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The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Bernard Sanders
Chairman
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor, and Pensions
United States Senate

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

Hospital emergency departments are a major component of the nation's health care safety net as they are open 24 hours a day, 7 days a week, and generally are required to medically screen all people regardless of ability to pay.[1] From 1997 through 2007, U.S. emergency department per capita use increased 11 percent.[2] In 2007, there were approximately 117 million visits to emergency departments; of these visits, approximately 8 percent were classified as nonurgent. The use of emergency departments, including use for nonurgent conditions, may increase as more people obtain health insurance coverage as the provisions of the Patient Protection and Affordable Care Act (PPACA) are implemented.[3]

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

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

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

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

Health centers may serve as a less costly alternative to emergency departments, particularly for individuals with nonurgent conditions. Like emergency departments, the nationwide network of health centers is an important component of the health care safety net for vulnerable populations, including those who may have difficulty obtaining access to health care because of financial limitations or other factors. Health centers, which are funded in part through grants from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services, as well as referrals to specialty care—without regard to a patient's ability to pay. They also provide enabling services, such as case management and transportation, which help patients access care. In 2009, more than 1,100 health center grantees operated more than 7,900 delivery sites and served nearly 19 million people. With increased funding from PPACA—projected to be $11 billion over 5 years for the operation, expansion, and construction of health centers[6]—health center capacity is expected to significantly expand, with the National Association of Community Health Centers estimating that health centers could more than double their capacity to 40 million patients by 2015.[7]

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

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

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

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

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

describe strategies that health centers have implemented that may help reduce the use of hospital emergency departments.

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

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

Results in Brief

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

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

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

the effectiveness of these strategies, but some officials provided anecdotal reports that the strategies have reduced emergency department use. Health center officials described several challenges in implementing strategies that may help reduce emergency department use, such as the difficulty in changing the behaviors of patients who frequent the emergency department. HHS provided a technical comment on a draft of this report, which we incorporated.

Background

Emergency department visits are often made at night and on weekends by patients with varying sources of payment and levels of severity. Not all emergency department visits may be necessary; some visits may be handled in less costly settings or even avoided altogether through better management of chronic conditions. Lack of awareness of other sources of care, lack of access to primary care and other providers, and financial barriers can contribute to emergency department use, including use for nonurgent conditions. Health centers, which are required to serve patients regardless of ability to pay, are an important safety net provider for financially or otherwise vulnerable populations.

Emergency Department Use

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

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

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

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

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

Table 1: Emergency Department Visits by Source of Payment, 2007

Source of payment	Number of visits (in thousands)	Percentage of visits
Private insurance	45,580	39
Medicaid[a]	29,379	25
Medicare	20,133	17
No insurance[b]	17,926	15
Unknown[c]	10,484	9
Other[d]	4,587	4

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

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

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

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

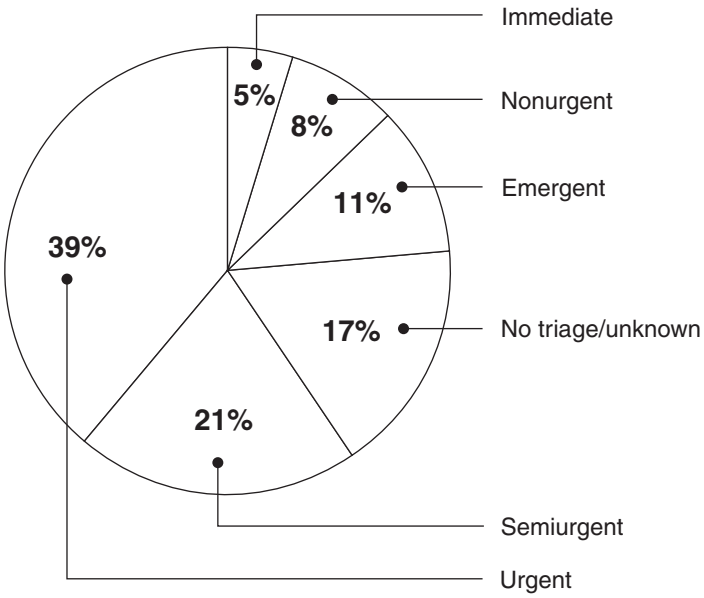
[c]Unknown includes visits where the payment source was either unknown or blank.

[d]Other includes visits where the payment source was workers' compensation or other.

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

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

Figure 1: Percentage of Emergency Department Visits by Acuity Levels, 2007



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

Notes: The National Center for Health Statistics developed time-based acuity levels based on a five-level emergency severity index recommended by the Emergency Nurses Association. The acuity levels describe the recommended time frame for being seen by a physician. The recommended time frames to be seen by a physician are less than 1 minute for immediate patients, between 1 and 14 minutes for emergent patients, between 15 minutes and 1 hour for urgent patients, greater than 1 hour to 2 hours for semiurgent patients, and greater than 2 hours to 24 hours for nonurgent patients. Because of rounding, percentages do not add to 100.

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

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

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

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

emergency departments generally provide medical screenings to patients regardless of their ability to pay.

HRSA's Health Center Program

To increase access to primary care services for the medically underserved, HRSA provides grants to health centers nationwide under Section 330 of the Public Health Service Act.[16] Health centers participating in HRSA's Health Center Program are private, nonprofit community-based organizations or, less commonly, public organizations such as public health department clinics. Health centers are required to have a governing board, the majority of which must be patients of the health center.[17]

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

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

[16]42 U.S.C. § 254b.

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

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

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

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

Health Centers Have Implemented Three Types of Strategies That May Help Reduce Emergency Department Use

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

- **Emergency Department Diversion**. Health centers' emergency department diversion strategies are intended to encourage certain emergency department patients to use a health center as an alternative to emergency department care. Such diversion strategies, which generally are implemented in collaboration with a hospital, focus on educating emergency department patients on the appropriate use of the emergency department; informing them about the services offered at the health center; and arranging appointments at, or referrals to, the participating health center. Emergency department diversion strategies may be targeted at patients whose visits are nonurgent, who lack a regular source of care, who are uninsured or who have Medicaid, or who are frequent users of the emergency department.[21] According to the health center officials we interviewed, their diversion strategies most commonly focused on preventing future visits to the emergency department, typically involving health center or hospital officials interacting with patients after those patients were seen by emergency department physicians. However, a Colorado health center's program refers emergency department patients triaged with less acute conditions to walk-in appointments for treatment at the health center's site, located less than a mile from the hospital. (See table 2 for other examples of emergency department diversion strategies implemented by selected health centers.) According to health center officials, for an emergency department diversion strategy to be successful, there must be good communication between the health center and the hospital and buy-in from the hospital's administration and emergency department staff. Such buy-in is essential because, according to experts and health center officials we interviewed, hospitals and emergency department physicians may face financial disincentives to divert patients.[22]

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

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

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

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

Health center (state)	Description of emergency department diversion strategy
Baltimore Medical System (MD)	The health center works with a local hospital to link eligible patients—specifically, Medicaid and uninsured patients with two or more emergency department visits in the previous year—to a primary care provider at the health center. • The health center stations community health workers at the emergency department from 8 a.m. to 11 p.m. weekdays and some weekend hours. • Community health workers meet with eligible patients after triage by emergency department staff to discuss the benefits and services available at the health center. • Community health workers schedule follow-up appointments for patients who would like to receive care at the health center. • The health center uses charitable contributions from corporations to pay for the patient's first health center visit and first prescriptions. • At their first health center appointments, patients are connected to primary care providers who, in coordination with case managers, oversee the patients' future needs.
Brockton Neighborhood Health Center (MA)	The health center works with two local hospitals to develop treatment plans for health center patients identified as having 12 or more emergency department visits within a year. • Hospital staff notify the health center if an identified patient presents at the emergency department. • Health center and hospital staff work together to develop a discharge plan for the patient, including scheduling an appointment for the patient at the health center, if necessary. • During monthly meetings, health center and hospital staff discuss why targeted patients use the emergency department and how care plans can be improved to prevent future use.
LifeLong Medical Care (CA)	As a participant in a countywide initiative, the health center collaborates with other providers in the community to provide linkages to services and manage care for frequent emergency department users, defined as patients who had 10 or more visits in 12 months, or 4 or more visits in each of 2 consecutive years. • Health center case managers conduct outreach at three hospital emergency departments to identify patients in the target population and offer to connect them to a comprehensive set of health and social services. • The case managers follow up with patients after they leave the emergency department to help ensure that the patients receive needed services; the case managers provide incentives, such as food and transportation, to encourage the patients to come to the health center for medical services.

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

- **Care Coordination**. By coordinating the care of their patients, health centers may help reduce emergency department use by working to ensure that patients first seek care at health centers instead of emergency departments and by focusing on the prevention of disease-related emergencies. Care coordination may include establishing a plan of care that is managed jointly by the patient and the health care team, anticipating routine needs, and actively tracking progress toward patient care plan goals. Health center officials we spoke with described two types of care coordination strategies—the medical home model and chronic care management. The medical home model uses a care team led by a physician who provides continuous and comprehensive care to patients with the aim of maximizing health outcomes.[23] Chronic care management focuses on monitoring and managing chronic conditions, such as diabetes, asthma, and heart disease, through preventative care, screening, and patient education on healthy lifestyles. (See table 3 for examples of care coordination

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

strategies implemented by selected health centers.) Some health center officials we interviewed noted the importance of including mental health services and patient education as key components to the success of care coordination. They also noted that health centers' electronic medical records, especially when compatible with hospital systems, are helpful in coordinating care but that acquiring the technology can be expensive.

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

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

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

- **Accessible Services**. Health centers employ various strategies to make their services accessible and to raise community awareness of the services they offer, which can help position the health center as a convenient and viable alternative to the emergency department. Such strategies include expanding health center hours to include evenings and weekends; providing same-day or walk-in appointments; providing transportation to health center locations; and locating health center sites in convenient places, such as in or near hospitals, schools, and homeless shelters. Health centers also use strategies to provide care to patients outside of the health center, such as through telemedicine, home visits, and mobile clinics, and may use translators to reduce linguistic and cultural barriers to care. In addition, health centers may engage in outreach activities to increase awareness of their services. For example, a health center in Wisconsin works with individuals at local community agencies that serve the poor and uninsured, including public health workers, clergy, and social workers, to encourage them to refer individuals to the health center for services. (See table 4 for other examples of strategies health centers have implemented to increase the accessibility of their services.)

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

Health center (state)	Examples of strategies to increase accessibility of services
Access Community Health Network (IL)	The health center has several strategies to help ensure that its services are accessible and that the community is aware of the services offered. For example: • The health center has 58 sites, including sites located in schools and a few sites established on hospital campuses. • The health center's sites accept walk-in patients and most have extended hours; most sites offer Saturday hours, many sites are open until 8 p.m. a few nights per week, and 1 site is open until 10 p.m. Monday through Friday. • The health center provides phone answering service coverage through which patients can talk to physicians when necessary, even after hours when health center sites are closed. • The health center provides sign language interpretation and has bilingual and multicultural staff members, who reflect the population of the communities served. • The health center increases awareness of its services through outreach to social service agencies, participation in health fairs, and co-branding signs and other informational materials with a local hospital.
Community Health Centers (OK)	To increase access to its services, the health center • has evening hours, until 7 p.m., 3 days a week at one site and 1 day a week at a second site; • schedules appointments only 3 days in advance at one of its sites to reduce wait times for an appointment and maximize appointment times; and • provides transportation to the health center for homeless individuals by distributing bus tokens at one homeless shelter and providing van services from several other shelters.
United Neighborhood Health Services (TN)	To increase access to its services, the health center • operates 16 sites, including a site targeted to homeless patients, 5 school-based clinics, and sites near local hospitals and also operates 2 mobile clinics; • offers Saturday hours at 3 sites and evening hours (until 10 p.m.) at 1 site 5 days per week; and • accepts walk-in patients at all health center sites any day the site is open.

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

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

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

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

Agency Comments

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

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

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

Debra A. Draper
Director, Health Care

Enclosures – 2

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

Characteristics of Individual Health Centers Interviewed, 2010

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

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

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

[b]The totals may not add up to 100 percent because of rounding.

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

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

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

Enclosure II

GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

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

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