PERFORMANCE AUDIT

Report Highlights

Office of the Washington State Auditor
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Reducing Nonemergency Use of Emergency Systems

Everyone who calls 911 needs help, but many calls are not for emergencies. In many communities, calls for medical help are routed to a local fire department, which then sends out paramedics or emergency medical technicians (EMTs) to provide lifesaving care. Often these responders serve as de facto primary care providers, caring for common ailments and chronic conditions instead of true emergencies. When paramedics and EMTs respond to nonemergencies, it ties up resources, such that they might not be available for other people at critical moments. In addition, when paramedics and EMTs transport patients without emergencies to the ER, it contributes to overcrowded ERs filled with patients who could have been better served in another setting.

Some fire agencies in Washington have established CARES programs to reduce nonemergency use of emergency systems. Although the programs differ, they all aim to reduce repeat 911 calls. Studies have shown CARES programs can improve patient outcomes and lower costs by, for example, providing patients with more appropriate care while avoiding expensive ambulance trips. Although the Department of Health establishes regulations and issues guidance for emergency medical services, no statewide organization identifies, tracks or regulates CARES programs. This audit identified existing CARES programs and the barriers fire agencies face when trying to establish a program in a new location.

Fire agencies operate more than 50 CARES programs, but many more communities could benefit from a program

Many fire agencies address nonemergency needs in their communities through CARES programs. We identified 52 CARES programs across Washington. The results of our survey of fire agencies and interviews with eight programs show community needs drive the types of services a program provides. Most programs work with people who repeatedly call 911, connecting them with services, such as behavioral health services, home health care providers, or others who can help with issues like housing and transportation. Programs also often visit people in their homes to help reduce their risk of falls or to check in with them after being discharged from a hospital. Other programs specialize in case management to help coordinate care for people with complex needs, or in overdose response mitigation to help prevent overdoses in people with substance use disorder. Some

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programs focus on responding to patients experiencing a behavioral health crisis. To do these types of work, program staff often include social workers, emergency medical technicians (EMTs), paramedics, nurses and other types of professionals. About half of the programs we surveyed relied on multiple funding sources, most often from a combination of local government funds and grants.

The Puget Sound region has many CARES programs, while other areas of the state need and want one. Statewide, almost one-third of fire agencies surveyed participated in a CARES program, which were based primarily in urban and suburban communities. Meanwhile, only one-sixth of rural fire agencies participated in a program. Nevertheless, almost half of the fire chiefs without a program thought their community needed one, including in rural areas. Counties with high rates of avoidable ER use and nonemergency calls, or limited access to primary care, might benefit from starting or expanding CARES programs.

CARES programs encounter many barriers, most significantly the lack of sustainable funding

Fire agencies described barriers to starting or maintaining CARES programs. Insufficient funding forms the most critical barrier to starting a program. Funding is also a challenge for existing programs: nearly three-quarters of programs surveyed said they were at risk of having insufficient funding in the next five years.

Staffing is another barrier. Professional shortages and unfamiliarity with this emerging, interdisciplinary field make it difficult to find personnel. Furthermore, many rural fire agencies are volunteer-based, making it even harder to establish and maintain needed programs. Lack of guidance and local support deterred some fire agencies from starting needed programs. And due to an absence of statewide expectations, community paramedics are limited in the services they can provide.

CARES programs tracked their performance, but due to lack of centralized coordination some were unaware of state requirements

State law requires programs to track two metrics: reductions in 911 calls and in ER visits. While CARES programs tracked a variety of performance measures, only half fully met state requirements. Program directors' reasons for not tracking the required metrics included being unaware of the requirement, not knowing how to track the information, and programs maturing to the point that early referrals preempted patterns of repeat 911 calls. These reasons suggest a lack of centralized coordination at the state level, as no one is responsible for ensuring all programs are aware of required tracking or providing technical assistance to do so. Furthermore, no one is advocating for possible changes to legal requirements.

Programs used a variety of other measures to track their performance, often to comply with grant requirements. However, the time and effort spent complying with grant requirements took time away from helping patients. Upcoming changes to a national database for emergency medical services should make it easier to systematically measure CARES program success.

Insurers, hospitals and fire agencies can support each other in reducing nonemergency use of emergency systems

CARES programs can generate substantial savings for private insurance companies, Medicaid and hospitals by reducing avoidable ambulance trips, ER visits and hospital readmissions. However, in doing so, fire agencies absorb costs that would otherwise have been borne by hospitals and insurers. For example, community

paramedics may spend hours with a patient, even visiting them multiple times over the course of a few months, to ensure the patient is connected with behavioral health and housing services. Without the program, the fire agency could just repeatedly transport that patient to an ER, leaving hospitals and insurers to incur costs while the patient's needs go unmet. As such, insurers and hospitals could partner with CARES programs, supporting them with a portion of the savings they generate.

Some programs lacked access to medical records, limiting their ability to address patient needs and demonstrate program value. While the best solution would be for CARES programs to work with hospitals to gain access, the Emergency Department Information Exchange offers a partial solution for programs that are unable to do so. Without access to medical records, programs' inability to track frequent ER users hinders their ability to demonstrate their value and meet the state's requirement for performance measurement.

State Auditor's Conclusions

In 2013, state lawmakers approved legislation that gives fire departments in Washington the authority to create service programs to improve people's health. Some 52 fire agencies across the state are now running programs to better serve their communities by trying to keep people out of the emergency room if they are not in a life-threatening situation. These programs, called Community Assistance Referral and Education Services (CARES), are each structured a little differently in their communities but all work toward a common goal: improving people's health while making sure some of the most expensive health care we have – a hospital emergency room – is not the first line of care.

This audit is a robust look into the creative, compassionate and innovative ways these local government programs serve Washingtonians and make services more effective and efficient. We found a great variety in these programs. From partnerships with nearby universities that train social workers, to visiting people in their homes to help reduce the risk of falls, to connecting people with behavioral health services – the professionals working in CARES programs are both reducing costs and improving patient outcomes.

Washington needs more of these programs. This report contains rich, detailed stories from those working in the field right now. And we list a series of recommendations to a wide variety of stakeholders, all of whom told us they welcomed our work and valued an outside, independent view into further improvements.

The biggest hurdle to forming more such programs is financial. Right now, each program is funded slightly differently, representing a cobbled-together budget from grants, levies and other sources. I hope state and community leaders find value in this report and work together to advance ideas on how we can keep investing in programs, like CARES, that work for Washingtonians.

Recommendations

We recommended the Legislature amend state law to develop ways to reimburse services provided by CARES programs, pending the results of a study by the Office of the Insurance Commissioner. We also recommended it take steps to address a lack of centralized coordination and regulatory barriers for CARES programs. To address other challenges fire agencies face when starting a CARES program, or trying to strengthen an existing program, we made recommendations to the University of Washington School of Social Work, the Washington State Association of Fire Chiefs, the International Association of Fire Fighters, the Washington State Hospital Association and existing CARES programs.