Community Collaboration for Appropriate Emergency Department Care
Grant Proposal

State of Washington

Establishment of Alternate Non-Emergency Services Providers

Contact Person:
Alice Lind
Phone: (360) 725-1629
Fax: (360) 753-7315
Lindar@dshs.wa.gov

This grant is approved by the Washington State Medicaid Director:

Douglas Porter, Assistance Secretary, Health and Recovery Services Administration

Abstract: Between 2000 and 2006, Washington Medicaid costs for Emergency Department (ED) Services have grown by 107%. Claims review suggests that 50% of these visits are non-emergent or capable of being prevented with utilization of a medical home. A review of the literature was completed to understand initiatives that might reverse rising ED utilization. Based on this review, Washington's Medicaid agency, the Health and Recovery Services Administration (HRSA), proposes to issue a request for proposals (RFP) to establish community health clinics (CHCs) as alternate non-emergency service providers. The RFP will require that participating CHCs be located in a HPSA and have a collaborating community hospital as a partner. One to four collaborating partnerships will be included in this project which will jointly serve 50,000 Medicaid beneficiaries who reside within defined entities such as a city or county. The project will reduce ED utilization through three strategies:

1. Assure 24 hour access to professional services for Medicaid enrollees by providing a nurse-triage line to Medicaid enrollees in project communities. All new enrollees will receive a mailing about the service including self care information on common non-emergent conditions;
2. Improve the ability of CHCs to be effective medical homes and alternate emergency care providers by providing funds for CHCs to expand primary care services into the evenings and/or weekends, initiate behavioral health services as a component of the medical home, or to locate services with or close to Hospital EDs; and
3. Create a case management system to follow-up on Medicaid ED visits. Case management will be integrated with the nurse-triage system to:
   - Contact Medicaid beneficiaries after an ED visit to follow-up on their health status;
   - Assure the client knows how to contact their primary care provider (PCP);
   - Make follow-up appointments with their PCP; and
   - Connect them with other needed services such as disease management programs for asthma/diabetes, housing assistance, mental health services or substance abuse treatment.

EDs will use low literacy and translated educational materials which explain how to address non-emergent conditions that most frequently send patients to the ED and that provide information on how to contact the nurse-triage line. These initiatives are expected to achieve a 25% reduction in ED utilization in the second year of the project. Once fully established, the project is expected to reduce ED costs to HRSA by $1.27 million a year. The cost of the grant is expected to be $980,469 in the first year and $933,112 in the second year for a total of $1,963,581. Costs in third and subsequent years are expected to decline as start-up costs are eliminated and fewer ED visits require less case management time. HRSA expects that savings achieved through the project will be sufficient to allow continuation of the project after grant funding ends and to replicate it in additional Washington communities. HRSA also expects to see care redirected from the acute ED setting to the primary care setting with improved patient satisfaction with care and improved achievement of standards of preventive care.

Statement of Project/Need: Washington State has worked to establish effective medical homes for its Medicaid beneficiaries since the origination of Medicaid managed care in the early 1990s. One strategy has been to support robust medical homes through the State's network of CHCs which integrate primary medical, dental, and behavioral health services. Evidence of our success is the fact that Washington's CHCs serve nearly 10% of the state's population compared to 5% nationally. They serve 23% of Medicaid beneficiaries compared to 11% nationally.[1]

A second strategy has been to embrace managed care. Approximately one-half of Washington's Medicaid beneficiaries are in managed care programs. ED utilization is 13% lower among Medicaid beneficiaries enrolled in managed care plans compared to those enrolled in Fee for Service Programs (FFS).[2]

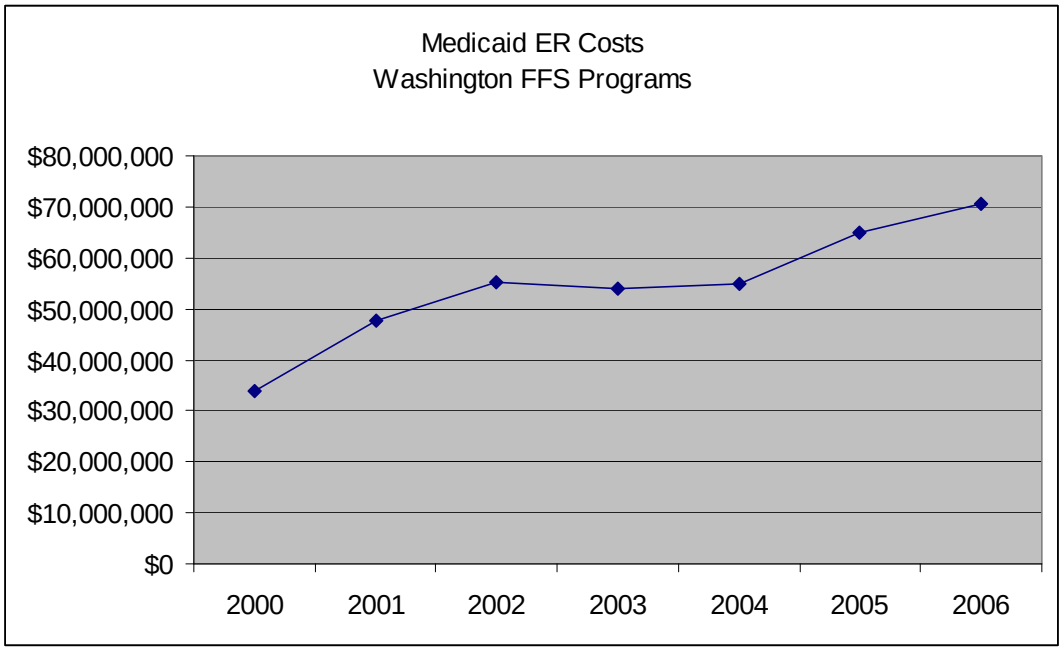
Strong CHCs and high penetration of Medicaid managed care contribute to ED utilization rates well below the national average. Washington State Medicaid had an ED utilization rate of 47.6 visits per 100 beneficiaries in 2004 compared to 80.3 visits per 100 Medicaid enrollees nationally.[3] Still, Washington is not satisfied with its considerable achievements. The cost of Medicaid ED utilization in FFS is rising, see graph below:

---

[1] Medicaid enrollment by State and Nationally for December 31, 2006 is available at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr06.pdf. Community Health Center Medicaid users for 2006 nationally is available at http://bphc.Washington Medicaid.gov/uds/2006data/National/NationalTable4Universal.htm. Data on Medicaid Users served by Community Health Centers in Washington State is available by special request in the Bureau of Primary Health Care Section 330 Grantees in the Washington Rollup Report. In 2005, Washington Health Centers reported serving 227,519 Medicaid users out of 999,031 enrolled in Medicaid on December 31st, 2006.

[2] Washington Medicaid claims data for 2006 showed 55.7 ED visits per 100 enrollees in Fee for Service programs compared to 49.2 visits per 100 enrollees in Managed Care programs.

[3] Advance Data from Vital and Health Statistics, Number 372, June 23, 2006, page 3.



Washington Medicaid expenditures for ED care increased from $34 million in 2000 to $71 million in 2006, an increase of 107% in FFS programs. Similar increases occurred in Washington managed care programs. Claims review using the methodology described by New York University[4] suggests that 50% of these ED visits were for non-emergency care that could have been treated in a primary care setting.

In a Massachusetts study, 21% of ED visits were non-emergent, while 25.5% were designated as emergent, but could have been treated in a primary care setting, or avoided with better primary care.[5] Massachusetts data mirrors that found in Washington state. A review of Washington Medicaid ED visits found that 50% of visits are non-emergent and may be preventable with access to quality primary care.

High ED utilization is a significant problem for a subset of Medicaid clients. One percent of Massachusetts residents made 5 or more ED visits and accounted for 17.6% of

[4] This ER visit classification algorithm was developed by New York University researchers John Billings, Nina Parikh and Tod Mijanovich in 2000 at the Center for Health and Public Service Research. More information about models, articles, and methodology are available at: http://wagner.nyu.edu//chpsr/index.html?p=62

[5] Massachusetts Division of Health Care Finance and Policy. "Non-Emergent and Preventable ED Visits, FY05." Analysis Brief, Number 11; February 2007.

total ED visits. Frequent users were hospitalized at higher rates and were sicker than infrequent users. Chronic conditions, migraines, along with mental health and substance abuse disorders were much more prevalent among frequent users.[6]

A second study confirmed results from Massachusetts finding that 8% of ED users with 4 or more visits were responsible for 28% of adult ED visits. Characteristics independently associated with frequent use included poor physical health, poor mental health, greater than or equal to 5 outpatient visits annually, and family income below the poverty threshold.[7]

Washington State made similar observations in their analysis of clients seeking frequent emergency room care for narcotics. Strong links were made between frequent emergency room utilization and drug/alcohol abuse/mental disorders. Further, the number of narcotic prescribers (providers) was more indicative of problem behavior, supporting the need for a medical home. The study showed that 9 out of 10 FFS clients using 31 or more ED [visits] in a year had a substance abuse disorder, a mental illness, or both[8].

Visits among "Frequent Users" may not have been inappropriate, but may be preventable if given access to quality primary care and enrollment in case and disease management programs that can refer individuals for appropriate behavioral health care. Improved primary care may prevent repetitive ED visits, improve quality of life and reduce hospitalizations for preventable conditions.

---

[6] Fuda, Kathleen, Immekus, Rachel. Frequent Users of Massachusetts Emergency Departments: A Statewide Analysis. Annals of Emergency Medicine 48.1 (July 2006): 9-16.
[7] Hunt, Kelly A. MPP. Characteristics of Frequent Users of Emergency Departments. Annals of Emergency Medicine, 48.1 (July 2006): 1-8.
[8] "Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness, Washington State's Aged, Blind, and Disabled Clients" *Publication Date: 1/2004. Report Number 11.119*. found at: http://www1.dshs.wa.gov/rda/research/11/119.shtm

Washington's Medicaid agency, the Health and Recovery Services Administration (HRSA), sees the need to press forward with further ground breaking strategies to reduce non-emergent ED utilization and assure a robust medical home to all in Washington. This was recently reinforced by the Blue Ribbon Commission on Health Care Costs and Access which resulted in legislation requiring work on both ED diversion and medical homes[9]. Three strategies will be supported by this grant:

1. Assure 24 hour access to professional services for Medicaid enrollees by providing a nurse-triage line to Medicaid enrollees in selected markets.
   All new enrollees will receive a mailing about the service along with self-care information on common non-emergent conditions.
2. Improve the ability of CHCs to be effective medical homes by providing funds for CHCs to expand primary care services into the evenings and/or weekends, integrate behavioral health services as a component of the medical home, or to locate services with or close to hospital EDs.
3. Create a case management system to follow-up on Medicaid clients seeking ED services. Case management will be integrated into the nurse-triage system. Case Managers will contact all Medicaid beneficiaries after an ED visit to follow-up on their health status, assure they know how to contact their PCP, make follow-up appointments with their PCP or connect them with other needed services such as education about asthma/diabetes, housing assistance, mental health services or substance abuse treatment.

[9] The complete Washington State Blue Ribbon Commission report can be found at http://www.governor.wa.gov/priorities/healthcare/BlueRibbon_FinalReport.pdf.

Emergency departments will use low literacy and translated educational materials which explain how to address the non-emergent conditions that most frequently send patients to the ED and that provide information on how to contact the nurse-triage line.

There is an abundance of research on strategies that work to optimize ED utilization. HRSA will set aside grant funds to contract with an internal or external research institution to design an evaluation strategy. Options could include a before and after study or a match of communities selected to participate in the project to a control community with an ED utilization comparison between the matched communities before, during and after the project period.

HRSA will implement this strategy in one to four selected communities by publishing an RFP. To be eligible, projects will be required to:

- Demonstrate collaboration between a CHC and a community hospital. Preference will be given to established hospital/CHC collaborations.
- Demonstrate an HPSA score equal to or greater than 5.
- Participate in the case management system by hospital referrals of all Medicaid clients seeking ED services to the case management system. CHCs will need to assure grant funds are used to fund case management services focused on reduction of non-emergent ED utilization.
- Implement start up funds to establish service delivery sites at or close to a Hospital ED and incorporate behavioral health services into the medical home; or expand evening and weekend services at CHC sites.

Project Justification: Improved primary care provides an avenue to prevent repetitive ED visits, improve timely and appropriate care delivery, and reduce hospitalizations for preventable conditions. The way the Community Collaboration for Appropriate ED Care is modeled supports the findings from information described below.

- **Redirection of resources improves the use and effectiveness of primary care -** Increasing Medicaid expenditures for non-emergent ED utilization wastes public resources and restricts the State's ability to make other needed investments in the health of its citizens. By redirecting resources spent on non-emergent ED visits to improving the use and effectiveness of primary care or medical homes, preventive care and management of chronic disease is strengthened. Adding behavioral health resources at CHCs provides a ready source of appropriate care.
- **Members have increased access to primary care –** Increased access to primary care reduced ED utilization by children by 24% and non-urgent ED visits were reduced by 37%. Specific services that may be responsible for reducing ED use include the expanded availability of primary care physicians and the use of telephone triage systems.[10] Another study documented that 24-hour access to a primary care physician with ED gate keeping responsibility resulted in a 10% decline in ED visits and a 41% decline in "inappropriate visits."[11]
- **Access to care decreases ED visits** - Patients from practices with more than 12 evening hours/week used the ED 20% less than patients from practices without evening hours.[12] Access issues were identified as reasons for non-emergent ED visits, including beliefs regarding limited availability of after hour consultation services and of timely appointments at one's primary care site.[13] High ED utilization may not be an 'abuse' of the ED by patients with frequent visits, but

[10] Piehl, Mark D., et al. Narrowing the Gap: Decreasing Emergency Department Use by Children Enrolled in the Medicaid Program by Improving Access to Primary Care. Archives of Pediatrics and Adolescent Medicine 154.8 (August 2000):791-795.
[11] Sofia M. Franco, MD, et al. Primary Care Physician Access and Gate-keeping: A Key to Reducing Emergency Department Use. Clinical Pediatrics 36.2(1997):63-68.
[12] Lowe, Robert A., MD, MPH, et al. Association between primary care practice characteristics and emergency department use in a Medicaid managed care organization. Medical Care 43.8 (August 2005): 792-800.
[13] Guttman, Nurit. The Many Faces of Access: Reasons for Medically Non-urgent Emergency Department Visits." Journal of Health Politics, Policy and Law 28.6 (December 2003): 1089-1120.

rather an indicator that the health care needs of these patients have not been met in their usual primary care setting.[14]

- **Confirmed value for members** - These studies confirm the value of managed care in reducing non-emergent ED care, a strategy implemented by HRSA. It also suggests that access to a 24-hour nurse triage line for assessment and education may be an effective strategy for reduction of ED visits by children, as is expanded primary care hours in the evenings and/or weekends.
- **Decrease disparities through the use of a medical home** – A Medical home is an approach to delivering primary health care through a team partnership that ensures health care services are provided in a high quality and comprehensive manner. Key components of a quality medical home include accessibility and care coordination with an emphasis on care being family centered, compassionate and culturally effective. [15] Access to a medical home can reduce or eliminate racial and ethnic disparities in access and quality. A medical home improves access to needed care, receipt of routine preventive screenings, and substantially improves management of chronic conditions. Rates of cholesterol, breast cancer and prostate screening are higher among adults who receive patient reminders, and when minority patients have medical homes, they are just as likely as whites to receive these reminders. [16]
- **Evidence based study -** This pilot will provide the evidence needed to address crucial problems with the over-use of our ED systems and provide evidence based solutions to those problems.

---

[14] Lucas, Raymond H. MD and Sanford, Sandra M. RN, MSN. An Analysis of Frequent Users of Emergency Care at an Urban University Hospital. Annals of Emergency Medicine 32.5 (1998): 563-568.
[15] For more information on the Washington State definition of Medical Home see http://www.medicalhome.org/4Download/keymessages2007.pdf
[16] Beal, A.C., Doty, M.M., Hernandez, S.E., et al. Crossing the Divide: How Medical Homes Promote Equity in Health Care. June 2007. Publication available at www.commonwealthfund.org

- From these studies, the outlines of effective strategies to reduce non-emergent ED utilization emerge that are incorporated into this proposal:
- Improve access to high quality medical homes that integrate medical, oral and behavioral health services and that provide evening and weekend access.
- Provide access to 24-hour nurse-triage services.
- Make available case management services to follow-up on ED visits and connect patients to primary care and disease management services.
- In summary, the project will help save valued health care dollars by decreasing non-emergent ED utilization and increasing access to quality care and a medical home.
- **Project Goals and Outcomes:** The goals of this project are as follows:
- Reduce ED utilization and achieve savings that can be invested in improving a primary care home.
- Connect Medicaid beneficiaries utilizing ED services with quality primary care homes and case management services.
- Educate Medicaid beneficiaries about appropriate use of the ED and primary care.
- Improve access to primary care homes through expansion of evening and weekend hours or by locating services in close proximity to Hospital EDs.
- Improve quality of care and patient satisfaction with care.
- Reduce disparities in health care due to racial/ethnic differences by providing access to a medical home.
- The outcomes to be achieved are as follows:
- Reduce Medicaid Fee For Service ED utilization in project communities from 55.7 visits per 100 enrollees to 44.6 visits per 100 enrollees.

- Reduce Medicaid Managed Care ED utilization in project communities from 49.2 to 39.6 visits per 100 enrollees.
- Achieve savings of $1.27 million in Medicaid ED costs.
- Improve HEDIS measures and patient satisfaction with access to care in project communities.

Estimate the Impact to Beneficiaries: This project will serve 50,000 Medicaid enrollees or 5% of the estimated 1,000,000 Medicaid clients in Washington State**.** HRSA will solicit proposals statewide. Proposals will be funded that serve communities centered on a single community hospital or that involve multiple collaborating hospitals and CHCs that are within a common boundary such as a city or county. HRSA expects improvements in patient satisfaction as ED visits are prevented through effective telephone triage and education and as hours and locations of primary care improve. HRSA expects measures of preventive care will improve as visits are moved outside of the acute care focused ED and into the primary care setting.

Description of the Impact to Medicaid: Serving 50,000 Medicaid enrollees, the project will reduce ED utilization from 52.5 to 42 visits per 100 enrollees, eliminating 5,250 ED visits during the second and subsequent years. At an average ED cost of $242/visit this will represent a savings of $1,270,500, yielding a projected savings of $270,500 a year over the $1,000,000 cost of operating the project. Studies suggest that reducing ED utilization, at least among children, does not increase primary care utilization[17]. The projected savings may be higher if improved primary care and case management services that employ health literacy messages reduce hospitalizations.

[17] Grossman, LK, Et al. Decreasing Non-Urgent Emergency Department Utilization by Medicaid Children. Pediatrics 102.1(July 1998): 20.

Project Sustainability: Certain project costs are expected to be one-time costs to facilitate start-up of evening and/or weekend hours, co-location of CHC services with hospital EDs, or incorporation of behavioral health services into the medical home. These start-up costs will not persist as expenses to the project. As ED visits are reduced, it is expected that initial levels of case-management staffing can be reduced, lowering the cost of sustaining the program. As expected reductions in ED utilization are achieved, HRSA will re-direct savings formerly spent on ED care to sustaining the program for its FFS clients. Starting in the second year of the project, HRSA will share program accomplishments with Medicaid Managed Care health plans and seek to partner with them to sustain the program into the future. If successful, HRSA will work to expand the most effective aspects of its model to additional communities around the state that can demonstrate committed collaborations between hospitals and CHCs, using savings achieved to fund the expansions.

Evaluation Plan: HRSA will budget grant resources to contract with a research organization to evaluate the impact of this project on the cost and quality of care provided. Through its claims management system, HRSA will measure ED visits and costs before and after project implementation. In addition, each project community will be matched with a similar community elsewhere in the State. ED utilization and costs will be measured before and after project implementation for the matched communities. Project effectiveness will be established if ED utilization and costs 1) decline progressively and reach statistical significance in the second project year; and 2) show statistically greater impact in project communities compared to matched control communities in ED costs and visits.

Project Implementation Readiness: HRSA has worked with the WSHA and WACMHC to establish collaborations between CHCs and Hospitals to reduce ED

utilization. The Board of WACMHC recently made the reduction of non-emergent ED utilization a strategic objective of the organization. WACMHC and WSHA have received letters of intent to develop CHC/Hospital collaborations to reduce ED use from several organizations. Following notification of grant receipt, HRSA would solicit full proposals from any qualifying project, but among the pilot projects that could be developed with grant funding are the following:

- Community Health Center of King County and Auburn Regional Hospital: Expand CHC clinic hours to evenings and weekends; care coordination between Hospital and CHC to establish a medical home for Medicaid ED users.
- Valley View Health Center and Providence Centralia Hospital: Care coordination between Hospital and CHC to establish a medical home for Medicaid ED users.
- Community Health Care and St. Claire Hospital: Co-location of CHC services with ED to divert non-emergent ED visits to an effective medical home and care coordination between hospital ED and CHC.
- Yakima Neighborhood Health Center, Yakima Valley Farmworkers Clinic, Community Health of Central Washington, Sunnyside Community Hospital, and Yakima Valley Memorial Hospital: Care coordination for children utilizing ED services to connect them with an effective medical home.
- Interfaith Community Health Center and St. Joseph's Hospital: Care coordination between people utilizing ED services to connect them with an effective medial home. Expansion of hours to include evenings/weekends
- La Clinica and Lourdes Hospital: Co-location of CHC services with ED to divert non-emergent ED visits to the CHC and improve and care coordination between hospital ED and CHC.

HRSA will send out a Request for Proposals (RFP) within 30 days of receiving notification of funding. The RFP will provide 30 days to respond. HRSA will select one to four projects to fund within two weeks thereafter. Criteria for project selection will include the ability to have a project operational within 90 days.

Implementation Tasks	**Due Date**	**Responsible Party**
RFP published to Washington CHC/Hospital Collaborations	November 30, 2007	HRSA
Response to RFP	December 30, 2007	Interested CHC/Hospital Collaborations
RFP published to providers of Nurse Triage Services	November 30, 2007	WSHA/WACMHC
RFP Response for Triage Service	December 30, 2007	Nurse Triage Services
Selection of CHC/Hospital Collaborations for funding	January 15, 2008	WSHA/WACMHC
Selection of Nurse Triage Service	January 21, 2008	HRSA
Implementation of Nurse Triage	April 1, 2008	Nurse Triage Provider
Implementation of Case Mgmt and other project services	April 1, 2008	Selected CHC/Hospital Collaborations
First quarterly report to CMS	January 30, 2008	HRSA

COMMUNITY COLLABORATION FOR APPROPRIATE ED CARE
ALTERNATE NON-EMERGENCY SERVICES PROVIDERS OR NETWORKS
ESTIMATED BUDGET

BUDGET ITEMS	Year One	Year Two	TOTAL
Personnel Costs			
Personnel	**$ 284,655**[18]	**$396,030**[19]	**$680,685**
Fringe Benefits	**7 1,164**	**99,007**	**$170,171**
Total Personnel	**$ 355,819**	**$495,037**	**$850,856**
Contractual Costs			
Nurse Triage Services	**$ 292,500**	**$172,800**	**$465,300**
CHCs Start-up Costs	**$ 250,000**	**$180,000**	**$430,000**
Project Evaluation	**$ 20,000**	**$ 80,000**	**$100,000**
Total Contractual Costs	**$ 562,500**	**$432,800**	**$995,300**
Supply Costs			
	$ 10,000	**$ 10,250**[20]	**$ 20,250**
Equipment Costs			
Case Management Software	**$ 15,000**	**$ 15,375**[21]	**$ 30,375**
Telephones	**$ 7,000**	**$ 7,175**[22]	**$ 14,175**
Computers	**$ 11,150**	**$ 3,000**	**$ 14,150**
Total Equipment Costs	**$ 33,150**	**$ 25,550**	**$ 58,700**
Other Costs			
Travel & Conferences	**$ 19,000**	**$ 19,475**[23]	**$ 38,475**
TOTAL	**$ 980,469**	**$983,112**	**$1,963,581**

[18] Case Manager 4 FTEs, Case Manager Paraprofessional 3 FTEs, Registered Nurse 1 FTE, Project Manager 1 FTE, & Washington Medicaid Contract Manager .5 FTE
[19] Case Managers 6 FTEs, Case Manager Paraprofessional 4 FTEs, Registered Nurse 2 FTEs, Project Manager 1 FTE,& Washington Medicaid Contract Manager .5 FTE
[20] 2.5% increase
[21] 2.5% increase
[22] 2.5% increase
[23] 2.5% increase

Budget Description

Personnel: Case Managers will be linked with the 24 hour nurse-triage line. Case Manager Paraprofessionals will make the initial contact with ED users. Registered nurse case managers will work with repeat ED users or those with chronic diseases, the Project manager will run the over-all program, while the Washington Medicaid Contract Manager will manage the contract(s).

Fringe Benefits: Fringe benefits will be at 25% of salary and include monthly health insurance.

Contractual Costs: Nurse Triage Services, Start-up costs for CHCs to enhance access to medical home, initiate behavioral health services, co-locate CHC and ED services, and/or expand evening/weekend primary care hours.

Supplies: General office supplies for Medicaid personnel working with the project.

Equipment: Equipment includes computers, telephones, fax machines, case management software, printers, etc.

Travel: Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

Request for Preference: Washington's Medicaid agency, the Health and Recovery Services Administration (HRSA), requests preference based on serving rural or underserved areas where Medicaid beneficiaries may not have regular access to primary care services. HRSA will issue a Request for Proposal (RFP) to select collaborations between community health centers (CHCs) and community hospitals to establish the CHC as an alternative emergency service provider. A condition of the RFP will be that the collaborating partnership be located within a Health Professional Shortage Area (HPSA)[24].

HRSA has worked with the Washington State Hospital Association (WSHA) and the Washington Association of Community and Migrant Health Centers (WACMHC) to establish collaborations between CHCs and Hospitals to reduce ED utilization for non-emergent care. The Board of WACMHC recently made the reduction of non-emergent ED utilization a strategic objective of the organization. WACMHC and WSHA have received letters of intent to develop CHC/Hospital collaborations to reduce ED use from the following organizations:

Collaborating Organizations	**Project**
Community Health Center of King County Auburn Regional Hospital	Expand CHC clinic hours to evenings and weekends and care coordination between Hospital and CHC to establish a medical home for Medicaid ED users.
Valley View Health Center Providence Centralia Hospital	Care coordination between Hospital and CHC to establish a medical home for Medicaid ED users.
Community Health Care St. Claire Hospital	Co-location of CHC services with ED to divert non-emergent ED visits to an effective medical home and care coordination between hospital ED and CHC.
Yakima Neighborhood Health Center Yakima Valley Farmworkers Clinic Community Health of Central Washington Sunnyside Community Hospital Yakima Valley Memorial Hospital	Care coordination for children utilizing ED services to connect them with an effective medical home.
Interfaith Community Health Center St. Joseph's Hospital	Care coordination between people utilizing ED services to connect them with an effective medial home. Expansion of hours to include evenings/weekends
La Clinica Lourdes Hospital	Co-location of CHC services with ED to divert non-emergent ED visits to the CHC and improve and care coordination between hospital ED and CHC.

HRSA received letters of support from the WSHA and WACMHC for the Community Collaboration for Appropriate Emergency Department Care Project.

[24] For more information about Health professional Shortage designations and scores for each state, go to: http://hpsafind.hrsa.gov/HPSASearch.aspx.