

**Porter Hospital**  
**Community Health Needs Assessment**  
**Update of 2012 Report**  
**June, 2015**



## **ADDISON COUNTY - OVERVIEW OF OUR COMMUNITY**

Addison County is located in the lower Champlain Valley of Vermont with Lake Champlain and the Adirondacks to our west and the Green Mountains to our east. The unique landscape of Addison County – the fertile farmlands of the Champlain Valley and the predominantly wooded settings near the foothills of the Green Mountains – provides a variety of lifestyles and a nicely balanced blend of light industry and dairy farming. Addison County is rural and known for its dairy farming. It has the most farm acreage in the state and leads the state in the value of agricultural products sold. The County is home to three local newspapers, seven service or fraternal organizations and more than 100 faith communities. The major employers in the county include Middlebury College, Porter Medical Center and Goodrich Corporation, now a part of United Technologies (UTC Aerospace Systems).

Addison County is bordered to the north by Chittenden County, Vermont's most densely populated county, which includes Vermont's largest city (Burlington) and its surrounding suburbs. The northern portion of Addison County is considered a "commutable" distance to Burlington so residents have the option of traveling north for employment, healthcare, shopping and other services. Addison County is bordered to the south by Rutland County. Rutland County is the home of Vermont's second largest city, Rutland. Residents who live in the southern portion of Addison County have the option of traveling to Rutland County for work, healthcare, etc. The southernmost communities of Addison County - Leicester, Whiting and Orwell - are part of school supervisory unions that primarily serve Rutland County students. Addison County is bordered to the east by Windsor, Orange and Washington Counties. For the eastern Addison County communities of Hancock and Granville, accessing services within our county is challenging particularly in winter as this typically necessitates traveling over mountains.

According to the U.S. Census Bureau, the population of Addison County is approximately 36,760. This number reflects a 2.2% increase from ten years earlier and also represents approximately 6% of the State's total population. In Addison County, 21% of the population comprises persons aged 18 and under, 5% - persons under the age of 5, and 13.3% persons aged 65 years and older. By gender, there is nearly an even split with 50.3% females and 49.7 percent males in the county. The median age is 36. In terms of race and ethnicity, 96% of the population is Caucasian and Latinos represent the most prevalent among ethnic groups at 1.2%. In 2014, the median household income was \$56,585 and 9.5% of the County's population was below poverty level. The unemployment rate as of March, 2014 was 8.2%.

Regarding education, most towns in Addison County offer preschools and all have elementary education programs. For secondary education, students go to consolidated school districts which serve neighboring communities. There are three school districts in Addison County: Addison Central Supervisory Union, Addison Northeast Supervisory Union and Addison Northwest Supervisory Union. In addition to traditional secondary schools, the Patricia A. Hannaford Career Center offers an integrated work and learning program to students in all three districts. Public School Enrollment for FY'09 was: 2,713 for pre K-6, 772 for grades 7 & 8, and 1,679 for

grades 9-12. The 2013-14 high school completion rates for our three respective high schools were 92.8%. In addition to public schools, Addison County is the home of Middlebury College, a prestigious liberal arts college, a branch of the Community College of Vermont, and Northlands Jobs Corps., a residential and educational training program for economically challenged youth ages 16-24.

### **Population Centers:**

#### **Middlebury**

Middlebury, the shire town of Addison County, was chartered in 1761 and was settled just after the Revolutionary War. Today, the village is listed on the National Register of Historic Places and is home to many shops, businesses and architecturally distinguished churches and public buildings. It is the largest community in the county with a population of approximately 8,200. Middlebury is home to prestigious Middlebury College, the region's largest employer. Middlebury is the hub for medical services in the county with Porter Hospital, a critical access Hospital with 25 beds, Helen Porter Healthcare and Rehabilitation Center and the majority of area physician offices.

#### **Vergennes**

Established in 1788, Vergennes is Vermont's oldest and first incorporated city. It is home to about 2,800 residents and encompasses approximately 1,200 acres of land that was carved from the three neighboring towns of Ferrisburgh, Panton and Waltham. Vergennes is home to United Technologies, another large employer in the region. In the last decade, Vergennes experienced a downtown revitalization, which began with significant renovations to the Vergennes Opera House. At one time, Vergennes' Main Street consisted primarily of boarded up window fronts but it is now thriving with notable restaurants and shopping.

#### **Bristol**

Bristol, known as the "Gateway to the Green Mountains", was founded in 1762 and is currently home to approximately 3,800 residents. Bristol has a vibrant main street and a strong artist community. The town supports a busy recreation department with a myriad of classes, a clay studio, skate park, teen center and skating rink. Bristol's town green has been part of the village throughout its history. The Bristol Band has presented outdoor summer concerts on the town green every Wednesday since shortly after the Civil War. The green also hosts 4<sup>th</sup> of July events, farmers' markets, Movies in the Park, the Harvest Festival and many other activities. Finally, a truly unique feature about Bristol is that garbage and recycling is picked up by horse-drawn wagon.

### **Smaller Towns and Villages:**

Approximately 60% of Addison County's residents live outside the three population centers. These outlying towns are small and rural with few local services. These communities are governed by select boards and most have their own elementary school. There are small stores

with some food choices but limited fresh produce. The large grocery stores are located in the population centers along with other shopping, banking and healthcare services. Transportation is a significant issue in our county. Addison County Transit Resources provides bus and volunteer driver services but these services are somewhat limited and work for some but not all situations. Agencies such as Parent Child Center, Addison County Home Health and Hospice and Elderly Services provide transportation for their clients for specific purposes but in general, transportation is a concern for those who do not drive and those without a reliable vehicle.

There are ample opportunities for outdoor physical activity in Addison County but in outlying communities there is concern that the roads are dangerous for walking and biking due to fast moving traffic and narrow shoulders. There are few, if any, sidewalks and people often drive short distances because of this. There are no fitness clubs or other indoor facilities for classes and open gym time. There is no paid recreation staff in the outlying towns; some have volunteer recreation or trail committees whose activities are dependent upon the interest and energy of those involved.

## **INTRODUCTION/RESOURCES AND EXECUTIVE SUMMARY:**

At the outset of the original CHNA project, a number of resources were read, reviewed and/or reevaluated in order to better prepare for our interviews and position ourselves to assess and draw meaningful conclusions from our findings. Included in this review were: *Porter Medical Center's Act 53 Community Needs Assessment, Healthy Vermonters 2020, The Health Disparities of Vermonters, 2012, AHEC's 2012 Snapshot of the Vermont Primary Care Workforce, and Vermont's Blueprint for Health.*

Interviews, information and data were collected from a variety of sources and individuals throughout our community, including information from the newly formed (2015) "Community Health Action Team" (CHAT) which is comprised of the following organizations:

- *Porter Hospital*
- *Porter Practice Management*
- *Helen Porter Healthcare & Rehabilitation Center*
- *Counselling Service of Addison County*
- *Addison County Home Health & Hospice*
- *Open Door Clinic*
- *Elderly Services*
- *SASH*
- *VCCI*
- *Department of Health*
- *Agency of Human Services*
- *Turning Point Center*
- *Addison Respite Care Home*
- *United Way of Addison County*

- *Parent Child Center*
- *Mountain Health Center FQHC*
- *Rainbow Pediatrics*
- *Middlebury Family Health/Health First*
- *Blueprint Project Manager*
- *Blueprint Practice Facilitator*
- *OneCare VT*

**CHAT** is a steering committee comprised of representatives from Addison County health and human service agencies, representing the entire continuum of services available to the people of our service area.

**Purpose:** Through collaboration and a commitment to ensuring efficient, high quality health and human services, identifying and implementing best practices and using available data, our committee endeavors to build upon the existing strengths of our local organizations, as well as address gaps and unmet needs, in order to ensure access to services, facilitate smooth and seamless transitions between organizations and improve the health status of our community.

**Principles:** The Middlebury Health Service Area will:

- Include leaders from the medical community, health care community, local/regional community agencies and health care leadership.
- Ensure that members have an equal voice on the committee and will work to reach consensus on decisions.
- Identify opportunities to collaborate and utilize the Middlebury HSA Blueprint as the infrastructure to advance the health care delivery system to a Medical neighborhood.
- With population health management, consider a “whole person” approach including physical health, mental health and socio-economic well-being.
- Align the quality of care goals and care coordination systems with OneCare VT and the Blueprint.
- Identify and work to address gaps in services, duplication of services and rework within the health care system
- Serve as a sounding board and make recommendations about new programs related to healthcare delivery within the Middlebury HSA.
- Charter, monitor and evaluate performance improvement teams to reach the OneCare VT goals.
- Provide required reports, feedback and recommendations to the OneCare VT Clinical Advisory Board.
- Take direction and guidance from the OneCare VT Clinical Advisory Board.

The members of the CHAT group will:

- Represent their organization or agency and services provided
- Secure the support and commitment from their organization or agency to fully participate
- Openly share their views and ideas
- Support the consensus and decisions of this committee
- Represent the work of this committee

**Scope:** The scope of CHAT is to address the population health in the Middlebury Health Service Area. The focus will be on quality outcomes, cost and value. The approach will be system changes including utilizing the Middlebury Blueprint infrastructure for primary care, and panel management.

### **Update on Key Community Health Issues (from 2012 CHNA Report)**

#### **Access – to primary care, primary care providers, insurance, etc.**

“Good access to health care influences a person’s use of health care services and improves overall health. While the subject of health insurance is often at the center of any discussion about health care, access to care involves more than simply having health insurance coverage. The most recent data released by the State of Vermont (January, 2015) suggests that only 3.7% of Vermonters have no health insurance, and 4.2% of people in Addison County are uninsured (including 205 children according to the 2015 *“Vermont Household Health Insurance Survey”*).

Since the passage of the Affordable Care Act, the number of uninsured Vermonters has been reduced by 50% from 6.8% to 3.7%. Of those with health insurance, 54% have private insurance, 21% have Medicaid, 17 % have Medicare and 3% have some type of military coverage.

The Affordable Care Act provided funding for “Navigators” who were hired by local organizations to assist people enroll in the new Vermont Health Connect insurance program. As of April of 2015, a total of 1,430 Addison County residents have enrolled in VHC which is 3.9% of the county as compared to 5% state-wide.

Barriers to timely and comprehensive health care are many: a shortage of providers or hospitals, lack of reliable transportation or long drives to care, cultural or personal beliefs, language and education—as well as a lack of insurance or being underinsured.

The first objective of the *Healthy Vermonters 2020* is to establish primary care. Getting patients in to see a “primary care professional ensures that a complete medical history and other health information is easily available, and that medical

care is consistent and coordinated over time. It was also noted that “repeated messages from a health care professional are very important in changing adult behavior,” which would most likely come from a primary care physician.

Addison County is the home of the Porter Hospital network of physician practices (PPM Network) which consists of six primary care practices (including one in Brandon/Rutland County) and six specialty practices. All practices are currently open to new patients; ensuring access to primary and specialty care for the residents of the county and surrounding communities.

### **Dental Care/Oral Health**

Many individuals interviewed expressed the sentiment that dental care is often viewed as a “luxury” as compared to other types of medical care, though it is clear that oral health is central to overall health. Access to dental care is important in Addison County and it remains a serious issue.

A significant barrier in the system is the poor reimbursement rates for adult Medicaid patients. Many dentists are not willing to take these patients due to this financial barrier.

A 2014 survey showed that the most common type of health care that was deferred or not sought altogether due to lack of insurance coverage was Dental Care (56.9% for children under the age of 17 and 30.5% for adults).

### **Mental Health**

The remnants of Hurricane Irene did what policymakers hadn’t been able to accomplish for more than a decade — close the state’s antiquated psychiatric hospital. The state hospital was described as antiquated and in crisis resulting in decertification and the loss of federal funding in 2003. As a result of the state hospital closing, mental health patients had no place to go. They were being sent to places not qualified to care for mental health patients.

There are recent efforts to reconstruct the mental health care in Vermont. A new psychiatric hospital was lauded as the key component in the governor’s long-term plan to replace the care that had been offered at the 54-bed Vermont State Hospital in Waterbury, but he also proposed mid-term remedies to the current care crisis, including renovations, services, and expansions across the state in order to help the mental health needs of the state.

## Substance Abuse

Substance abuse is gaining recognition around the state of Vermont. The underground nature of the issue raises unanswered questions and serious concern. Despite the secretive nature of the problem, there is no denying the deadly effect it has on the Vermont population. In the original CHNA in 2012, Keith Flynn, Vermont public safety commissioner, said, “opiates are our biggest killer in Vermont. Last year, more people died in Vermont from opiates than from automobile crashes and murders combined.

Since the last CHNA in 2012, new programs are underway or in the works in Addison County to offer addicts treatment closer to home, transportation and even acupuncture.

*Following are excerpts from an article published in the Rutland Herald in May of 2015:*

“People have just stepped up in an incredible way,” said Marcia LaPlante, director of community services and planning for the Vermont Department of Health.

“They got no additional state funds for this, and that has really been the remarkable thing,” she said of Addison County’s efforts.

Among the strides, the county now has at least three doctors providing medically assisted treatment to opiate addicts, so some patients don’t have to travel to Burlington or Rutland, nearly an hour away in either direction, for buprenorphine.

“There was not any treatment in our area,” said Dr. Emily Glick of Bristol Internal Medicine, who served on the local committee advocating for treatment. “There was kind of an outcry from the community, but also I was just seeing it a lot in my practice.” She became trained to prescribe buprenorphine in 2013, and two other doctors in the practice joined the effort last year. Together they now are treating about 75 patients.

Community efforts to tackle opiate abuse have been part of the state’s strategy. The Governor’s Community Forum on Opiate Addiction on June 16, 2014, brought together teams of health care providers, law enforcement members, volunteers and community leaders from around the state to share community-based solutions.

The teams were then encouraged to continue to meet.

The focus in the past year in Addison County has been on treatment, and it shows. The number of people in treatment jumped 40 percent in Addison County between January 2014 and January 2015, compared with a 26 percent increase statewide.

“They’re just doing phenomenal work,” said Moira Cook, the Health Department’s health services district director in Middlebury.

Doctors are also referring patients receiving treatment to the Turning Point of Addison County



for recovery support. The Turning Point Center also is distributing Narcan, a heroin overdose antidote, weekly. As of last month, 75 people had received it and training in how to use it in case they, a friend or family member overdoses.

Acupuncture therapy is now also available to addicts.

Aside from the treatment, Burlington Labs is developing a free van service to help patients get to treatment and recovery support groups and services. The grass-roots effort also has produced a document on the warning signs of addiction that has been distributed to schools and other outlets and some Mount Abraham High School students are helping to create a website with information about addiction treatment, recovery and prevention, including videos of people who have recovered.

“I am incredibly humbled by the work that they have produced,” Cook said of the committees’ work.

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Members of the Addison County health care community agree that there is much more work to do to address the growing problem of opiate addiction in Addison County, but the steps taken since 2012 represent a significant improvement in access to treatment.

## **Long Term Care**

With the Baby Boomer generation growing older, nursing homes and home care are getting more attention from both the local community and the U.S. as a whole.

State policy changes over the past 15 years has shifted the emphasis to more home-based and community-based services over “institutionalized” care, and has resulted in significant downward pressure on nursing home occupancy throughout the State and especially in Addison County.

Additionally, a 2015 report by the United Health Foundation found that Vermont is the healthiest state for seniors (rising from fourth place in 2014). Vermont ranked in the top 10 in 21 of the 43 overall measures including behavioral health, clinical care and hospital readmissions.

Given both state payment policy and the health status of our Vermont population as noted above, Helen Porter Healthcare and Rehabilitation Center feels the pressure to do the best it can with the physical plant and structure that is already in place.

It has re-engineered itself from a 118-bed facility to a new more diversified model, including 20 short-term rehab beds, a burgeoning dementia care program, and a number of other “cultural” changes (adding more home-like touches to their decorum, implementing decentralized dining, and even using different language to denote respectfulness and places in the surrounding natural environment. At any given time, approximately 60% of Addison County people who are Medicaid eligible to be in nursing homes are still living at home...and the state average is in the “mid 20’s”...and the state goal is 40%.

Additionally, HPHRC has collaborated with the Addison County Respite Home (ARCH) organization to create three new “End of Life” rooms within its facility to further diversify and provide a necessary new resource for the people of Addison County.

## **Blueprint for Health/Chronic Disease**

**“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” (Vermont Statute Creating the Blueprint for Health, 2006).**

The Vermont Blueprint for Health recognizes that “chronic conditions are the leading cause of illness, disability, and death in Vermont. Common chronic conditions in adults include diabetes, hypertension (high blood pressure), cardiovascular disease, asthma, arthritis, cancer, respiratory diseases, depression and other mental health disorders, substance dependence and many others.”

The Blueprint for Health is a plan for prevention. “The goals of prevention are to improve the length and quality of life by forestalling illness, decreasing the incidence of disease and premature death, reducing suffering, and saving money.”

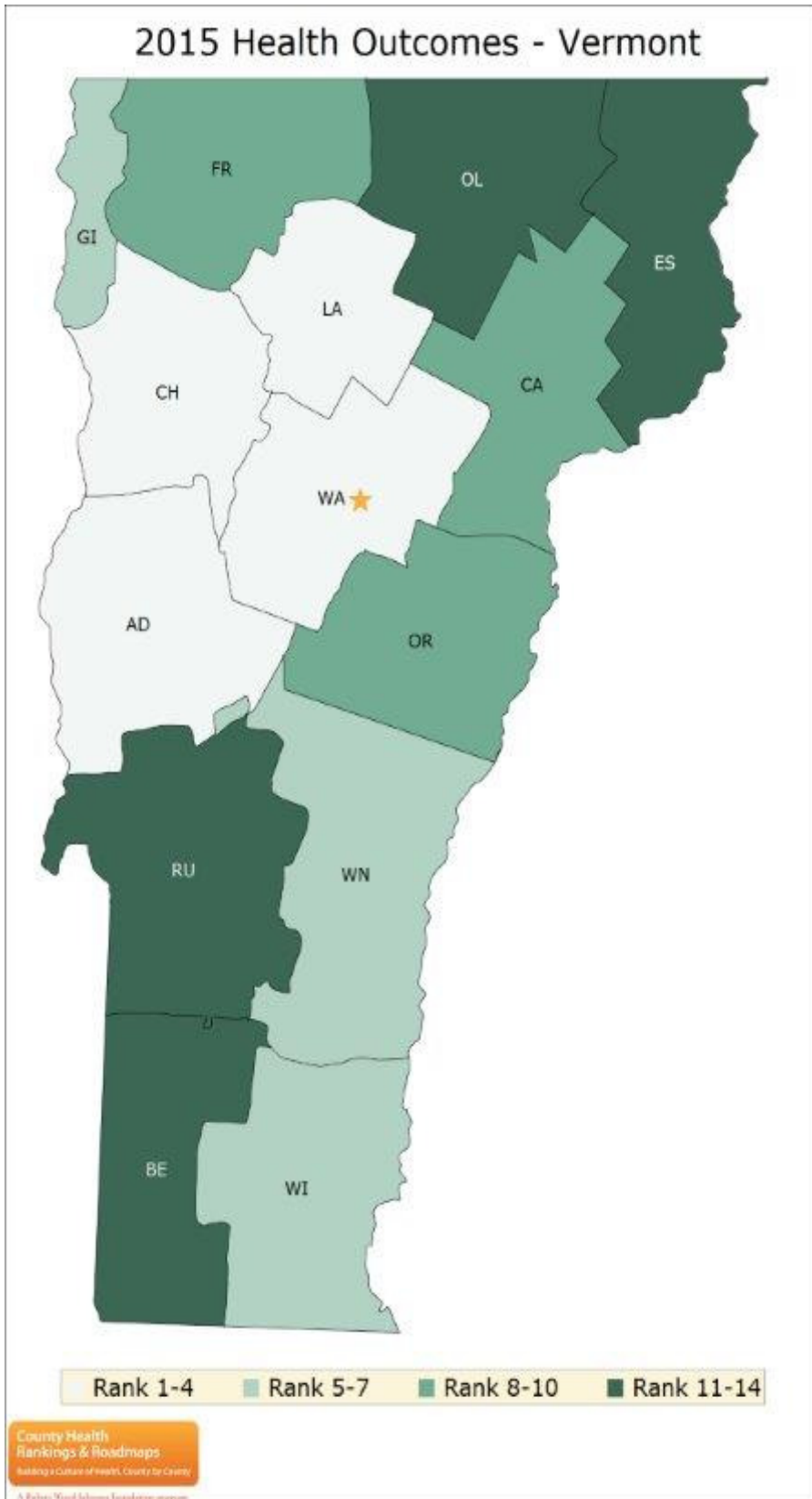
Below are a number of graphs and charts which illustrate the current data relative to the Middlebury Health Service Area (HSA) provided by the Vermont Blueprint for Health:

# Vermont Blueprint for Health

## Community Health Team (CHT)



**Vermont Counties Ranked by Health Outcomes (Vermont Department of Health 2015)**



- Chittenden 1
- Addison 2
- Washington 3
- Lamoille 4
- Windsor 5
- Grand Isle 6
- Windham 7
- Orange 8
- Caledonia 9
- Franklin 10
- Rutland 11
- Bennington 12
- Orleans 13
- Essex 14

**Diabetes: HbA1c Testing**

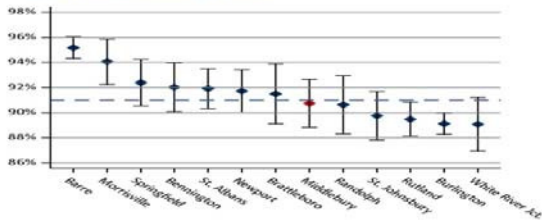


Figure 9: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, that received a hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

**Diabetes: LDL-C Screening**

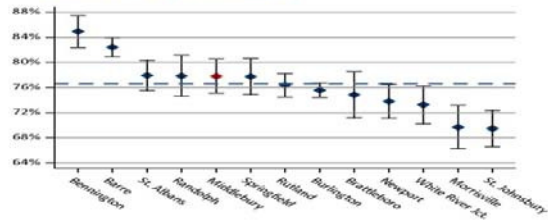


Figure 10: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, that received an LDL-C screening during the measurement year. The blue dashed line indicates the statewide average.

**Diabetes: Eye Exam**

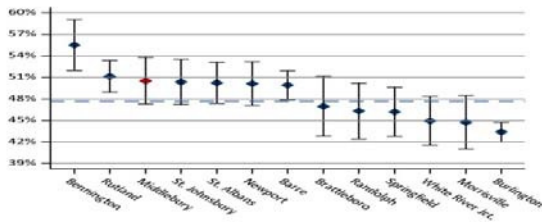


Figure 11: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, that had an eye screening for diabetic retinal disease during the measurement year. The blue dashed line indicates the statewide average.

**Diabetes: Nephropathy Screening**

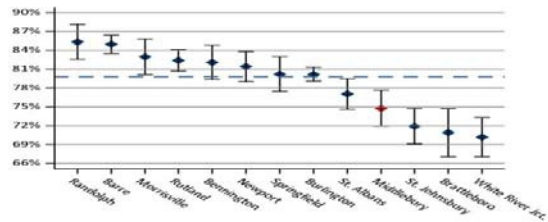


Figure 12: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, that had a nephropathy screening test or evidence of nephropathy documented in the claims data. The blue dashed line indicates the statewide average.

**Total Expenditures per Capita**

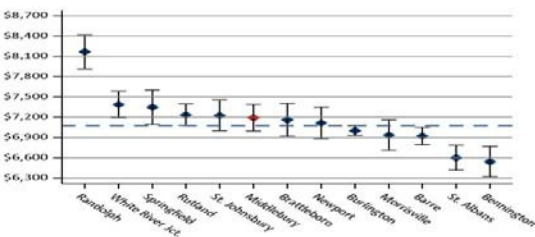


Figure 1: Presents annual risk-adjusted rates, including 95% confidence intervals, with expenditures capped statewide for outlier patients. Expenditures include both plan payments and member out-of-pocket payments (i.e., copay, coinsurance, and deductible). The blue dashed line indicates the statewide average.

**Total Expenditures by Major Category**

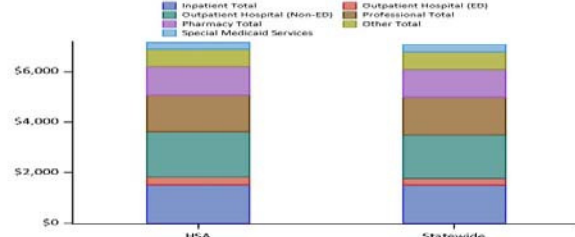


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS).

**Total Expenditures (Excluding SMS)**

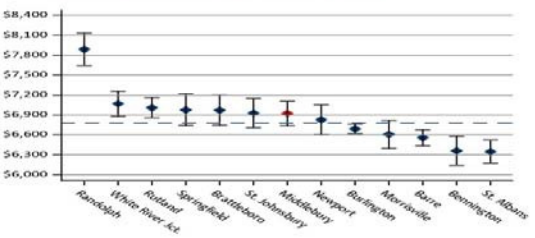


Figure 3: Presents annual risk-adjusted rates, including 95% confidence intervals, with expenditures capped statewide for outlier patients. Expenditures include both plan payments and member out-of-pocket payments (i.e., copay, coinsurance, and deductible) and exclude Special Medicaid Services. The blue dashed line indicates the statewide average.

**Total Resource Use Index (RUI) (Excluding SMS)**

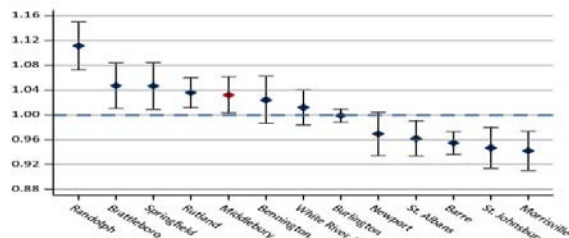


Figure 4: Presents annual risk-adjusted rates, including 95% confidence intervals. Since price per service varies widely, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated capped cost based on utilization and intensity of services across major components of care and excludes Special Medicaid Services. The HSAs are indexed to the statewide average (1.00), which is indicated by the blue dashed line.

**Cholesterol Management, Cardiac (Core-3, MSSP-29)**

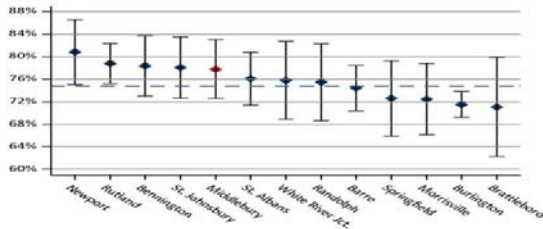


Figure 21: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18-75 years, discharged alive for acute myocardial infarction (AMI), coronary artery bypass grafting (CABG), or percutaneous coronary intervention (PCI) in the year prior to the measurement year or with a diagnosis of ischemic vascular disease (IVD) during the measurement year and year prior and with an LDL-C screening during the measurement year. The blue dashed line indicates the statewide average.

**Avoidance of Antibiotic Treatment, Acute Bronchitis (Core-6)**

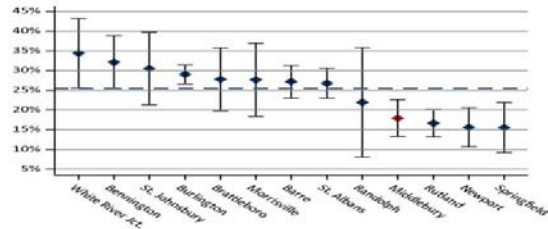
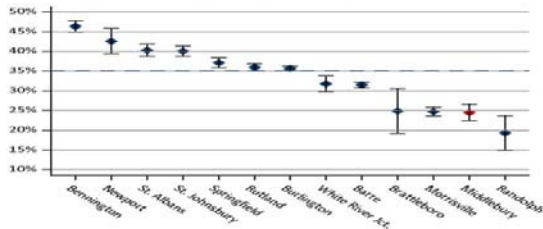
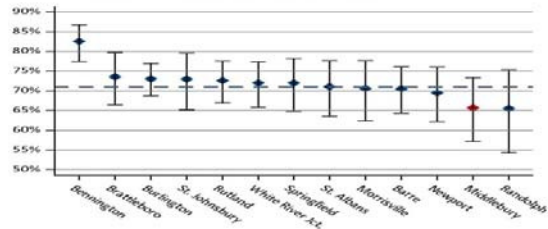


Figure 22: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18-64 years, that received a diagnosis of acute bronchitis but was not dispensed an antibiotic prescription. The blue dashed line indicates the statewide average.

**Influenza Vaccination (MSSP-14)**



**Pneumonia Vaccination (MSSP-15)**



**Diabetes: Composite (Core-16, MSSP 22-25)**

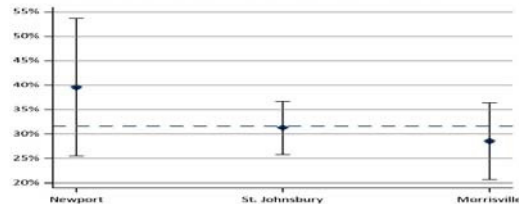


Figure 32: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, in control for hemoglobin A1c (<8%), LDL-C (<100 mg/dL), blood pressure (<140/90 mmHg), and tobacco non-use during the measurement year. Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for all four components of this measure within the measurement year. The blue dashed line indicates the statewide average.

**Diabetes: Poor Control (Core-17, MSSP-27)**

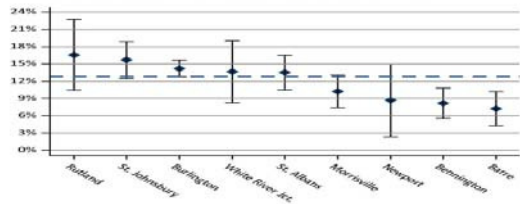


Figure 33: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18-75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>8%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

**Comparison of Patients by HbA1c Control Status, Statewide**

| Metric                                       | Diabetes A1c in Control       | Diabetes A1c not in Control (>9%) |
|--|-------------------------------|-----------------------------------|
| Members                                      | 4,220                         | 568                               |
| Annual expenditures per capita               | \$12,507 (\$12,059, \$12,954) | \$15,267 (\$13,867, \$16,667)     |
| Inpatient hospitalizations per 1,000 members | 181.7 (168.7, 194.7)          | 275.0 (231.1, 318.8)              |
| Inpatient days per 1,000 members             | 877.8 (849.2, 906.4)          | 1,524.0 (1,421.6, 1,627.2)        |
| Outpatient ED visits per 1,000 members       | 532.1 (509.8, 554.4)          | 752.2 (654.0, 796.4)              |

Note: Risk-adjusted rates with 95% confidence intervals are provided in parentheses. Outliers beyond the 99th percentile have been excluded.

Table 2: Presents a comparison of health care expenditures and utilization in the measurement year for continuously enrolled members, ages 18-75 years, whose diabetes hemoglobin A1c was in control (<8%) compared to those with poor control (>9%). Rates have been adjusted for age, gender, and health status. The rates in this table are presented at the state level only. Members with poor control had statistically significant higher total expenditures, inpatient hospitalizations, inpatient days, and outpatient ED visits.

**Hypertension: Blood Pressure in Control (Core-39, MSSP-28)**

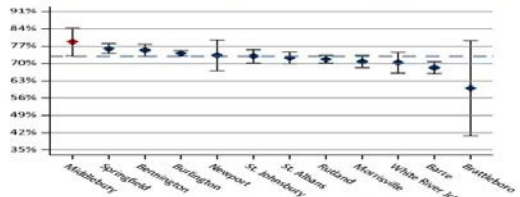


Figure 34: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with hypertension were identified using claims data. The denominator was then restricted to those with DocSite results for a blood pressure reading during the measurement year. The blue dashed line indicates the statewide average.

**Inpatient Discharges**

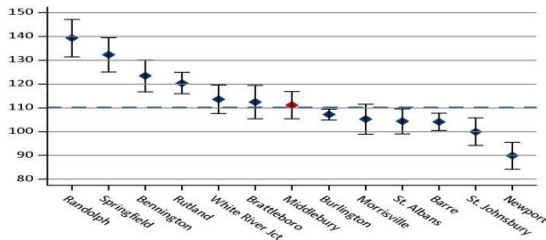


Figure 6: Presents annual risk-adjusted rates, including 95% confidence intervals, of inpatient discharges per 1,000 members. Additional detail measures for inpatient utilization — Inpatient Days, Inpatient Readmissions within 30 Days, and Inpatient Discharges for Ambulatory Care Sensitive (ACS) Conditions — can be found in Table 5.

**Outpatient ED Visits**

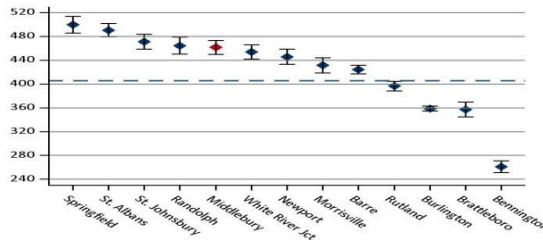


Figure 7: Presents annual risk-adjusted rates, including 95% confidence intervals, of outpatient emergency department (ED) visits per 1,000 members. An additional detail measure — Outpatient Potentially Avoidable ED Visits — can be found in Table 5.

**Advanced Imaging (MRIs, CT Scans)**

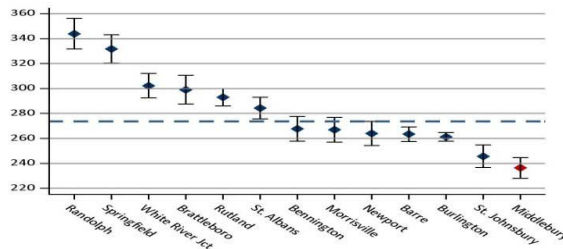


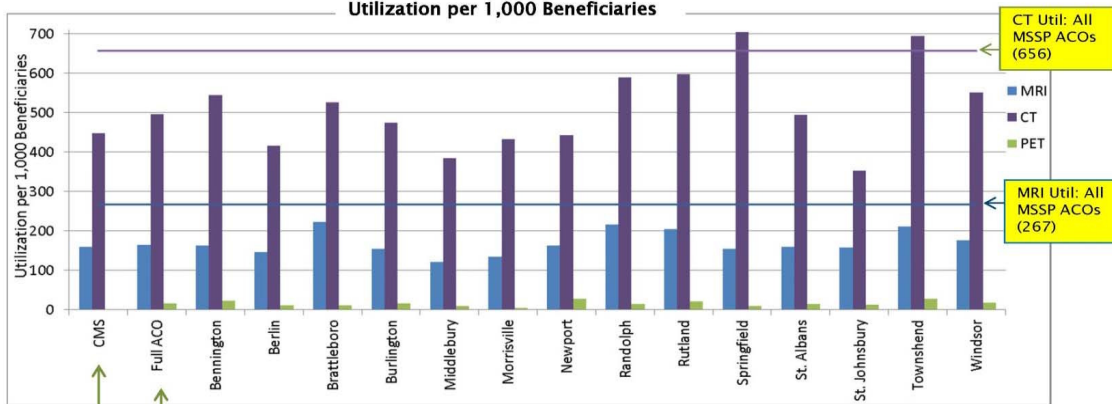
Figure 8: Presents annual risk-adjusted rates, including 95% confidence intervals, for advanced imaging diagnostic tests (i.e., MRIs, CT scans) per 1,000 members.

**Advanced Imaging**

Utilization per 1,000 Beneficiaries:

|     | Full ACO | Bennington | Berlin | Brattleboro | Burlington | Middlebury | Morrisville | Newport | Randolph | Rutland | Springfield | St. Albans | St. Johnsbury | Townshend | Windsor |
|-----|----------|------------|--------|-------------|------------|------------|-------------|---------|----------|---------|-------------|------------|---------------|-----------|---------|
| MRI | 164      | 163        | 146    | 223         | 154        | 122        | 134         | 163     | 217      | 204     | 155         | 160        | 158           | 211       | 176     |
| CT  | 495      | 544        | 416    | 527         | 474        | 384        | 433         | 442     | 589      | 598     | 704         | 494        | 353           | 694       | 551     |
| PET | 16       | 24         | 11     | 12          | 16         | 10         | 4           | 28      | 14       | 22      | 10          | 14         | 13            | 28        | 18      |

**Utilization per 1,000 Beneficiaries**



Calculated using data available to OCV.

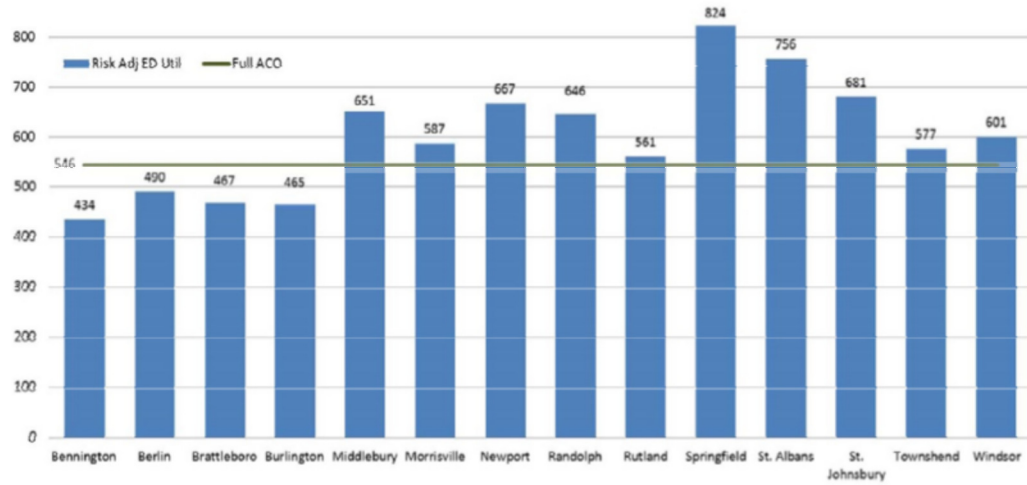
Calculated by CMS using data for all OCV beneficiaries (including beneficiaries that have opted out of data sharing). Annualized and weighted by Medicare enrollment type. PET utilization not available.

National Utilization per 1,000 Beneficiaries:

| National FFS |     |
|--------------|-----|
| MRI          | 232 |
| CT           | 597 |
| PET          | -   |

OCV Claims data 4/1/2013 - 3/31/2014 with claims run out through 6/30/2014. For beneficiaries attributed to OCV 2013.

## Risk Adjusted ED Utilization Per 1,000 Beneficiaries by HSA



|                                  | Full ACO    | Bennington | Berlin    | Brattleboro | Burlington  | Middlebury | Morrisville | Newport   | Randolph  | Rutland   | Springfield | St. Albans | St. Johnsbury | Townshend | Windsor   |
|----------------------------------|-------------|------------|-----------|-------------|-------------|------------|-------------|-----------|-----------|-----------|-------------|------------|---------------|-----------|-----------|
| Total Beneficiaries <sup>1</sup> | 48,682      | 5,286      | 5,549     | 1,897       | 13,754      | 2,961      | 2,052       | 3,027     | 2,253     | 4,026     | 1,731       | 1,253      | 1,643         | 1,056     | 1,994     |
| Risk Score <sup>2</sup>          | 1.09        | 1.17       | 1.06      | 1.06        | 1.06        | 1.04       | 1.08        | 1.16      | 1.08      | 1.15      | 1.11        | 1.05       | 0.99          | 1.23      | 1.11      |
| Total ED Cost                    | \$7,262,984 | \$643,194  | \$850,221 | \$263,664   | \$1,744,361 | \$547,767  | \$292,376   | \$470,266 | \$353,238 | \$684,256 | \$363,408   | \$245,895  | \$230,449     | \$172,386 | \$401,503 |
| ED Cost PBPM                     | \$12.43     | \$10.14    | \$12.77   | \$11.58     | \$10.57     | \$15.42    | \$11.87     | \$12.95   | \$13.07   | \$14.16   | \$17.50     | \$16.35    | \$10.42       | \$13.60   | \$16.78   |
| Risk Adj ED Cost PBPM            | \$11.40     | \$8.65     | \$12.01   | \$10.89     | \$9.97      | \$14.85    | \$10.98     | \$11.17   | \$12.13   | \$12.37   | \$15.81     | \$15.53    | \$10.52       | \$11.05   | \$15.16   |
| ED Util                          | 596         | 509        | 520       | 497         | 493         | 676        | 635         | 774       | 696       | 642       | 912         | 796        | 674           | 710       | 665       |
| Risk Adj ED Util                 | 546         | 434        | 490       | 467         | 465         | 651        | 587         | 667       | 646       | 561       | 824         | 756        | 681           | 577       | 601       |





