a community health team, there has been a significant bending of the curve. There was a steady increase in costs taking care of Medicaid patients. When we looked at our two communities there was a significant decrease in that steady increase. That was seen also, but not as too much of an extent, in the one community that has only had this grant for 1 year. When they looked at nonpilot sites across the State, the Medicaid costs continued on the same projection. So there was evidence that what we have been doing started to significantly decrease the costs of care, at least for Medicaid patients.

In the private sector they did a per member/per month analysis and showed that we had an 11 percent decrease in the per member/per month costs of caring for patients. This was a \$48 cost—\$48 decrease per member in the communities where we had this

team. It costs the State about \$4 per member/per team in running the community health team and in extra reimbursement that we get at the pilot sites per member/per month. So they got a \$48 saving for a \$4 investment. This is the private insurers.

We feel that our community health team that really helps patients to navigate the system so that they are able to decrease barriers to getting excellent health care has really helped, so that we are decreasing emergency room, both non-urgent emergency room costs by being open and also by keeping people healthier so they are no longer needing to use the emergency room or the hospital.

Senator SANDERS. OK, thanks.

Let me ask Ms. Draper and then maybe Dr. Cunningham. I want to get to Dr. Eck in one second. I am going to give the mic over to Senator Paul when I am finished.

Is it fair to say that honest people can have differences of opinion ascertaining what is, in fact, utilization of emergency rooms, whether it is for a true emergency or not? In other words, we can agree that if somebody got shot it is an emergency. If somebody has a common cold, it is not an emergency. But there is a lot of gray area in between that.

The report, the GAO report that we looked at suggested that maybe 8 percent, as I recall, of utilization in emergency rooms were nonemergent. I have heard statistics which go as high as 50 percent. Is it fair to say that there may be some differences of opinion as to the extent of nonemergency use of emergency rooms?

Ms. DRAPER. I think that is fair to say. The non-urgent classification is really someone who needs to be seen within 2 to 24 hours. It is not that the care that they receive in the emergency room—it is not inappropriate care, but they may have been able to be seen somewhere else at a more cost-effective setting.

Senator SANDERS. OK. Dr. Cunningham, did you want to comment on that?

Mr. CUNNINGHAM. Yes, I would agree. I think about 15 percent of visits are visits that need to be seen, either immediately or within 15 minutes. The emergency—

Senator SANDERS. What are your—I'm sorry, 15 or 50?

Mr. CUNNINGHAM. Fifteen percent—

Senator SANDERS. Fifteen, yes.

Dr. CUNNINGHAM [continuing]. Are true emergencies in that sense. So yes, there is a whole range of visits that fall into the urgent and the semi-urgent category. I think probably where you see the differences in terms of the estimates or where people say that it is appropriate or not—or inappropriate, probably reflects that group. I think furthermore, whether it is appropriate or inappropriate probably depends on whether there is other resources in the community for people to go to. If it is 3 a.m. on a Sunday morning and there is no other place to go, well I don't think it would—most people would say it is inappropriate to go to the ER for maybe a semi-urgent problem.

Senator SANDERS. OK. Thanks.

Let me just ask Dr. Eck a question. First of all, thank you very much for what you do. Your volunteer activities are much appreciated.

Let me ask you this, in a sense, philosophical question. We have gone a little bit into philosophy today. I believe, many people in my own State believe that health care is a right, R-I-G-H-T, regardless of income. That every American has the right to the best quality health care that the system can offer, regardless of income. That if you are a low-income kid, or you are a wealthy kid, you have the same opportunity to access the health care system. Do you believe that?

Dr. ECK. I believe that every person ought to get good health care. The Hippocratic Oath says that I would provide health care regardless of whether the person pays me or not. I definitely believe that people need health care. The question is how do we do that.

Senator SANDERS. If I may? I will give you a chance to respond. We all know people do need health care when they get sick. But is it a right? Should all people, regardless of income, have access to the same quality system or should we have a two-tier or three-tier system, in your judgment?

Dr. ECK. If health care is a right then so is food care and shelter care and clothing care. Food, clothing and shelter I think are at least as important as health care and yet we don't expect the government to provide food, clothing and housing to everybody.

Senator SANDERS. Not to everybody we don't, but we do have a food stamp program which does provide to low-income people.

Dr. ECK. When you call something a right—it is different to have a right—a freedom to act and to do what is best for one's family in a free America, it is another thing to have your rights impose obligations on other people. That is a whole different philosophy, and I am not so sure that is what the Constitution guarantees.

Senator SANDERS. OK. Let me ask you this, and I have gone on too long, I am going to give it over to Senator Paul.

Again, I applaud you for your free services and your volunteer efforts, but don't you think it is a little bit apples to oranges to say that, if somebody does something for nothing obviously the cost is going to be lower than somebody who is paid. A physician is usually paid, nurses are paid, surgeons are paid. Two questions—I mean isn't that basically true? Second of all, it is one thing to run a primary health care free clinic, as important as that is. Somebody walks into your office, they are diagnosed with cancer, they have to go to a hospital for an extensive number of tests and treatments which could run up tens of thousands of dollars. How does that person pay for that in a free clinic environment?

Dr. ECK. In the United States you will notice people aren't dying on the street. People are taking care of patients and people are coming down with cancer, have no insurance, they are getting medical care. The hospitals absorb it, the oncologists take care of them for free. That is already being done. It is not as bad as it sounds.

What we are suggesting though is what we have in this country is patients are taking on the liability of patient—or physicians are taking on the liability of taking care of patients who are not paying them, and yet the liability is huge. And that is why the whole idea of the malpractice coverage in exchange for free care.

I have spoken with physicians, informally and I have done internal polls. I will send out an email—Survey Monkey—and ask them,

would you do this, would you provide 4 hours a week of free care in a nongovernment free clinic where you get no compensation. Every specialty says yes, they would do it in a heartbeat. I am suggesting that neurosurgeons maybe do two cases a month, maybe an obstetrician do two deliveries a month for free and that would account for their post-op time. They all say that they would be happy to do that.

So we are talking no money, we are not going to—it is free. How can you argue with free? And it is universal access. How can you agree with that? It sounds like something on your side of the alley.

Senator SANDERS. OK. Thanks very much.

I have gone over my time. I am going to give the mic over to Senator Paul.

Senator PAUL. Thank you very much.

With regard to the idea of whether or not you have a right to health care, you have to realize what that implies. It is not an abstraction. I am a physician, that means you have a right to come to my house and conscript me. It means you believe in slavery. It means that you are going to enslave not only me but the janitor at my hospital, the person who cleans my office, the assistants who work in my office, the nurses. If you have a right to their services basically once you imply a belief and a right to someone's services, do you have a right to plumbing, do you have a right to water, do you have a right to food, you are basically saying that you believe in slavery. You are saying you believe in taking and extracting from another person.

Our founding documents were very clear about this. You have a right to pursue happiness, but there is no guarantee of physical comfort, there is no guarantee of concrete items. In order to give something concrete or someone's service, you have to take it from someone. So there is an implied threat of force.

If I am a physician in your community and you say you have a right to health care, do you have a right to beat down my door with the police, escort me away and force me to take care of you? That is ultimately what the right to free health care would be. If you believe in a right to health care you are believing in basically the use of force to conscript someone to do your bidding.

Now just because it is a noble thing to believe that we are obligated, as Christians, we are obligated through the Hippocratic Oath, we have always done this. Since the beginning of modern medicine we have always provided 100 percent access. I do it in exchange for privileges. I do it because I believe in the Hippocratic Oath, but my hospital also says to me, "You can only operate in this hospital if you agree to see everyone coming through the emergency room." I always have. We have always treated. We have always had 100 percent access through our emergency room. Those were for emergencies, they are not the best place for primary care, we all agree with that, but we have always had 100 percent free access.

Going back to one specific question with Dr. Kraus, do you receive, personally, more money because you work in a Federal clinic? Do you get higher Medicare and Medicaid reimbursements to you personally for working in a health clinic?

Dr. KRAUS. Me personally, I think I get well below the national average for an annual income of a primary health provider.

Senator PAUL. But do you specifically get more from Medicare and Medicaid because you have a health clinic?

Dr. KRAUS. Me, personally?

Senator PAUL. When you have billed—do you, as a physician, get a higher rate because you work in a health clinic? I believe the answer is yes.

Dr. KRAUS. I am paid by a salary. The health center is reimbursed at a higher rate, but me as a salaried position is given the same salary that I would—I also would note, that I was taught to be self-sufficient and hardworking, that is how I was brought up. When I look at our budget and I see that there is a big component of my budget coming as a grant from the Federal Government, that doesn't make me happy. The reason that I am getting that grant, however, is because the current health care system is not reimbursing primary care adequately in the first place. If there was adequate reimbursement for primary care physicians in the first place, then we wouldn't require the extra funding for a federally qualified health center.

Senator SANDERS. This is going to be an interesting year, I will tell you that.

[Laughter.]

I think it is fair to say that Senator Paul and I have some slight philosophical differences.

All right. My profound question to Dr. Kraus is, do you, as an employee at a federally qualified health center consider yourself as a slave?

[Laughter.]

Dr. KRAUS. I love my job. I chose there. I do not feel like a slave. Thank you.

Senator SANDERS. Ms. Draper, the implication, again from my friend Senator Paul, is that we have kind of solved the problem of health care access in America, that any place in the country, I guess anybody who has a problem, if you are on Medicaid, if you have no health insurance, maybe if you have health insurance, you can just walk in the door tomorrow and find a doctor to treat you. Is that true, in your judgment?

Ms. DRAPER. There is a huge body of literature that discusses the difficulties, particularly Medicaid beneficiaries have to finding a physician. There are many physicians who are unwilling to accept Medicaid patients and also for those who are uninsured face equally challenging or maybe more so challenging access issues.

I think you can look at the experience in Massachusetts with reform and, the issue there is that wait times have increased for people who have already had insurance and even more so for those who are newly insured. I think I saw one study where the wait times had doubled from 17 days to 30-some days for people that are with reform.

There are some lessons learned. I think there is a Kaiser Family Foundation study that talked about some lessons learned from the Massachusetts' experience and a couple of those are that, when you have insurance coverage initiatives, that there will be a higher demand for primary care services—particularly from low-income and

underserved communities and also that there needs to be an investment in primary care. We see in many parts of the country that there are major shortages of primary care physicians. Those are some of the lessons from the Massachusetts' experience.

Senator SANDERS. All right. My last question is for Dr. Kraus, again picking up on Senator Paul's comment. As you know, Vermont is moving toward a Medicare for all single payer approach. Are you worried that if we consider health care as a right in the State of Vermont that the St. Johnsbury Police Department, in the middle of the night, is going to break down your door and force you to treat a patient. Is this an immediate concern of yours?

Dr. KRAUS. No.

Senator SANDERS. OK. Thank you.

I want to thank Senator Paul for being here. It was a provocative, interesting discussion. I want to thank mostly the panelists for being here. I think we are discussing an issue of great importance. Again, thank you all for your participation.

The meeting is now adjourned. The record is open for 10 days for any additional comments.

Thank you. The meeting is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF MATTHEW S. BOWMAN, ESQ., LEGAL COUNSEL,
ALLIANCE DEFENSE FUND (ADF)

I write to discuss the occurrence of abortions and illegally compelled participation in services such as abortion at Federally Qualified Community Health Centers (hereinafter FQHCs) that receive Federal funding from section 330 of the Public Health Service Act as well as from various other Federal sources.

1. FQHCS CAN PERFORM ABORTIONS, AND SOME DO

Despite some public comments to the contrary, FQHCs can and do perform abortions. For example, the Institute for Family Health in New York, NY is an FQHC and its cluster of clinics have received millions of Federal dollars annually for many years. The abortion advocacy organization NARAL Pro-Choice New York lists the Institute for Family Health Sidney Hillman Family Practice and Phillips Family Practice as performing surgical and medical abortions.¹ The Institute for Family Health's Web site also indicates that one "Sidney Hillman" clinic doctors works at Planned Parenthood.²

This is merely one example. Another abortion advocacy group, the Reproductive Health Access Project, provides detailed guidance on the ways in which FQHCs can perform abortions while working around some restrictions relating to their Federal funding.³ FQHCs have many referral and other connections with abortion providers, such as in South Carolina, where Planned Parenthood boasts that the founder of PP's Aiken County clinic, Margaret Weston, went on to found local FQHCs under the name of the Margaret J. Weston Community Health Centers.⁴

2. FQHCS MIGHT BE USING FEDERAL MONEY FOR ABORTIONS AND RELATED SERVICES

Several Federal law loopholes apparently allow FQHCs to use Federal funds to pay for abortions and related services, and FQHCs may already be doing so. For example, the above-mentioned Institute for Family Health in New York has already received Federal funding under the "Affordable Care Act Teaching Health Center (THC) Graduate Medical Education (GME) Payment Program." Nothing in the Patient Protection and Affordable Care Act of 2010 (PPACA) prohibits the funds directly appropriated under PPACA from being used for abortions. Such restrictions on PPACA appropriated funds were proposed but rejected in the legislative process.

The Hyde amendment, an annual Labor/HHS appropriations rider,⁵ prohibits using funds from that appropriations package on any abortion or on health coverage that includes coverage of abortion. But the Hyde amendment does not apply to funds appropriated directly to PPACA including \$11 billion that PPACA directly appropriates for FQHCs. (Although the Hyde amendment does apply to any funds in the same trust fund as Hyde-applicable funds, PPACA creates a separate trust fund for its FQHC funds. PPACA, §10503.) And even if an entity gets funds to which the Hyde amendment does apply, such as section 330 funds, the amendment does not prohibit the entity from performing abortions—it only prohibits the entity from expending Hyde-applicable funds on any abortion.

President Obama's Executive Order 13535 issued in connection with PPACA does not fix this loophole. The order states, "I hereby direct the Secretary of HHS to ensure that program administrators and recipients of Federal funds are aware of and comply with the limitations on abortion services imposed on CHCs by existing law." But in "existing law," the Hyde amendment does not restrict PPACA-appropriated funds.

3. FQHCS CLAIM TO BE VIOLATING FEDERAL CONSCIENCE LAWS

A leading FQHC advocacy organization recently told the Department of Health and Human Services that its FQHCs are apparently forcing their employees to assist abortion-related activities and other practices in violation of longstanding Federal conscience statutes.

¹ See http://prochoiceny.org/boc/sect3_4.shtml (last viewed on May 6, 2011).

² See <http://www.institute2000.org/health/manhattan/hillman.htm> (last viewed May 6, 2011).

³ See http://www.reproductiveaccess.org/getting_started/faq.htm (last viewed on May 6, 2011).

⁴ See <http://www.plannedparenthood.org/health-systems/history-28077.htm> (last viewed May 6, 2011).

⁵ See, e.g., Omnibus Appropriations Act, 2010, Div. D, tit. V, § 507.

The National Association of Community Health Centers (NACHC), whose Web site claims to represent at least 1,250 CHCs around the country, sent a letter in September 2008 asking that HHS not require its FQHCs to comply with Federal statutes that are applicable to them. Those laws require FQHCs not to force their employees to violate their conscientious beliefs. NACHC declared that if the centers were actually made to comply with these Federal statutes, patients would be deprived of “access” to services that their FQHCs are providing.⁶

For example, FQHCs, by virtue of their receipt of funds of section 330 and/or Title X of the Public Health Service Act, must comply with 42 U.S.C. §300a-7(d), which prohibits the FQHCs from requiring any “individual” to “perform or assist in the performance of any part of a health service program . . . funded in whole or in part” by the HHS funds, “if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.” Moreover, by virtue of the Weldon amendment (attached to Labor/HHS appropriations at §508), FQHCs that participate in Federal programs funded by HHS cannot “subject[] any institutional or individual health care [professional] to discrimination on the basis that the health care [professional] does not provide, pay for, provide coverage of, or refer for abortions.”

Nonetheless, at pages 4 and 5 of its letter to HHS, NACHC specifically objected to its centers being required to comply with this exact statutory language that applies to them. NACHC even specifically objected that its centers must not be forced to follow the law prohibiting them from forcing employees to “refer for abortions” in violation of the Weldon amendment.

Despite the fact that 42 U.S.C. §300a-7(d) says no employee of a FQHC can be required to even assist in “any part” of a program even partially funded by HHS, NACHC opined that disaster would follow if HHS actually enforced this language against FQHCs, because it would cause a “substantial negative impact” on the services that FQHCs already deliver.

It is necessarily true that if FQHCs are presently providing a service, and if their being made to comply with conscience-respecting statutes would reduce their provision of that service, then the FQHCs must be presently discriminating against present or prospective employees who conscientiously object to assisting in those services. The NACHC letter is therefore an admission that FQHCs are engaged in widespread violation of Federal conscience statutes.

NACHC lamented that its FQHCs must be able to force individuals to assist in the performance of parts of their federally funded programs against their religious beliefs, including “a vast array” of services that FQHCs perform themselves, and a “wide” practice of referring and counseling patients to obtain “services that the health center does not (or cannot) provide” from “a wide network of community providers.”

NACHC objected that centers should not be required to follow Federal statutes that prohibit them from forcing individuals to assist in morally objectionable federally funded programs, because “if health care personnel and support staff are allowed to “opt-out” of performing services which they find objectionable, effectively health centers will be unable to meet their statutory and regulatory obligations to furnish required services to all residents of their service area.”

In other words, even in NACHC centers that do not perform abortions themselves, the FQHCs use Federal money to counsel and refer patients for abortions at locations such as nearby Planned Parenthood centers (the “wide network of community providers”), and the FQHCs do commit other potentially objectionable practices, but they claim they will not be able to do such things unless they are allowed to force employees to participate in violation of Federal law.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
May 8, 2011.

Hon. ORRIN HATCH,
104 Hart Senate Office Building,
Washington, DC 20510.

DEAR SENATOR HATCH: On behalf of the American College of Emergency Physicians (ACEP), I am writing to share with you information about the Nation’s emergency departments that I believe will be very useful in preparation for your hearing on Wednesday. Based on the title of the hearing, “Diverting Non-urgent Emergency Room Use: Can It Provide Better Care and Lower Costs,” ACEP wants to be sure

⁶ See <http://www.nachc.com/client/documents/Provider%20Conscience%20Role%20Comments%209.25.08.pdf> (last accessed on May 6, 2011).

that the members of your subcommittee have all of the relevant facts at their disposal when discussing this significant issue.

First, the Center for Disease Control and Prevention's (CDC) 2008 study states that of the nearly 124 million annual patient visits to emergency departments, only 8 percent have non-urgent ("needing care in 2 to 24 hours") conditions. By comparison, the number of non-urgent patients in 2005 was 14 percent. Furthermore, the CDC states that the term "nonurgent" does not imply unnecessary.

Second, it is important to understand that all services provided in the emergency department, including physician services, account for less than 2 percent of the Nation's health care costs. According to the Agency for Healthcare Research and Quality (AHRQ), total spending on emergency care in the United States was \$47.3 billion in 2008. However, total health care expenditures were estimated at \$2.4 trillion in 2008.

Third, while it may cost more for patients to visit an emergency department than to obtain services at a physician's office or community health center, the comprehensive care available in the emergency department, due to our access to diagnostic imaging, lab tests, other physician services, etc., is unequalled. Unlike most other health care providers, our services are available 24 hours a day, 7 days a week, and 65 percent of emergency department patients arrive after normal business hours. Emergency departments are prepared to diagnose and care for the most complex medical conditions, and physicians regularly refer their patients to us. In a poll ACEP recently conducted, 97 percent reported that patients are referred daily to their emergency departments by primary care physicians.

Emergency physicians and their departments are essential to the Nation's health care delivery system. They are truly America's health care safety net and many emergency physicians dedicate their lives to injury prevention and educating the public about how to prevent medical emergencies. However, the reality of the Nation's population demographics, as well as physician shortages and an analysis of those seeking emergency care, show that dissuading patients from using emergency departments is not likely to be an effective strategy. In addition, the nature of emergencies, which are unscheduled events, and the needs of patients must be taken into account as policymakers and health care stakeholders develop new paradigms for how health care will be provided in the future. We look forward to working with the HELP Committee and the Primary Health and Aging Subcommittee as it works to balance health care costs and the need to maintain a vibrant emergency care system.

Sincerely,

SANDRA SCHNEIDER, M.D., FACEP,
President.

U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO),
WASHINGTON, DC 20548,
April 11, 2011.

Hon. TOM HARKIN, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate.

Hon. BERNARD SANDERS, *Chairman,*
Subcommittee on Primary Health and Aging,
Committee on Health, Education, Labor, and Pensions,
United States Senate.

Subject: *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*

Hospital emergency departments are a major component of the Nation's health care safety net as they are open 24 hours a day, 7 days a week, and generally are required to medically screen all people regardless of ability to pay.¹ From 1997

¹In order to participate in Medicare, hospitals are required to provide a medical screening examination to any person who comes to the emergency department and requests an examination or treatment for a medical condition, regardless of the individual's ability to pay. Social Security Act §§1866(a)(1)(I), 1867 (codified at 42 U.S.C. §§1395cc(a)(1)(I), 1395dd). Medicare is the Federal health program that covers seniors aged 65 and older, certain disabled persons, and individuals with end-stage renal disease.

through 2007, U.S. emergency department per capita use increased 11 percent.² In 2007, there were approximately 117 million visits to emergency departments; of these visits, approximately 8 percent were classified as nonurgent. The use of emergency departments, including use for nonurgent conditions, may increase as more people obtain health insurance coverage as the provisions of the Patient Protection and Affordable Care Act (PPACA) are implemented.³

Some nonurgent visits are for conditions that likely could be treated in other, more cost-effective settings, such as health centers—facilities that provide primary care and other services to individuals in communities they serve regardless of ability to pay. Care provided in an emergency department may be substantially more costly than care provided in a health center. The average amount paid for a non-emergency visit to the emergency department was seven times more than that for a health center visit, according to national survey data.⁴ While there are many reasons individuals may go to the emergency department for conditions that could also be treated elsewhere, one reason may be the lack of timely access to care in other settings, possibly due to the shortage of primary care providers seen in some areas of the country.⁵

Health centers may serve as a less costly alternative to emergency departments, particularly for individuals with nonurgent conditions. Like emergency departments, the nationwide network of health centers is an important component of the health care safety net for vulnerable populations, including those who may have difficulty obtaining access to health care because of financial limitations or other factors. Health centers, which are funded in part through grants from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services, as well as referrals to specialty care—without regard to a patient's ability to pay. They also provide enabling services, such as case management and transportation, which help patients access care. In 2009, more than 1,100 health center grantees operated more than 7,900 delivery sites and served nearly 19 million people. With increased funding from PPACA—projected to be \$11 billion over 5 years for the operation, expansion, and construction of health centers⁶—health center capacity is expected to significantly expand, with the National Association of Community Health Centers estimating that health centers could more than double their capacity to 40 million patients by 2015.⁷

² In 1997, there were an estimated 35.6 emergency department visits per 100 people compared to 39.4 visits in 2007. See P. Nourjah, "National Hospital Ambulatory Medical Care Survey: 1997 Emergency Department Summary," *Advance Data*, no. 304 (1999), and R. Niska, F. Bhuiya, and J. Xu, "National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary," *National Health Statistics Reports*, no. 26 (2010).

³ For purposes of this report, we refer to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, as PPACA. According to estimates from the Congressional Budget Office (CBO), an additional 32 million individuals are projected to obtain health insurance coverage by 2019; CBO also estimates that gaining insurance increases an individual's demand for health care services by about 40 percent. See D. Elmendorf, Director, CBO, "Economic Effects of the March Health Legislation" (presentation at the Leonard D. Schaeffer Center for Health Policy and Economics, University of Southern California, Los Angeles, CA, Oct. 22, 2010).

⁴ According to estimates from the 2008 Medical Expenditures Panel Survey (MEPS), the average amount paid for a nonemergency visit to an emergency department was \$792, while the average amount paid for a health center visit was \$108. Similarly, the average charge for a non-emergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—\$2,101 compared to \$203. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States.

⁵ In 2009, we reported that patients' lack of access to primary care services was one factor that may contribute to emergency department crowding. The report, which provided a followup to a 2003 report on emergency department crowding, also noted that crowding continued to occur in hospital emergency departments and that some indicators of emergency department crowding—such as the amount of time patients must wait to see a physician—suggested that the situation may have worsened. See GAO, *Hospital Emergency Departments: Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames*, GAO-09-347 (Washington, DC: Apr. 30, 2009), and *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities*, GAO-03-460 (Washington, DC: Mar. 14, 2003).

⁶ Specifically, PPACA appropriated \$9.5 billion for fiscal years 2011 through 2015 to a new Community Health Centers Fund to enhance funding for HRSA's community health center program. It also provided \$1.5 billion over that same time period for the construction and renovation of community health centers. Pub. L. No. 111-148, §10503, 124 Stat. 119, 1004 (2010); Pub. L. No. 111-152, §2303, 124 Stat. 1029, 1083.

⁷ National Association of Community Health Centers, *Expanding Health Centers Under Health Care Reform: Doubling Patient Capacity and Bringing Down Costs* (Bethesda, MD, June 2010).

Given the increased use of emergency departments, concern over adequate access to primary care, and increased Federal support for health centers, you requested that we examine how health centers may help reduce the use of emergency departments. In this report, we describe strategies that health centers have implemented that may help reduce the use of hospital emergency departments.

To conduct our work, we interviewed officials from 9 health centers about strategies that they have implemented that may help reduce emergency department use. We selected health centers to provide geographic variation and to ensure that health centers serving rural and urban areas were represented. We based our selection on our review of relevant literature published in the past 5 years and interviews with officials from HRSA and experts, specifically representatives from the National Association of Community Health Centers and individuals who have conducted research on health centers and emergency department utilization. We also e-mailed all State and regional primary care associations—private, nonprofit membership organizations of health centers and other providers—to identify specific health centers in their jurisdictions that had implemented strategies that may have reduced emergency department use.⁸ (Enc. I provides selected characteristics of the individual health centers interviewed.) To gain additional insights and perspectives on the information obtained from the nine individual health centers, we also conducted group interviews with officials from multiple health centers operating in three States.⁹ In our interviews, we asked health center officials to describe the strategies they have implemented that may help reduce the use of emergency departments for conditions that might also be treated in other care settings, such as health centers. We also asked health center officials to describe key factors contributing to the strategies' success and any challenges to implementation. Additionally, we requested any data or evaluations the health centers had on the effectiveness of each strategy implemented. We also collected information about health centers' strategies from the literature and our interviews with agency officials and experts.

We conducted this performance audit from November 2010 through April 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS IN BRIEF

Health centers have implemented three types of strategies that may help reduce emergency department use. These strategies focus on (1) emergency department diversion, (2) care coordination, and (3) accessibility of services. For example, some health centers have collaborated with hospitals to divert emergency department patients by educating them on the appropriate use of the emergency department and the services offered at the health center. Additionally, by improving care coordination for their patients, health centers may help reduce emergency department visits by encouraging patients to first seek care at the health center and by reducing, if not preventing, disease-related emergencies from occurring. Finally, health centers employed various strategies to increase the accessibility of their services, such as offering evening and weekend hours and providing same-day or walk-in appointments—which help position the health center as a convenient and viable alternative to the emergency department. Health center officials told us that they have limited data about the effectiveness of these strategies, but some officials provided anecdotal reports that the strategies have reduced emergency department use. Health center officials described several challenges in implementing strategies that may help reduce emergency department use, such as the difficulty in changing the behaviors of patients who frequent the emergency department. HHS provided a technical comment on a draft of this report, which we incorporated.

BACKGROUND

Emergency department visits are often made at night and on weekends by patients with varying sources of payment and levels of severity. Not all emergency department visits may be necessary; some visits may be handled in less costly settings

⁸We received responses from 21 of 52 regional and State primary care associations we contacted.

⁹Specifically, we conducted group interviews with officials from 6 health centers in Colorado, 13 health centers in Pennsylvania, and 9 health centers in Wisconsin. Similar to our individual health center selection, these States were selected to provide geographic variation and to ensure that health centers serving rural and urban areas were represented.

or even avoided altogether through better management of chronic conditions. Lack of awareness of other sources of care, lack of access to primary care and other providers, and financial barriers can contribute to emergency department use, including use for nonurgent conditions. Health centers, which are required to serve patients regardless of ability to pay, are an important safety net provider for financially or otherwise vulnerable populations.

Emergency Department Use

There were an estimated 116.8 million emergency department visits in 2007, according to the most recent publicly available report from HHS's National Center for Health Statistics (NCHS).¹⁰ For a majority of these visits (about 65 percent), patients arrived in the emergency department on weekdays from 5 p.m. to 8 a.m., and on the weekends.

Emergency department visits were made by patients with varying sources of payment. Individuals with private insurance coverage represented the largest percentage of emergency department visits followed by those with health insurance coverage through Medicaid or the State Children's Health Insurance Program (CHIP).¹¹ (See table 1.) Research indicates that Medicaid patients have a disproportionately higher share of emergency department use compared to patients with other sources of payment.¹²

Table 1.—Emergency Department Visits by Source of Payment, 2007

Source of payment	Number of visits (in thousands)	Percentage of visits
Private insurance	45,580	30
Medicaid ¹	29,379	25
Medicare	20,133	17
No insurance ²	17,926	15
Unknown ³	10,484	9
Other ⁴	4,587	4

Source: GAO analysis of National Center for Health Statistics data.

Note: There were 116.8 million emergency department visits in 2007. Because more than one expected source of payment may be reported per visit, the total number of visits by source of payment exceeds 116.8 million and the sum of the percentage of visits by source of payment exceeds 100 percent.

¹Medicaid includes visits where the payment source was the State Children's Health Insurance Program.

²The National Center for Health Statistics defines no insurance as having only self-pay, no charge, or charity as payment sources.

³Unknown includes visits where the payment source was either unknown or blank.

⁴Other includes visits where the payment source was workers' compensation or other.

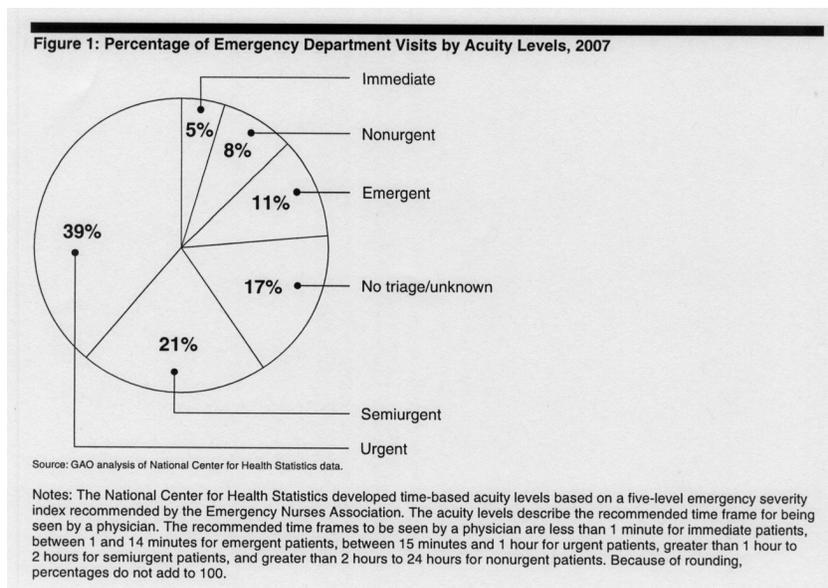
Patients present to the emergency department with illnesses or injuries of varying severity, referred to as acuity level.¹³ Each acuity level corresponds to a recommended timeframe for being seen by a physician—for example, patients with “immediate” conditions should be seen within 1 minute and patients with “emergent” conditions should be seen within 1 to 14 minutes. In 2007, urgent patients—patients who should be seen by a physician within 15 to 60 minutes—accounted for the highest percentage of visits to the emergency department. Nonurgent patients—patients who should be seen within 2 to 24 hours—accounted for 8 percent of visits. (See fig. 1.)

¹⁰NCHS is an agency within HHS's Centers for Disease Control and Prevention that compiles statistical information to guide actions and policies to improve health. Annually, NCHS collects data on U.S. hospital emergency department utilization using a nationally representative survey, the National Hospital Ambulatory Medical Care Survey.

¹¹Medicaid is a joint Federal-State program that finances health care for certain low-income adults and children. CHIP is a joint Federal-State program that finances health care coverage for children in families with incomes that, while low, are above Medicaid eligibility requirements.

¹²See, for example, Committee for the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point* (Washington, DC: National Academies Press, 2007).

¹³NCHS developed time-based acuity levels based on a five-level emergency severity index recommended by the Emergency Nurses Association.



Studies have shown that some emergency department visits may have been avoided through the use of appropriate and timely primary care and preventive care.¹⁴ Additionally, better management of chronic conditions, such as diabetes, asthma, and congestive heart failure, could also reduce the need for emergency department visits.

There are a number of factors that contribute to the use of emergency departments. Some patients may believe the emergency department provides more convenient, comprehensive, and better quality care than care provided in other settings. In addition, some patients may be unaware of alternative sources of care available within their community or may experience difficulty accessing primary or specialty care. Specifically, patients may have difficulty finding providers willing to accept new patients; patients with certain types of health coverage, such as Medicaid; or patients who are uninsured. There may also be difficulty finding providers with available and convenient appointment times. For example, studies have found that emergency department utilization is higher in areas with fewer primary care providers, including areas with fewer health centers, and that growth in emergency department visits among patients with mental health conditions has coincided with reductions in the general availability of mental health service providers.¹⁵ Finally, some patients may perceive the emergency department to be an affordable source of care, as emergency departments generally provide medical screenings to patients regardless of their ability to pay.

HRSA's Health Center Program

To increase access to primary care services for the medically underserved, HRSA provides grants to health centers nationwide under Section 330 of the Public Health Service Act.¹⁶ Health centers participating in HRSA's Health Center Program are private, nonprofit community-based organizations or, less commonly, public organizations such as public health department clinics. Health centers are required to

¹⁴ For a review of literature on emergency department utilization, including utilization of the emergency departments for potentially preventable conditions, see D. DeLia and J. Cantor, *Emergency Department Utilization and Capacity*, Research Synthesis Report No. 17 (Princeton, N.J.: The Robert Wood Johnson Foundation, The Synthesis Project, July 2009).

¹⁵ See, for example, P. Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs*, vol. 25, no. 5 (2006), and P. Cunningham, K. McKenzie, and E. Taylor, "The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illness," *Health Affairs*, vol. 25, no. 3 (2006).

¹⁶ 42 U.S.C. § 254b.

have a governing board, the majority of which must be patients of the health center.¹⁷

Health centers also are required to provide comprehensive primary health care services, including preventive, diagnostic, treatment, and emergency services. Moreover, they are required to provide referrals to specialty care and substance abuse and mental health services. Health centers may use program funds to provide such services themselves or to reimburse other providers.¹⁸ A distinguishing feature of health centers is that they are required to provide enabling services that facilitate access to health care, such as case management, translation, and transportation. Additionally, HRSA requires health centers to provide services at times and locations that ensure accessibility and meet the needs of the population to be served, and to provide professional coverage for medical emergencies during hours when the center is closed. Health center services, which may be offered at one or more delivery sites, must be available to all individuals in the center's service area with fees adjusted based on an individual's ability to pay. Uninsured individuals are charged for services based on a sliding fee schedule that takes into account their income level.

Health centers primarily serve low-income populations in medically underserved areas. According to HRSA data, in 2009, the majority of health center patients whose family income was known had income at or below the Federal poverty level.¹⁹ In addition, 38 percent of health center patients were uninsured and 25 percent spoke a primary language other than English, the latter of which could indicate a potential barrier in accessing primary care at other settings that do not offer translation services. In 2009, half of all HRSA-funded health centers were located in rural areas.

Research has shown that the annual health care expenditures for patients receiving care at health centers were lower than those for other patients. For example, one study showed that average health care expenditures for a person who received care at a health center were \$3,500 compared to \$4,594 for a similar person who did not receive care at a health center.²⁰

HEALTH CENTERS HAVE IMPLEMENTED THREE TYPES OF STRATEGIES THAT MAY HELP REDUCE EMERGENCY DEPARTMENT USE

Health centers have implemented three types of strategies that may help reduce emergency department use, namely strategies for (1) emergency department diversion, (2) care coordination, and (3) increasing the accessibility of services, according to our interviews with experts and health center officials. Our review of the literature also identified similar types of strategies.

- **Emergency Department Diversion.** Health centers' emergency department diversion strategies are intended to encourage certain emergency department patients to use a health center as an alternative to emergency department care. Such diversion strategies, which generally are implemented in collaboration with a hospital, focus on educating emergency department patients on the appropriate use of the emergency department; informing them about the services offered at the health center; and arranging appointments at, or referrals to, the participating health center. Emergency department diversion strategies may be targeted at patients whose visits are nonurgent, who lack a regular source of care, who are uninsured or who have Medicaid, or who are frequent users of the emergency department.²¹ According to the health center officials we interviewed, their diversion strategies most commonly focused on preventing future visits to the emergency department, typically involving health center or hospital officials interacting with patients after those pa-

¹⁷ 42 U.S.C. § 254b(k)(3)(H). Under certain circumstances, the requirement for a governing board may be waived, such as for centers funded to serve only one or more of the following: homeless, migrant, or public-housing populations.

¹⁸ Health centers funded to serve homeless individuals are required to provide substance abuse services.

¹⁹ Family income was known for approximately 75 percent of health center patients.

²⁰ The study, which compared 2006 annual medical expenditures of people who received care at health centers and those who had not, made adjustments for an array of factors, including age, gender, income, insurance coverage, and health status. See L. Ku, P. Richard, A. Dor, E. Tan, P. Shin, and S. Rosenbaum, "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform," *Geiger Gibson/RCHN Community Health Foundation Research Collaboration, Policy Research Brief No. 19*. (Washington, DC: The George Washington University School of Public Health and Health Services, June 30, 2010).

²¹ Health center officials we interviewed provided varying definitions of frequent users, ranging from individuals with 2 or more visits per year to individuals with 12 or more visits per year.

tients were seen by emergency department physicians. However, a Colorado health center’s program refers emergency department patients triaged with less acute conditions to walk-in appointments for treatment at the health center’s site, located less than a mile from the hospital. (See table 2 for other examples of emergency department diversion strategies implemented by selected health centers.) According to health center officials, for an emergency department diversion strategy to be successful, there must be good communication between the health center and the hospital and buy-in from the hospital’s administration and emergency department staff. Such buy-in is essential because, according to experts and health center officials we interviewed, hospitals and emergency department physicians may face financial disincentives to divert patients.²²

Table 2.—Examples of Emergency Department Diversion Strategies Used by Selected Health Centers

Health center (State)	Description of emergency department diversion strategy
Baltimore Medical System (MD)	<p>The health center works with a local hospital to link eligible patients—specifically, Medicaid and uninsured patients with two or more emergency department visits in the previous year—to a primary care provider at the health center.</p> <ul style="list-style-type: none"> • The health center stations community health workers at the emergency department from 8 a.m. to 11 p.m. weekdays and some weekend hours. • Community health workers meet with eligible patients after triage by emergency department staff to discuss the benefits and services available at the health center. • Community health workers schedule followup appointments for patients who would like to receive care at the health center. • The health center uses charitable contributions from corporations to pay for the patient’s first health center visit and first prescriptions. • At their first health center appointments, patients are connected to primary care providers who, in coordination with case managers, oversee the patients’ future needs.
Brockton Neighborhood Health Center (MA)	<p>The health center works with two local hospitals to develop treatment plans for health center patients identified as having 12 or more emergency department visits within a year.</p> <ul style="list-style-type: none"> • Hospital staff notify the health center if an identified patient presents at the emergency department. • Health center and hospital staff work together to develop a discharge plan for the patient, including scheduling an appointment for the patient at the health center, if necessary. • During monthly meetings, health center and hospital staff discuss why targeted patients use the emergency department and how care plans can be improved to prevent future use.
LifeLong Medical Care (CA)	<p>As a participant in a countywide initiative, the health center collaborates with other providers in the community to provide linkages to services and manage care for frequent emergency department users, defined as patients who had 10 or more visits in 12 months, or 4 or more visits in each of 2 consecutive years.</p> <ul style="list-style-type: none"> • Health center case managers conduct outreach at three hospital emergency departments to identify patients in the target population and offer to connect them to a comprehensive set of health and social services. • The case managers followup with patients after they leave the emergency department to help ensure that the patients receive needed services; the case managers provide incentives, such as food and transportation, to encourage the patients to come to the health center for medical services.

Source: GAO analysis of information obtained through communications with, and documents provided by, officials from selected health centers.

²² Officials from one health center stated that some emergency department physicians are paid based on volume and, therefore, may be less willing to divert patients. Additionally, experts and health center officials indicated that hospitals may have an incentive to only divert uninsured patients, who may provide no payment to the hospital or health center.

• **Care Coordination.** By coordinating the care of their patients, health centers may help reduce emergency department use by working to ensure that patients first seek care at health centers instead of emergency departments and by focusing on the prevention of disease-related emergencies. Care coordination may include establishing a plan of care that is managed jointly by the patient and the health care team, anticipating routine needs, and actively tracking progress toward patient care plan goals. Health center officials we spoke with described two types of care coordination strategies—the medical home model and chronic care management. The medical home model uses a care team led by a physician who provides continuous and comprehensive care to patients with the aim of maximizing health outcomes.²³ Chronic care management focuses on monitoring and managing chronic conditions, such as diabetes, asthma, and heart disease, through preventative care, screening, and patient education on healthy lifestyles. (See table 3 for examples of care coordination strategies implemented by selected health centers.) Some health center officials we interviewed noted the importance of including mental health services and patient education as key components to the success of care coordination. They also noted that health centers’ electronic medical records, especially when compatible with hospital systems, are helpful in coordinating care but that acquiring the technology can be expensive.

Table 3.—Examples of Care Coordination Strategies Used by Selected Health Centers

Health center (State)	Description of care coordination strategy
Health West (ID)	The health center coordinates care for patients with chronic diseases, such as diabetes and cardiovascular disease, by proactively scheduling appointments for care. The health center’s physicians indicate when patients need to come in for their next visits. The information is recorded in the health center’s electronic medical records and a report is generated each week identifying patients due for appointments. Health center staff then contact each patient to schedule an appointment.
Lincoln Community Health Center (NC)	The health center has education and support groups for patients with certain chronic conditions, including diabetes and hypertension. The groups include patient education, such as food and nutrition instruction provided by a dietician; social support, such as a walking club to encourage exercise; and medication management and guidance on prescription compliance. In addition, health center staff work to coordinate care for all patients by, among other things, following up on missed appointments and scheduling appointments to coincide with patients’ needs for prescription refills.
Northern Counties Health Care (VT)	Through its medical home model, the health center’s primary care physicians are responsible for coordinating all levels of patient care, including referring patients to specialty care, and connecting patients to community services. The primary care physicians work with a team of providers, including behavioral health therapists and chronic care coordinators, to ensure that patients receive necessary care. For example, patients may be referred to the behavioral health therapist for smoking cessation or assistance managing drug and alcohol dependence.

Source: GAO analysis of information obtained through communications with, and documents provided by, officials from selected health centers.

• **Accessible Services.** Health centers employ various strategies to make their services accessible and to raise community awareness of the services they offer, which can help position the health center as a convenient and viable alternative to the emergency department. Such strategies include expanding health center hours to include evenings and weekends; providing same-day or walk-in appointments; providing transportation to health center locations; and locating health center sites in convenient places, such as in or near hospitals, schools, and homeless shelters. Health centers also use strategies to provide care to patients outside of the health center, such as through telemedicine, home visits, and mobile clinics, and may use translators to reduce linguistic and cultural barriers to care. In addition, health centers may engage in outreach activities to increase awareness of their services. For

²³ Under the medical home model, the care team is responsible for providing for all of a patient’s health care needs or appropriately arranging for care with other qualified professionals. This includes the provision of preventive services and treatment of acute and chronic illness.

example, a health center in Wisconsin works with individuals at local community agencies that serve the poor and uninsured, including public health workers, clergy, and social workers, to encourage them to refer individuals to the health center for services. (See table 4 for other examples of strategies health centers have implemented to increase the accessibility of their services.)

Table 4.—Examples of Strategies Used by Selected Health Centers to Increase the Accessibility of Their Services

Health center (State)	Examples of strategies to increase accessibility of services
Access Community Health Network (IL)	<p>The health center has several strategies to help ensure that its services are accessible and that the community is aware of the services offered. For example:</p> <ul style="list-style-type: none"> • The health center has 58 sites, including sites located in schools and a few sites established on hospital campuses. • The health center’s sites accept walk-in patients and most have extended hours; most sites offer Saturday hours, many sites are open until 8 p.m. a few nights per week, and one site is open until 10 p.m. Monday through Friday. • The health center provides phone answering service coverage through which patients can talk to physicians when necessary, even after hours when health center sites are closed. • The health center provides sign language interpretation and has bilingual and multicultural staff members, who reflect the population of the communities served. • The health center increases awareness of its services through outreach to social service agencies, participation in health fairs, and co-branding signs and other informational materials with a local hospital.
Community Health Centers (OK)	<p>To increase access to its services, the health center:</p> <ul style="list-style-type: none"> • has evening hours, until 7 p.m., 3 days a week at one site and 1 day a week at a second site; • schedules appointments only 3 days in advance at one of its sites to reduce wait times for an appointment and maximize appointment times; and • provides transportation to the health center for homeless individuals by distributing bus tokens at one homeless shelter and providing van services from several other shelters.
United Neighborhood Health Services (TN)	<p>To increase access to its services, the health center:</p> <ul style="list-style-type: none"> • operates 16 sites, including a site targeted to homeless patients, 5 school-based clinics, and sites near local hospitals and also operates 2 mobile clinics; • offers Saturday hours at three sites and evening hours (until 10 p.m.) at one site 5 days per week; and • accepts walk-in patients at all health center sites any day the site is open.

Source: GAO analysis of information obtained through communications with, and documents provided by, officials from selected health centers.

Health center officials told us that they had limited data about their strategies’ effectiveness at reducing emergency department use and indicated that because health centers often implemented multiple strategies, evaluating the effectiveness of any one would be challenging. Officials from one health center we spoke with did have an evaluation of the countywide emergency department diversion program it participated in, which found that emergency department visits for participating patients decreased by 63 percent 1 year after patients enrolled in the program. Other health center officials provided anecdotal reports of the impact of various strategies they implemented. For example, health center officials from Pennsylvania reported that offering extended hours did help reduce the use of the emergency department. Additionally, officials from a health center that provides care coordination indicated that they have seen an increase in routine visits, which they believe is helping to prevent some emergency department visits.

Health center officials described several challenges in implementing strategies that may help reduce emergency department use. Specifically, officials noted that some services, such as those provided by case managers, are generally not reim-

bursed by third-party payers, but instead must be funded in total by the center.²⁴ Another challenge, according to health center officials, is that health centers do not benefit from any cost savings resulting from reductions in emergency department visits. Additionally, health center officials noted that it is difficult to change the care-seeking behaviors of certain patients who frequently use the emergency department, including those who are homeless or have substance abuse and mental health problems. Finally, some health center officials noted challenges with recruiting the necessary health providers to serve their patients. Given that the demand for services may increase as more individuals gain health insurance coverage as a result of PPACA, several health center officials we spoke with reported that they have applied for, or expect to apply for, additional health center funding from HRSA to expand services (such as by hiring new providers), open new sites, or renovate existing sites.

AGENCY COMMENTS

We provided a draft of this report to HHS for review and comment. HHS provided a technical comment that we incorporated.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in enclosure II.

DEBRA A. DRAPER,
Director, Health Care.

ATTACHMENT I

Characteristics of Individual Health Centers Interviewed, 2010

Health center (State)	Number of sites	Latest week-day closing time ¹	Saturday hours ¹	Number of patient visits in 2009	Percentage of patients by coverage status in 2009 ²			
					Uninsured ³	Medicaid ⁴	Medicare	Private
Access Community Health Network (IL)	58	10 p.m.	Yes	799,065	32	55	4	9
Baltimore Medical System (MD)	12	7 p.m.	Yes	168,552	20	48	11	21
Brockton Neighborhood Health Center (MA)	2	8 p.m.	Yes	100,586	31	60	5	4
Community Health Centers (OK)	4	7 p.m.	No	49,768	73	18	4	5
Health West (ID)	6	6:30 p.m.	No	23,000	47	17	12	24
LifeLong Medical Care (CA)	9	9 p.m.	Yes	170,098	28	35	26	11
Lincoln Community Health Center (NC)	7	8 p.m.	Yes	139,694	80	12	6	3
Northern Counties Health Care (VT)	8 ⁵	7 p.m.	No	76,250	8	26	22	44
United Neighborhood Health Services (TN)	16	10 p.m.	Yes	89,454	51	34	4	11

Source: GAO analysis of information obtained through communications with, and documents provided by, officials from selected health centers.

¹ Evening and Saturday hours may not be available at all of a health center's sites and evening hours may not be available all weeknights.

² The totals may not add up to 100 percent because of rounding.

³ Uninsured also may include self-pay patients, those who paid out-of-pocket.

⁴ Medicaid may also include people enrolled in the State Children's Health Insurance Program.

⁵ The health center also offers a home health and hospice program, which provides services 24 hours a day, 7 days a week.

²⁴ We previously reported that care coordination services are generally not covered by health insurance. See GAO, *Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges*, GAO-11-49 (Washington, DC: Nov. 16, 2010).

ATTACHMENT II.—GAO CONTACT AND STAFF ACKNOWLEDGMENTS

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Michelle B. Rosenberg, Assistant Director; Jennie F. Apter; Matthew Gever; Carolyn Feis Korman; Katherine Mack; Margaret J. Weber; and Jennifer Whitworth.

NEW JERSEY PRIMARY CARE ASSOCIATION, INC., (NJPCA),
MAY 12, 2001.

Hon. BERNARD SANDERS, *Chairman,*
Primary Health and Aging Subcommittee,
Committee on Health, Education, Labor, and Pensions,
428 Senate Dirksen Office Building,
Washington, DC 20510.

DEAR CHAIRMAN SANDERS: Thank you for allowing the New Jersey Primary Care Association to submit testimony on the subject of “Diverting Non-urgent Emergency Room Use: Can It Provide Better Care and Lower Costs?” We understand that there was a hearing on this topic on May 11, 2011 and the Federally Qualified Health Centers (FQHCs) have a great deal of experience with this subject.

New Jersey has 20 FQHCs that serve approximately 430,000 patients a year with over 1.3 million patient visits. These health centers have seen tremendous growth over the years with a 124 percent jump in their uninsured patients from 2002-9. New Jersey, unfortunately, was one of the States that had many distressed hospitals. Twenty-four have closed since 1992. In many cases, it was the FQHC who stepped up to ensure that the community still had access to good quality health care. FQHCs expanded services, sites, and providers and at present have 103 sites in 19 of the 21 counties. In addition the State of New Jersey recognizes that FQHCs are low cost, are comprehensive, and that they provide good quality care. As such, the State, through a bipartisan effort, has ensured that State funding flows to these centers so that thousands have access to primary and preventive care. The FQHCs in New Jersey average \$1.17 per day for care which is far lower than the cost of getting care in an emergency room.

New Jersey FQHCs have worked in partnership with hospitals to conduct emergency room diversion programs for quite some time. Timely use of primary and preventive care services reduce the need for episodic care that patients receive in hospital emergency rooms (ERs) when medical conditions go undetected and untreated. It is widely acknowledged that when patients have a regular source of care or a health care home, they are more likely to be in better health and less likely to be hospitalized for preventable conditions.

Many New Jersey health centers have collaborative relationships with their area hospitals to reduce inappropriate ER usage by their patients. One New Jersey health center, North Hudson Community Action Corporation (NHCAC), has been recognized in a NACHC publication as having a successful medical home delivery model that focuses on reducing ER usage by their patients. NHCAC, located in northern Hudson County has been a federally qualified health center since 1994. It serves about 70,000 patients annually via nine sites and one mobile center. The broad array of services provided by the center includes adult medicine, pediatrics, dental, prenatal and obstetrics and gynecology, mental health, and substance abuse treatment. Services are available 6 days a week with many sites open until 7 p.m. on weekdays and for extended hours on Saturdays. The main site is open until 10 p.m. on 4 days of the week and on Sunday for at least 6 hours. In an effort to provide health care that is easily accessible, continuous, timely, and comprehensive, NHCAC, in collaboration with Palisades Medical Center, has initiated an Emergency Department (ED) diversion program. Under this program, health center doctors provide care within the hospital through a 24 hours a day, 7 days a week with on-call service for pediatrics and OB/GYN. The program seeks to address the health care needs of NHCAC’s uninsured and underinsured patients who may be frequent users of the ED. Once a patient is seen by an on-call doctor at the ED, patients are given appointments at the health center for their timely followup care. The health center reserves approximately five appointment slots a day from 1-3 p.m. for these followup visits at the health center. The primary goal of this program is to improve and establish continuity of care for patients. Since the program’s inception,

both Palisades Medical Center and NHCAC have reported decreased overcrowding in the ED and improvement in receipt of continuous primary care by patients.

Two other centers are also working hard to promote timely use of primary and preventive care services and reduce unnecessary ER visits for their patients. In 2008, two New Jersey FQHCs, the Monmouth Family Health Center (MFHC) and the Newark Community Health Center (NCHC) received funding from CMS through the New Jersey Office of Medicaid to collaborate with two partnering hospitals to implement an ER Diversion project. The project titled "Community Partnership for ED Express Care and Case Management" is focused on identifying Medicaid patients who present at the ERs of the two collaborating hospitals for primary care conditions; treating and educating them on the proper use of the ER services; educating the patients on the benefits of having a primary care home; and setting them up for followup visits at the partnering health centers; and tracking patient care at the partnering health centers to evaluate the impact of the project. The focus of this project is on reducing inappropriate ER usage, educating patients on the benefits of having a health care home, and in the process improving the overall health status of the patients that show up in the ERs. As of December 2010 both Express Pilot EDs have handled 8,718 project patients and 7,596 of those patients have been referred to the partnering health centers for followup care. Another key component of this project was the ability of the hospital to use a terminal to pull up the appointment system of the FQHC to set up an appointment while the patient was still at the hospital.

Health centers in New Jersey are very focused on the use of Electronic Medical Records (EMR) and adoption of Health Information Technology (HIT) to ensure better quality and safety in patient care and reduce costs. More than half of New Jersey FQHCs have implemented their systems and are now linking with hospitals and with State agencies for seamless care. In addition, 95 percent of the health centers have used or are still using chronic disease patient registries. Health information technology can help providers improve quality of care, reduce medical errors, increase efficiency, reduce duplicative services, provide timelier patient/provider interactions and in the process provide significant savings in the delivery of healthcare services.

KATHERINE GRANT-DAVIS,
President and CEO.

[Whereupon, at 11:30 a.m., the hearing was adjourned.]

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