HealthierHere

Public Health
Seattle & King County

Reducing Emergency Department Utilization through Community Paramedicine and Mobile Health Resources for King County Communities

Process Evaluation of Year 1 (2020/2021)

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Background

In 2019, HealthierHere issued Requests for Applications (RFA) for "Reducing Emergency Department Utilization through Community Paramedicine and Mobile Health Resources for King County Communities" – one of the Innovation Fund areas sponsored that year. The goal was to fund programs designed to help reduce the volume of hospital emergency department visits that result from "low-acuity" 911 calls through the provision of or linkage to community support by first responders.

The Mobile Integrated Health (MIH) program, proposed by the Seattle Fire Department (SFD) in partnership with the Seattle Human Services Department Aging and Disability Services (ADS), was selected to be funded.

$300K awarded to organizations in King County

1 program selected to be funded

2 years of funded activities

Partnership

For grantees, **benefits of being in partnership** include: (i) being able to provide better and more holistic health care, (ii) being able to reach a larger number of clients, (iii) the staff's professional development through working on a cross-organizational team, and (iv) having a partner whose goals and mission closely align and that is also enthusiastic, willing, and flexible.

On the other hand, the **drawbacks** include (i) dealing with the bureaucracy of a local government agency; (ii) the fact that the rotation of assigned firefighters to the program meant that case managers often had to take on the role of providing training; and (iii) occasional frictions amongst team members due to political, cultural, or other differences.

> I think one of the main benefits of this partnership was the number of clients our Mobile Integrated Health Program was able to reach last year [2020]. We had approximately 933 responses to over 500 individuals. This is remarkable, especially during the Covid pandemic when many other services were shut down or not doing face to face work with clients.
>
> (Innovation Fund grantee)

What factors supported implementation?

- Being able to build upon **existing relationships** with referral partners.
- Having leadership and institutional **support**.
- The decision of **staffing** the teams with firefighters and social workers helped achieve success, due to their flexibility and problem-solving skills.
- **Having the right people involved** in the program: folks with years of experience and committed to the program.
- Open, frequent and direct **communication**, frequent feedback, and clearly setting goals, boundaries and expectations helped **team building** and the understanding of roles and approaches to interact with clients.
- Having a **training manual** to onboard new staff.
- Having a **Mental Health professional** run group debriefs sessions early on.
- Being **adaptable about the engagement model** and having a broad list of potential patients helped the program to have a steady source of clients.

What were the main challenges?

- Challenges with the implementing of a cross-organizational, civilian-uniformed, **multidisciplinary response team**: (i) Dealing with different organization cultures: differences in training, education, culture, approach, and outlook. (ii) Practical challenges figuring out how to best serve clients and do intakes as a team.
- The **limited number of crisis diversion facilities** and preferential access for EMS services.
- COVID-19 **increased the need for the services provided** through the program. At the same time, COVID-19 meant that suddenly there were fewer organizations to transport clients to for in-person services once a referral was made.
- **COVID-19** imposed logistical challenges: (i) Health One could no longer be used as a **transport** unit, as it was not safe to have clients and the team sharing an SUV; (ii) Training, meetings and team building had to be done virtually.

What made grantees feel like celebrating?

- Helping to **fill an unmet need in the community**: the program provides one of the few in-person teams in Seattle that can meet any client in any location.
- The fact that the **general hypothesis of the program appears to be true**: the MIH program can successfully reduce the burden of lower acuity alarms on SFD Operations companies, avoid unnecessary ED visits, and provide clients with improved referrals and access to necessary treatment and social services.
- Continuing to **strengthen partnerships** – with main partner in the program as well as other referral partners.
- The individual **client success stories**.

> On a client level, the team acknowledged individual client successes: moving an unsheltered client inside, successfully advocating for more in-home care hours, making first-time or renewed connections with primary care or substance use disorder treatment. Because of the high level of complexity and vulnerability of our clients, each individual success is meaningful.
>
> (Innovation Fund grantee)

What were some of the lessons learned?

- **Cross-organizational collaboration:** It is important to set common goals, expectations and define the team's shared values.
- **Choice of partner**: Having the Area Agency on Aging as the partner that provides social work and case management brings more efficiency to the work, as they have access to state systems. Working with non-profits or other organizations would be possible, but not as efficient.
- **Complexity of the work:** It takes significant time to build trust, engage and refer clients successfully.
- **Fragmentation of the healthcare system**: Providers are often unaware of other providers' work on the clients' behalf. Due to the system fragmentation, the MIH team ended up functioning as a bridge among these services. A partnership between the Fire Department and the Human Services Department is well-positioned to connect different service providers, due to their access to clients and ability to span many systems.
- **Measuring success:** Metrics such as number of clients engaged fail to consider the time necessary to achieve successful outcomes.

Some of the key takeaways from the evaluation

Grantees report that the program's hypothesis appears to be true: it can successfully reduce the burden of lower acuity alarms on SFD Operations companies, avoid unnecessary ED visits, and provide clients with improved referrals and access to services.

At times, taking a client to the ED can contribute to reducing ED utilization in the future – because it allows the MIH crew to advocate for the client with social work and other hospital-based services.

Having two City of Seattle entities helped the partnership work well because of their shared governance structures. Having firefighters on the team also helped implementation because they are flexible, adaptive, and trusted in the community.

Benefits of having the AAA as the partner that will provide case management and social work: (i) brings more efficiency to the work, as they have access to state systems; (ii) their experience working with the client population, and (iii) the depth and breadth of their experience.

The relationships with referral organizations are one of the key elements to this work. Having solid relationships and establishing preferential access can increase efficiency and the ability to serve clients.

Choosing the AAA as the partner could allow for replicating this program, as every jurisdiction has an AAA. The expansion of individual programs, however, is restricted by the limited supply of firefighters that can be pulled to do this work.

One of the keys to expand or replicate this work is having wide support from Labor Unions and leadership at the City level: Fire Department leadership, Department of Human Services' leadership, City Council and the Mayor's office.

A key factor in making these programs sustainable is to have funding that is flexible to meet clients needs. Having to bill for services and consider patients' insurance types as criteria can be a barrier to do this work.