California HealthCare Foundation

North Vallejo Patient Access Partnership:
"Right Care, Right Place" Project Evaluation

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by
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I. Project Background and Strategic Context

Reducing Avoidable Emergency Visits, Improving Patient Health Care Access

Guiding patients to more appropriate, better coordinated, and less costly care settings than emergency departments (ED) is a growing health care imperative. Hospitals in California provide more than 10 million ED visits annually, offering guaranteed access without regard to a patient's ability to pay. In California and nationwide, many hospitals are hard pressed to accommodate rising ED demand, whether due to changing demographics, challenging local economics, or other factors.[1]

One aspect of the problem is use of the ED for non-urgent or ambulatory sensitive conditions (ASC) such as asthma, hypertension, and diabetes, for which good outpatient care reduces the likelihood of hospitalization or ED use, and for which early intervention can prevent complications and more severe disease.[2] Use of the ED for ASC has been associated with patients' limited access, financial or otherwise, to primary care providers.[3] Thus, increasing primary care resources can be an important strategy for reducing rates of avoidable ED use and for taking pressure off of strained community EDs. Moreover, patients who have a regular, coordinated source of primary care are more likely to receive appropriate preventive services such as screenings and immunizations, and to have their chronic health conditions managed. Research also suggests that racial disparities are reduced when patients receive care from a well-functioning primary care "medical home."[4]

In addition to lacking primary care resources or a medical home, patients seek non-urgent medical care in the ED for various other reasons, among which are: lack of insurance; patient convenience; lack of primary provider appointments; care-seeking after regular physician business hours; and lack of understanding about what constitutes an urgent medical condition.[5]

Estimates vary widely, but studies suggest that an average of 35 to 40 percent of all ED visits can be appropriately managed in non-ED settings.[6] Notably, a National Association of Community Health Centers (NACHC) report determined that at least one-third of all ED visits are avoidable — meaning non-urgent or ASCs — and therefore treatable in a primary care environment.[7] Using an avoidable visit ED rate of 35 percent, the NACHC study estimated that the U.S. health care system wastes more than $18 billion annually serving patients in the ED who could have been appropriately and more cost-effectively cared for in a non-ED setting. For California, this figure was at least $1.8 billion. Appropriate ED use is thus not only a patient access issue but a major cost one as well.

To reduce avoidable ED visits, many hospitals have implemented fast-track programs and other strategies to triage and treat non-urgent patients more efficiently.[8] But preventing an ED visit or directing patients with non-urgent conditions away from the ED is a complex matter, one aspect of which is the federal Emergency Medical Treatment and Active Labor Act (EMTALA), a law that requires a medical screening exam of all patients who present to the ED for care, to determine whether an emergency medical condition exists.[9] These EMTALA requirements remain in place even though studies have shown that triaging patients out of the ED using a less extensive medical assessment to guide

them to alternate care settings can be accomplished safely, without significant patient risk.[10]

Providing health care in the most appropriate, cost-effective setting takes on added importance with implementation of the new health reform law. Insured patients use the ED at a higher rate than the uninsured do,[11] and the Patient Protection and Affordable Care Act is expected to significantly expand health insurance coverage in California, including adding up to 3.5 million more Medi-Cal enrollees by 2019, for a total of 10.5 million.[12] Ensuring adequate emergency care for this changing population, as well as providing community primary and urgent care capacity, will be essential to community health delivery systems. Indeed, funding to support the growth of community health centers (CHC) is a centerpiece of health reform, with more than $11 billion earmarked for CHCs over five years, starting in 2011.

Clearly there is a need for creative, collaborative solutions, but individual health care stakeholders—including CHCs, hospitals, physicians, health plans, and local governments—acting independently cannot meet the challenge of avoidable ED use and appropriate care access. Committed, coordinated action at the community level is required, and hospital–federally qualified health center (FQHC) partnerships are one of several strategies receiving attention.[13] The North Vallejo Patient Access Partnership "Right Care, Right Place" project was designed to offer a community-based model to address this nationwide challenge.

Community Context: Vallejo, Solano County, CA

Solano County (population 425,000) is situated midway between San Francisco and Sacramento in Northern California. More than 16 percent (about 70,000) of its ethnically diverse county residents are Medi-Cal recipients, and many residents face significant challenges accessing health care services.[14] Unemployment was 12 percent in 2010, and the county's uninsured rose nearly 53 percent—to 20.3 percent—between 2007 and 2009.[15] County residents experience among the highest statewide rates of asthma, diabetes, stroke, cancer, and obesity, as well as racial and ethnic health disparities.[16] Within the county, the city of Vallejo (population 121,000) has limited primary care options and the county's highest poverty rate (10 percent).[17]

The county is served by four hospitals, each with a basic ED, two of which are in Vallejo, but there is no county hospital. Kaiser Permanente Vallejo Medical Center and Sutter Solano Medical Center (SSMC) serve the Vallejo community. ED visits are

Figure 1. Solano County, California

Source: Solono County Maps 2.0, gis.solanocounty.com/solanomaps.

increasing and a recent county report noted that almost 80 percent were classified as non-urgent visits or urgent with moderate severity.[18] Similarly, Solano County enrollees in Partnership HealthPlan of California (PHC), a Medi-Cal managed care plan, reportedly use the ED at two to three times the rate of PHC's enrollees in neighboring counties.[19]

Issues of primary care access and affordability are not new to Solano County. In 1998, the nonprofit Solano Coalition for Better Health (SCBH) emerged in response to the threatened closure of a clinic for medically underserved residents. SCBH, in which the county's health care, business, and educational communities, and local government are represented, actively supports projects and services that address community need. As a community convener, SCBH was instrumental in making the North Vallejo Patient Access Partnership "Right Care, Right Place" project a reality.

II. Project Overview

In the absence of a county hospital, SSMC has long served as the de facto county facility for residents of the greater Vallejo area. Over time, its ED volume growth created a critical need for SSMC to identify strategies to improve community access to more appropriate levels of care. An existing, successful relationship with La Clínica de La Raza, a not-for-profit CHC organization with 25 health center sites in the San Francisco Bay Area, made it a logical partner for developing a new CHC for northern Vallejo, where SSMC is located.

Community, government, and health care leaders then coalesced to create a partnership in support of the venture. Working through SBCH, $1.2 million in funding was obtained to underwrite site improvements and projected operational losses in the FQHC's first three years.[20] It was envisioned that the health center would achieve financial viability and sustainability thereafter.

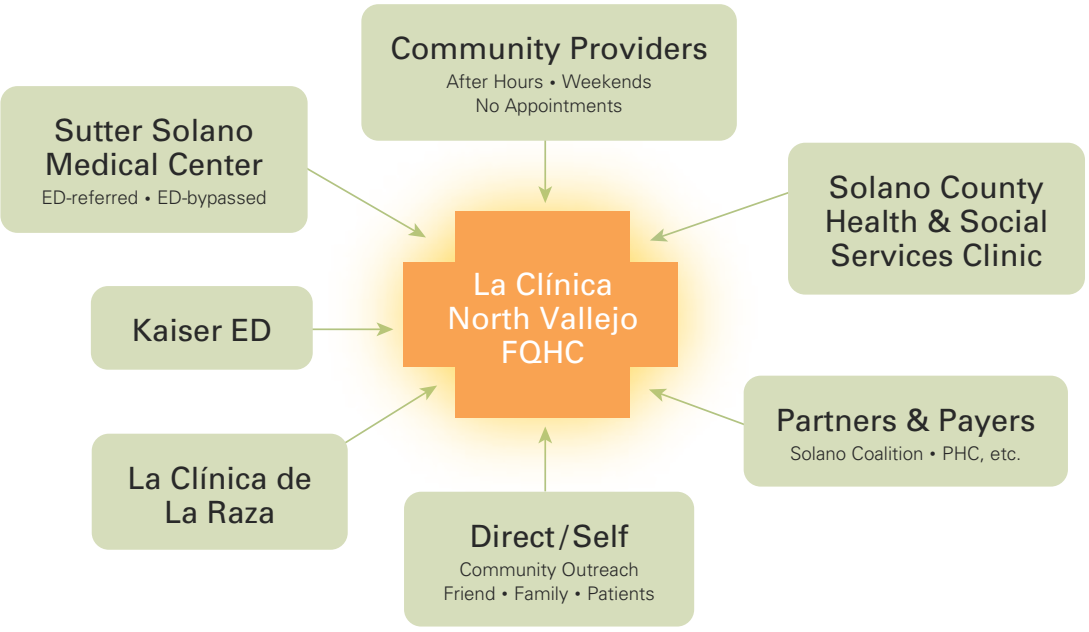
The goal was to create a comprehensive primary and urgent care resource that would connect patients to a medical home and support the local health care safety net by helping reduce avoidable ED visits. The level of cooperation and engagement among stakeholders who are often poorly connected—particularly hospital EDs and community clinics—provided the foundation on which to build the "Right Care, Right Place" project, and proved essential to its success.

A pivotal element of the project was coordination of ED-related patient referrals between SSMC and the new FQHC—La Clínica North Vallejo (LCNV)—to be located on the hospital's campus. Initially, ED patients were to be nurse triaged and, when appropriate, referred to LCNV without being treated in the ED. As the project unfolded, however, the triage model was abandoned, in part to address potential EMTALA compliance concerns, but also to implement other ED operational improvements. The project evolved to focus instead on ED-to-FQHC referral following an ED visit, and on patients coming directly to LCNV from the hospital, based on information about LCNV obtained there, without actually having been treated in the ED.

Although the focus of the project was on ED-to-FQHC referral, the health center was also expected to be both a primary and an urgent or after-hours care resource for the entire community and thereby help reduce avoidable ED use on a broader scale. Figure 2 (page 6) shows the project referral model.

An evaluation of the project was commissioned by the California HealthCare Foundation. Supplemental support was provided by the Safety Net and Community Benefits Program of Kaiser Permanente Northern California. The evaluation was conducted by the University of Southern California Center for Health Financing, Policy and Management. This report presents a summary of the project's context, approach, and implementation, and of the evaluation's findings. More comprehensive information regarding evaluation methodology, project implementation, and findings, as well as supplemental data, may be found in the full evaluation report at www.chcf.org.

Figure 2. "Right Care, Right Place" Project Referral Model



Source: USC Center for Health Financing, Policy and Management.

III. Project Approach

In launching LCNV, project stakeholders sought to address broad community-wide issues of health care access and delivery. In that context, an evaluation scoping was conducted, which resulted in the framing of seven research questions reflected in the Findings section of this evaluation report:

1. How effective was the project in helping community members gain access to appropriate and affordable health care?
2. Was it successful in redirecting ED patients from SSMC to the clinic?
3. Did the intervention show a measurable impact on overall ED utilization at SSMC?
4. Did the project positively impact the financial performance of the SSMC ED?
5. Did the project reduce the cost of care for avoidable ED visits?
6. Is the health center model financially viable and sustainable?
7. To what degree is development and implementation of the project transferable to other communities?

Evaluation Methodology

As the evaluation got underway, the North Vallejo Patient Access Partnership Advisory Group was convened to gain high-level stakeholder input, and met periodically thereafter. In addition, a Data Work Group provided both broad technical and organizational-level data support.

Evaluators needed a consistent definition of non-urgent or avoidable emergency room (AER) visits in order to make inter-organizational comparisons, and chose the California Department of Health Care Services Statewide ER Collaborative 170 ICD9-code definition of "potentially avoidable" ED visits for use in comparative evaluation measures. Quantitative and qualitative data collection took place over a 20-month study period (November 2008 through June 2010). Wherever possible, the evaluation sought to use existing organizational data systems, although primary data collection was also conducted. As the study progressed, evaluation parameters were modified to address the project's evolution. Unless otherwise noted, SSMC data presented in this report were provided by SSMC or by Sutter Health System; LCNV data were provided by La Clínica de La Raza or collected on-site at LCNV.

IV. Project Development and Implementation

La Clínica North Vallejo: A New Community Health Resource

FQHC Start-Up and Initial Operations

LCNV commenced operations in November 2008 on an intermittent, 20-hour per week basis, open mostly during times when primary care physicians' offices were likely to be closed, thus providing an alternative to the SSMC ED for urgent and after-hours care. Over time, hours were extended to 12-hour weekdays and Saturday half-days. In addition to providing routine primary and urgent care, LCNV established a flu clinic and a gynecology specialty clinic.

The health center's physical location in a hospital-owned office building on the SSMC campus provided important proximity to the hospital. The renovated space and new equipment offered eight treatment rooms, including a special procedure room. In addition to primary care providers, early recruitment of an experienced emergency medicine physician allowed LCNV to offer specific urgent care capabilities from the beginning. Cross-training served to broaden other providers' expertise in this area.

As capacity grew, LCNV further expanded its services to include a diabetes disease management program, plus a 340b prescription discount program in collaboration with a local pharmacy. Out-referrals to community provider specialists, to La Clínica's nearby dental clinic, and to LCNV's sister FQHC facility in southern Vallejo enhanced service access and patient care coordination. LCNV also implemented an extensive marketing and outreach program in the community and with SSMC; in particular, LCNV kept informational materials stocked in the SSMC ED.

Projecting Health Center Growth

LCNV's visit capacity was projected at approximately 5,400 in year one, 11,000 visits in year two, and 15,000 visits in year three. A year-one operating loss of $314,000 was budgeted, with an expected payer mix of 45 percent Medi-Cal, 39 percent self-pay, 11 percent private insurance, and 5 percent Medicare. Patients without coverage, and their families, received screening for government programs eligibility; a sliding-scale fee structure for self-pay patients was established, based on family size and financial status.

Medi-Cal managed care comprised a significant portion of the payer mix projections; LCNV began to accept PHC Medi-Cal enrollee assignments in May 2009. A special urgent care flat-rate payment was established for PHC enrollees who were not assigned to LCNV but who used the health center when their assigned physicians were not available. These patients were referred back to their physicians for follow-up care. Although not part of the original budget plan, a County Medical Services Program (CMSP) contract was also negotiated with Solano County to provide limited funding for low-income, indigent patients.

Collaboration with Sutter Solano Medical Center

SSMC championed the "Right Care, Right Place" project, and Valley Emergency Physicians (VEP), who joined SSMC as its ED medical group in late 2007, actively supported the new FQHC. As SSMC's ED strained to accommodate rising demand, it established an ED fast-track program staffed by VEP physician assistants who provided EMTALA-required medical screening exams, and treated and discharged patients. Due to high demand, however, patients often still had to wait before a provider became available. The opening of LCNV in late 2008 was thus eagerly anticipated.

Once LCNV opened, its management routinely participated in SSMC's monthly ED Collaborative meetings to promote hospital-FQHC information exchange and coordination. A high level of interaction among providers included auto-faxed ED discharge information sent to LCNV and inter-provider online appointment scheduling. Open communication, e.g., regarding specific patient referrals, ensured dialogue and mutual problem-solving, which was a hallmark of the "Right Care, Right Place" project.

V. Findings

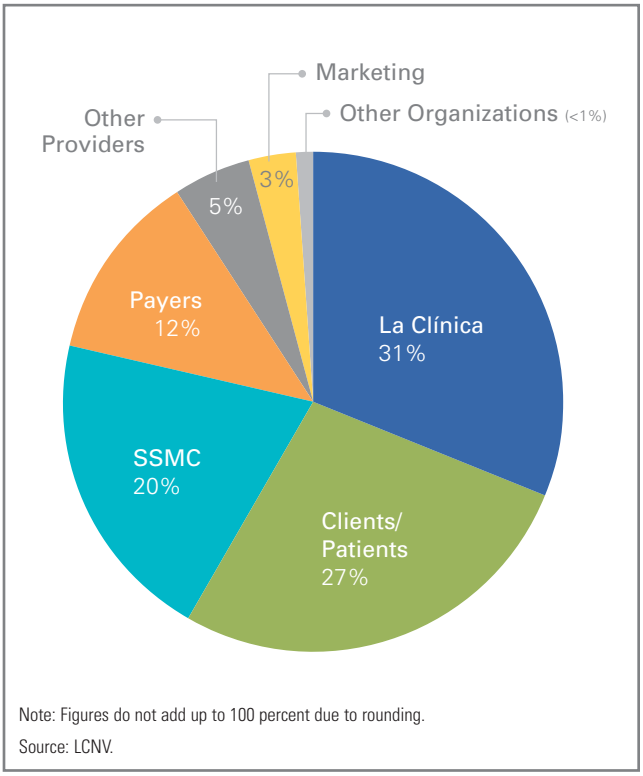
The North Vallejo Patient Access Partnership Advisory Group and individual project stakeholders worked closely with the evaluation team and reviewed project progress, interim quantitative results, and final evaluation findings. Findings are organized to address each of the seven evaluation research questions.

1. **The "Right Care, Right Place" project was highly successful in helping community members gain access to appropriate and affordable health care.**

LCNV offers convenient urgent care, including walk-in, evening, and weekend appointments. Over the 20-month study period, it served more than 4,600 patients who received 11,400 primary, urgent, and chronic care visits, 35 percent of which were identified as walk-ins. LCNV patients noted that they saw the health center as an ED alternative; 92 percent of those who completed a patient survey reported that, in the prior 12 months, they had not needed to use the ED due to a lack of same-day health center appointment availability. Significantly, 95 percent also indicated that they viewed LCNV as their primary care medical home, and nearly 500 specialty care out-referrals provided patient access to such services as mammography, radiology, orthopedics, diabetes education, cardiology, and gastroenterology. Of both new and returning patients, 14 percent said they would not have seen a doctor at all if not for the presence of LCNV in the community.

Referrals to LCNV were wide-ranging. La Clínica sources represented almost one-third of referred visits; SSMC direct or indirect referrals comprised 20 percent. Referrals from family, friends, and clients, plus walk-ins or self-referred patients, grew over time, as did payer referrals. Medical providers and community organizations remained consistent referral sources. (See Figure 3.)

Figure 3. LCNV Patient Visit Referrals by Source, Q1 2008 to Q2 2010



Note: Figures do not add up to 100 percent due to rounding.

Source: LCNV.

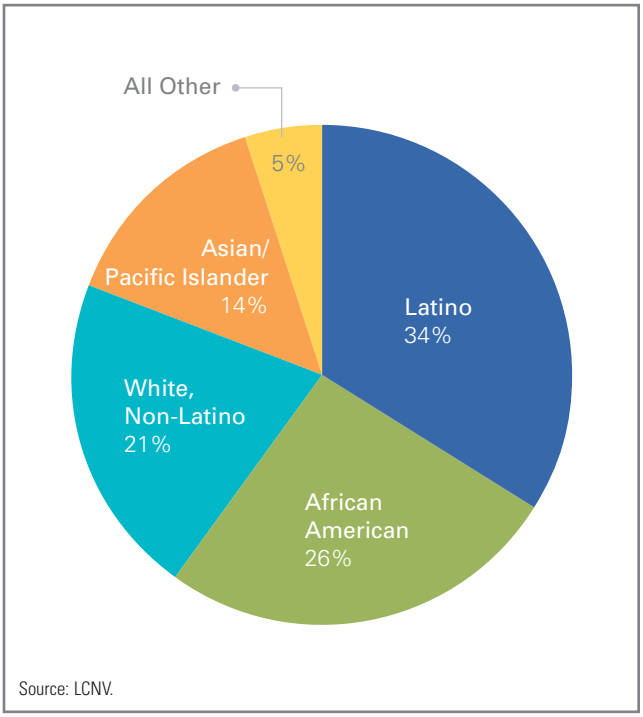
The breadth of LCNV's capabilities and its success in serving the health needs of the community were evident in the health center's top 20 patient diagnoses (57 percent of total visits). Seven of the top diagnoses (15 percent of visits) were AERs,

suggesting that patients who might otherwise have ended up in the SSMC ED were instead treated in the health center. Infant and child health exams was the LCNV top diagnosis. LCNV's primary care focus was also seen in high volume visits for general medical exams and routine women's health services. Other top diagnoses included acute upper respiratory infection (URI), cellulitis and abscess, pharyngitis, and lumbago (back pain). Among LCNV's top ten diagnoses, and of significance due to Solano County's high rates of asthma, diabetes, obesity, and stroke, were several ambulatory sensitive chronic health conditions: hypertension, diabetes, and asthma. Together, these totaled nearly 14 percent of all visits and trended upward, with quarterly trends showing rising patient visits related to obesity and overweight. Also, as county mental health service cutbacks took place, LCNV's behavioral health and health education services began serving higher volumes of patients with diagnoses of anxiety and depression.

Demographically, compared with the Vallejo community, patients served by the health center were more likely to be traditionally underrepresented Latinos or African Americans, and to be children. (See Figures 4 and 5.) About 85 percent of patients reported incomes below the federal poverty level.

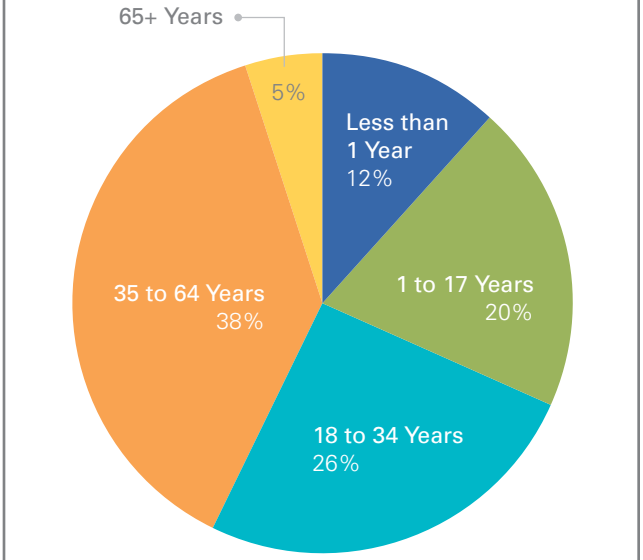
LCNV proved itself to be a valued local point of health care access, drawing predominantly from the city of Vallejo. Residents of the three Vallejo ZIP codes comprised 87 percent of the health center's patient volume. Given limited public transportation in two of those areas, LCNV's location on a bus line was particularly important. Another 8 percent of patients came from three adjacent cities; 5 percent lived in other communities.

Figure 4. LCNV Patient Profile by Race/Ethnicity, November 2008 to June 2010



Source: LCNV.

Figure 5. LCNV Patient Profile by Age Group, November 2008 to June 2010



Note: Figures do not add up to 100 percent due to rounding.

Source: LCNV.

2. The project was successful in redirecting ED patients to the FQHC.

On average, 52 patients per month were guided from SSMC to LCNV — either through formal ED referral following treatment (ED-referred or ED follow-up) or by going to the FQHC from the hospital without an actual ED visit (ED-bypassed). The combined total of these two categories of patients — jointly termed "SSMC-referred" — was 1,040 over the study period.

During project start-up, there were more SSMC-referred patients than there were once the center matured; over time these numbers decreased in part because established patients had now made LCNV their medical home and thus were no longer using the ED for primary care. In addition, the health center's first-come, first-served urgent care, as well as its evening and Saturday hours, visit capacity began to fill quickly, reducing the opportunity and convenience for patients to come to the health center from the hospital without a scheduled appointment.

The SSMC-referred patient population differed markedly from the health center's overall patient profile in ethnicity, age, and payer mix. For example, as a group, SSMC-referred patients were more likely than LCNV patients overall to be African American (33 vs. 26 percent) or white (26 vs. 21 percent). They also had less stable health coverage than the overall LCNV patient population and were more likely to be self-pay (25 percent SSMC-referred vs. 20 percent overall) or covered by CMSP (16 percent vs. nearly 10 percent).

SSMC-referred patients were equally split between ED-referred for follow-up and ED-bypassed, though the two patient subgroups were different demographically and diagnostically. For example, ED-bypassed patients were far more likely to be white, infants, and to have better health insurance coverage than those referred for ED follow-up care; the relatively high number of infants suggests that parents saw LCNV as an ED alternative for their young children.

On the other hand, ED-referred patients coming to LCNV for follow-up care tended to be adults and African American. Payer mix suggests that these patients may have had difficulty accessing routine primary care for financial reasons. More than half (56 percent) of ED-referred patients had been treated in the ED for non-urgent conditions. However, 41 percent were classified as urgent care, so their visits would not have contributed to a reduction of AERs for the ED. Top ED-referred diagnoses included lumbago and acute URI, with many secondary diagnoses of ASCs that would be more appropriately treated in a health center setting than in the ED.

3. There was evidence of modest to moderate impact on ED visits.

Over the 20-month evaluation period, the equivalent of 205 ED visits monthly (nearly 8 percent of its ED volume) were averted at SSMC due to the availability of LCNV. An additional 25 ED visits per month to Kaiser Permanente Vallejo Medical Center were also averted. In total, patient access to LCNV averted 4,600 ED visits in the Vallejo area. And despite growing overall ED volume, SSMC's proportion of non-urgent ED visits decreased 4 percent during the study period.

SSMC's annual AER rate prior to LCNV was 18 percent, but saw an H1N1- and recession-related increase in 2009 before returning to 18 percent in the first half of 2010. While the annual AER percentage rate did not decline over the study period, the last quarter had the lowest posted rate (15 percent), which suggests an opportunity for future AER reduction. In addition, seven of SSMC's top AER diagnoses decreased, and were correlated with top

AER diagnoses treated at LCNV. Notably, too, a 41 percent reduction in ED follow-up visits provided in the ED setting was strong evidence of the effect of referring to the health center for post-ED and continuing care.

4. Though not greatly improving overall ED financial performance, the project had a positive economic impact on the hospital, in addition to increasing community health care access.

Most ED visits that shifted to the health center financially benefited the hospital. The patient volumes seen in SSMC's ED were large relative to LCNV's modest capacity, however, and thus limited the new health center's ability to improve the ED's bottom line.

SSMC ED per-visit cost data were not available for this study, but average payment data provided clear evidence of the financial impact on the hospital. (Average payment represents the average amount paid for all applicable outpatient ED visits diagnoses, including insurance payment and co-pays less bad debt.) In particular, visits classified as AERs did not pay SSMC as well as outpatient ED visits overall, and average payment for AERs, as well as for other outpatient ED visits, deteriorated in 2009 (post-LCNV) compared with 2008 (pre-LCNV). (See Table 1.) So, to the extent that AER patients were shifted from the ED and seen instead at LCNV, these lower-paying visits were removed from the ED's payment mix.

Table 1. All Outpatient ED Visits vs. SSMC AER Visits, Average Payment, 2008 and 2009

YEAR	ALL OP ED	SSMC AER
2008	$483	$281
2009	$453	$233

Source: SSMC.

Further, the visits of patients using the health center for post-ED follow-up care paid well below even the AER average. Thus, shifting a proportion of these patients to LCNV likewise improved the ED's payment mix.

Payment variation was also evident by payer category. (See Table 2.) More than 44 percent of all SSMC-referred patients seen at LCNV had low-paying or no insurance coverage. Taken together with lower-paying AER and ED-referred for follow-up patients, these patients being seen at LCNV reduced a financial negative for the hospital, in addition to the fact that at the same time they were offered an opportunity to establish a regular, more appropriate source of care.

Table 2. SSMC All Outpatient ED Visits by Payer, Average Payment, Percentages of ED Visits and Total Revenue, 2009

PAYER	AVERAGE PAYMENT	% ED VISITS	% TOTAL REVENUE
Self-pay	$26	16.6%	0.9%
County	129	8.6%	2.5%
Medi-Cal	141	39.5%	12.3%
Medicare	386	15.6%	13.3%
Commercial	1,761	17.6%	68.5%
Other Insurance	552	2.0%	2.5%
Total	**$453**	**99.9%***	**100.0%**

*Due to rounding.

Source: SSMC.

5. Care received in the FQHC setting cost patients and health plans significantly less than an ED visit.

Guiding patients to an appropriate level of care at LCNV produced significant savings for patients, health plans, and overall health care costs. Payments made by patients or health plans for LCNV visits (average $58 to $84) were three to four times lower than those made for SSMC ED AER visits (average $233) and five to eight times lower than those made for all outpatient SSMC ED visits (average $453).[21] These ratios are in line with a 2003 Agency for Healthcare Research and Quality study that showed a five times higher expenditure rate for hospital ED versus physician office-based visits.[22]

6. The health center model has the potential to be financially viable and sustainable over the long term.

Key stakeholder funding of more than $1.2 million was instrumental to the establishment of LCNV and the early success of the "Right Care, Right Place" project, especially in light of an ailing economy. At the end of the 20-month evaluation period, LCNV posted a negative variance of approximately $82,000, with fewer than budgeted patient visits offset by grant revenue from one-time federal stimulus funds. This shortfall excludes an expected 2013 retroactive FQHC Medi-Cal rate adjustment and a contract settlement with the county, both of which will improve LCNV's financial performance.

LCNV's payer mix turned out to be more diverse and better than expected. Medi-Cal comprised 53 percent of volume, while self-pay, forecasted at 39 percent, made up a significantly smaller 20 percent. In part this was because original projections did not take into account a CMSP contract. Private insurance, at 6 percent, was about half of what had been projected, likely affected by patients' loss of employer coverage in the economic recession.

Overall, the health center appears positioned to become financially sustainable. However, long-term sustainability must address the end of start-up funds and will depend on volume growth and patient retention, productivity improvement, provider and staff recruitment and retention, a Medi-Cal mix of at least 50 percent, and continuing subsidies for uninsured clients. Successful grant development and cash flow management, particularly until LCNV receives a retroactive FQHC rate adjustment in 2013, are also critical.

7. Development and implementation of the project model had distinctive aspects, but also offered experiences and insights transferrable to other communities.

Out of the project stakeholders' successful navigation of myriad issues involved in the implementation and operation of LCNV, six critical success factors emerged: (1) the project was supported by an extensive stakeholder history of collaboration in solving community health care problems; (2) the model reflected and engaged the community; (3) there was significant financial support via pooled start-up funding of more than $1.2 million and key health plan contracts; (4) the FQHC was strategically located near the hospital; (5) La Clínica de La Raza, which operates LCNV, had extensive experience in FQHC operations; and (6) the stakeholders developed among themselves a pervasive culture of communication.

Through the project, stakeholders also garnered practical experience that can potentially benefit others considering implementation of a similar

model. The North Vallejo Patient Access Partnership project experience is noteworthy in several ways:

- **Collaboration.** The project established a collaborative model whereby hospitals, CHCs, health plans, and county government work together to improve community health care access by supporting an FQHC in its formative years, thereby increasing its chances for sustainability.
- **Connectivity.** The project fostered a relatively novel and high level of connectivity and engagement between a not-for-profit hospital and a CHC to address challenges of patient health care access and utilization.
- **Comprehensive patient care capacity.** While initially focusing on reducing avoidable hospital ED visits, the project built a comprehensive primary and urgent care capacity for all types of patients, not limited to frequent users of the ED, the uninsured, or any other specific patient population group.
- **Medical home**. The project was designed to guide patients away from the ED by offering a care alternative to those with AER health problems. Moreover, LCNV offers these patients, as well as other members of the community, the potential to establish a medical home. Stakeholders envision that the coordinated medical home approach will make a contribution to reducing community health disparities.
- **Awareness of options.** Stakeholders saw the project as an opportunity to work together to increase community and health care provider awareness, both of the new health center and of appropriate use of vital ED resources.

VI. Conclusion

The North Vallejo Patient Access Partnership's "Right Care, Right Place" project produced a new approach to providing a comprehensive primary and urgent care alternative to the hospital ED. In particular, close physical proximity and strong collaboration between the hospital ED and the FQHC facilitated care coordination that extended beyond ED referral and follow-up. The project not only built an effective bridge between a CHC and a not-for-profit hospital to address avoidable ED use and primary care access, but also created a unique and broadly-defined medical home model embraced by the community.

By joining to provide financial resources for start-up and initial operation, stakeholders in the North Vallejo Patient Access Partnership enabled the FQHC to launch and grow more rapidly than it otherwise could have. Also, as the model evolved, project participants were able to adapt rapidly, a necessary capability in today's dynamic health care environment.

Although the final ED referral aspect of the model lessened the potential for significant reductions in avoidable ED use, the project is nonetheless accomplishing its goals. The FQHC has engaged the community at all levels to guide patients to a more appropriate, less costly option for comprehensive ambulatory care. As the intervention matures, new opportunities for collaboration continue to emerge.

Some aspects of the model are distinctive, shaped by community needs and honed by local experience. However, much about the model is generalizable to others seeking creative avenues for increasing appropriate and affordable care options. As the health care industry prepares for the impact of health reform, the "Right Care, Right Place" project has demonstrated that hospitals and FQHCs are well positioned to collaborate in offering innovative solutions.

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facility, without regard to the patient's ability to pay. The cost of providing emergency care required by EMTALA is not directly covered by the federal government. EMTALA is aimed at the treating hospital and physician, but a physician assistant acting as an agent of the physician and/or hospital also falls under EMTALA governance. Both hospitals and physicians face potential sanctions for violating EMTALA regulations.

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21. The standard billed charge per LCNV visit averaged $116 for new patients and $84 for established patients. These averages take into account varying levels of visit complexity and actual mix. LCNV also provides services on a sliding-scale fee structure based on a patient's ability to pay. Including both sliding-scale fees and insurance payer mix, patients and payers on average paid $58 per visit. When calculated to include an anticipated retroactive Medi-Cal rate adjustment in 2013, LCNV's average payment per visit was $84.
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