PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Reducing Nonemergency Use of Emergency Systems

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Executive Summary

State Auditor's Conclusions (page 44)

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.

Background (page 8)

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 (page 13)

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 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

(page 25)

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 (page 33)

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 (page 37)

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.

Recommendations (page 45)

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.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time and location (leg.wa.gov/about-the-legislature/committees/joint/jlarc-i-900-subcommittee). Our Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology. See the **Bibliography** for a list of references and resources used to develop our understanding of topic area.

Background

Everyone who calls 911 needs help, but many calls are not for emergencies

From childhood on, Americans are taught to call 911 for help. In most communities, calls for medical help will be routed to 911 crews that can include paramedics or emergency medical technicians (EMTs). The sidebar explains the distinction between the two. These emergency medical services (EMS) are usually run and staffed by the local fire department.

Paramedics receive 1,200-2,500 hours of training focused on advanced life support procedures.

EMTs receive 150-190 hours of training focused on basic life support skills.

Over time, advances in fireproofing technology have resulted in fewer fires. Similarly, changes in how people access medical care – driven in part by rising health care costs and a diminishing number of local family-doctor practices – mean that more and more people do not know where else to turn for medical care other than 911 and a hospital emergency room (ER). The time firefighters spend responding to medical calls has steadily outpaced the time they spend actually fighting fires. Indeed, many firefighters are also trained as paramedics or EMTs.

In some communities, 911 crews serve as de facto primary care providers, spending much of their time providing basic treatment for common ailments like asthma. When 911 crews respond to minor medical concerns like sore throats and bladder infections at high speeds, with red lights and sirens, the crews and other road users are needlessly put at risk. Of greater concern: those resources are not available for true emergencies.

Calling 911 for nonemergencies is a poor use of the specialized skills of 911 crews and results in ERs crowded with nonemergency patients

People on 911 crews are trained to immediately provide lifesaving care. Repeat calls to 911 for nonemergencies result in highly trained crews repeatedly arriving at situations where there is little they can do, because the needed solutions are not within their resources or skill sets. For example, 911 crews may be repeatedly called because someone has fallen, but when they arrive the patient only wants help getting up and declines any transport. The patient's real need is likely consistent, ongoing support to age at home as safely as possible.

Historically paramedic and EMT training has focused on responding rapidly, stabilizing the people involved and transporting them to the ER for comprehensive

care. When this is the only care paramedics and EMTs can provide – regardless of the actual need – the burden is passed on to the ER. ER facilities end up crowded with patients who would almost certainly be better served in other settings, which compromises care for patients with true emergencies. Another consequence of overcrowded ERs: paramedics and EMTs can wait hours to transfer patients into hospital care, which means they are not available for other emergencies. Fire agencies in turn have less capacity to respond to more appropriate calls for service.

Fire agencies establish CARES programs to reduce nonemergency use of emergency systems

Given the high cost of using emergency systems for nonemergencies, fire agencies (briefly described in the sidebar) have developed a variety of programs, which go by different names, to reduce both repeat 911 calls and avoidable ER visits:

- **Community Assistance Referral and Education Services program (CARES).** Since 2013, Washington state law has used this term to describe fire agency programs focused on outreach and assistance to improve population health and advance injury and illness prevention.
- **Mobile integrated health.** Health care services such as wound care and vaccinations, provided outside a medical facility by any type of professional. Mobile integrated health often incorporates services provided by nurses, social workers, community health workers and behavioral health providers. Mobile integrated health programs first appeared in the 1990s.
- **Community paramedicine.** A health care model that allows paramedics and EMTs to operate in expanded roles by offering preventive and primary health care services to improve access to care for underserved populations. While EMTs provide basic life support and paramedics provide advanced life support, community paramedics also assess health and social needs, connect patients with primary care and social services, and care for patients with chronic needs and after discharge from the hospital. Community paramedicine programs also first appeared in the 1990s.
- **Co-response.** Partnerships between first responders (police and fire) and behavioral health providers to respond to calls involving patients with complex behavioral health or medical needs. Police departments developed the first co-response teams in the 1970s.

These terms are sometimes used interchangeably, but mobile integrated health is the broadest category, and community paramedicine and co-response can both be considered variations of mobile integrated health. Also, all of Washington's

The state's **400 fire agencies** include:

Fire departments – serve a specific city and report to the mayor or city council

Fire districts – serve counties, unincorporated areas and multiple communities, and report to the Board of Commissioners

Regional fire authorities – bring together two or more fire departments or districts, and report to a governing board

fire agencies operating programs do so under the authority of state law RCW 35.21.930, which established community assistance referral and education services programs. With that, for brevity this report refers to the programs described above as CARES programs, even though many would describe themselves as community paramedicine, mobile integrated health or co-response.

CARES programs have few state requirements for those fire agencies that choose to establish such a program. (Fire agencies are never required to develop one.) The program must measure both any reduction of repeat 911 calls and avoidable ER visits. Beyond that, the law also suggests the program identify community members using emergency systems for nonemergency needs and refer them to more appropriate resources, offering agencies great flexibility to develop a program tailored to community needs.

Several statewide organizations are involved in EMS, but none identify, track or regulate CARES programs

Several state agencies and organizations play important roles in the EMS system. None, however, are responsible for identifying, tracking or regulating CARES programs. These organizations include:

- **Department of Health (DOH).** Statutorily responsible for establishing the state's emergency medical services and trauma care system, but not CARES programs. It also establishes related regulations and issues necessary guidance for the EMS system.
- **The Washington Fire Chiefs Association.** Nonprofit professional association serving fire chiefs in Washington. It provides legislative updates and resources such as training on maximizing prevention and risk reduction efforts.
- **The Co-Responder Outreach Alliance (CROA).** Statewide organization of first responders, behavioral health professionals and project managers working in co-response programs. In 2022, the Legislature directed the University of Washington to collaborate with CROA to assess current capacities and funding strategies for co-response teams across the state, develop model training, and host annual statewide conferences.

  The University of Washington's participation was managed through its School of Social Work. Its Behavioral Health Crisis Outreach Response and Education center surveyed and mapped more than 60 co-response programs operating within police and fire departments. However, this work was specific to co-response and did not include the full breadth of CARES programs at fire agencies.

Behavioral health administrative service organizations also play a role in crisis response

Washington's crisis response system also relies upon the participation of 10 behavioral health administrative service organizations. These organizations provide regional networks of services for people facing behavioral health challenges, including the 988 Suicide & Crisis Lifeline hotline, established in 2022, and the mobile crisis outreach teams that respond to 988 calls. Washington state agencies also support the efforts of these organizations to help ensure people who have called 911 during a mental health crisis are appropriately connected to 988 Lifeline support. The 988 hotline is meant to lead to better care for the person in crisis, while also releasing fire agencies to focus on safety emergencies only they can respond to.

Notwithstanding positive efforts on the part of state agencies and local organizations, when the Behavioral Health Crisis Outreach Response and Education Center mapped co-response for the Legislature it identified gaps in delivering behavioral health services. Researchers acknowledged the 988 Lifeline system was still in development at the time, and called for better coordination between the traditional emergency response and behavioral health crisis systems.

Studies find that CARES programs can effectively improve patient outcomes and lower costs

Numerous studies have demonstrated CARES programs can produce improved patient outcomes in their communities. The Centers for Disease Control and Prevention (CDC) reported these programs can reduce barriers to needed health care, such as transportation and scheduling issues. The CDC also reported that these programs serve as an essential resource for several populations that have high rates of chronic diseases but limited access to critical care resources. The CDC and other researchers have reported programs can effectively reduce patients' risks from uncontrolled high blood pressure and diabetes, as well as hospital readmission within 30 days following discharge. Researchers also found programs can result in increased mobility and self-care, diminished pain, and reduced depression and anxiety.

Studies have also demonstrated CARES programs can be a cost-effective way to reduce nonemergency use of emergency systems. Researchers found the programs safely and effectively reduced the number of ER transports and hospital admissions, while admitted patients had shorter lengths of stay. Given the cost of ER visits, diverting patients to a more appropriate level of care can generate significant cost savings for health care systems. While there have been few large-scale longitudinal studies, several small studies evaluated the potential cost effectiveness of these programs. We describe three on the following page; the Bibliography contains more information about these and other studies.

- **South Carolina Rural Health Research Center** at the University of South Carolina (2018). Compared 68 people enrolled in a community paramedicine program with 125 similar patients and found the program resulted in decreased ER visits, shorter hospital stays and fewer repeat 911 calls. It provided the local health care system a return on investment of more than 20%.
- **Mathematica Policy Research** (a consulting company, 2016). Compared claims data for patients treated by community paramedics in Massachusetts to similar patients, for almost 16,000 "health care events" (also known as "episodes of care"). Using estimated health care costs and utilization rates, along with actual ER diversion rates, the study found patients diverted from the ER had lower average costs for their care. Savings for each patient were $791 for seven days after intervention, $3,677 for 15 days after intervention, and $538 for 30 days after intervention.
- **University of Texas Health Science Center** (2017). Cost-benefit analysis of a fire department that used telehealth consultations to evaluate if a patient needed to go to the ER and then arranged transport to an alternate destination if needed. The average cost for a telehealth patient was $167, which was $103 less than the control group. The program led to $2,468 in cost savings per averted ER visit, for an annual savings of $928,000.

This audit identified existing CARES programs and barriers to establishing them in new locations

Given these programs' potential to both reduce costs and improve patient outcomes, we designed this audit to identify existing programs across the state and to identify barriers to establishing needed programs. To learn more about these programs, we surveyed Washington's fire agencies, conducted case studies at eight selected programs (listed in the sidebar), and interviewed staff, program leaders and fire chiefs at local fire agencies.

The audit answered the following questions:

1. Where are community paramedicine/mobile integrated health programs located, what types of programs exist, and how are they funded?
2. Where are programs underrepresented and needed, and what factors prevent fire agencies from establishing programs?
3. What opportunities exist to systematically measure program success?

The eight case study sites

- Bellingham Fire Department
- Clark-Cowlitz Fire Rescue
- Port Angeles Fire Department
- Puget Sound Regional Fire Authority
- South County Fire
- Spokane Fire Department
- Walla Walla Fire Department
- West Pierce Fire & Rescue

Audit Results

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

Results in brief

Many fire agencies address nonemergency needs in their communities through CARES programs. The 52 CARES programs we identified operate in counties across Washington. Community needs drive the services these programs provide, and program staffing depends on the type of services provided. About half of the programs we surveyed relied on multiple funding sources, most often from a combination of local governments and grants.

The Puget Sound region has many CARES programs, while other areas of the state need and want one. Existing CARES programs mostly serve urban and suburban communities. Almost half of fire agencies without a CARES program thought their community needed one. Counties with high rates of avoidable ER use and nonemergency calls, or limited access to primary care, might benefit from CARES programs.

CARES
Community Assistance Referral and Education Services

Many fire agencies address nonemergency needs in their communities through CARES programs

Washington's fire agencies have established a variety of programs, which go by different names, to make better use of limited resources for emergency response. Whether called community paramedicine, mobile integrated health, CARES and co-response programs, they share common goals of reducing use of the 911 system for nonemergencies and helping people get appropriate care. While other agencies and organizations do similar work, such as home health agencies, the audit focused on CARES programs led by fire agencies. All these programs operate under the state law that established CARES programs, the umbrella term used in this report.

But to learn about these programs – their locations, funding, successes and barriers to success – is not straightforward. The state lacks a centrally maintained list of programs, so we sent a survey to the fire chiefs at more than 400 fire agencies in Washington to identify their CARES programs. We received responses from 257 of them, a 64% response rate. We did not project our survey results for all fire agencies

in Washington. Instead, we are reporting on responses we received. We also conducted online research and asked experts in Washington's CARES programs to identify any programs that were not mentioned in the survey.

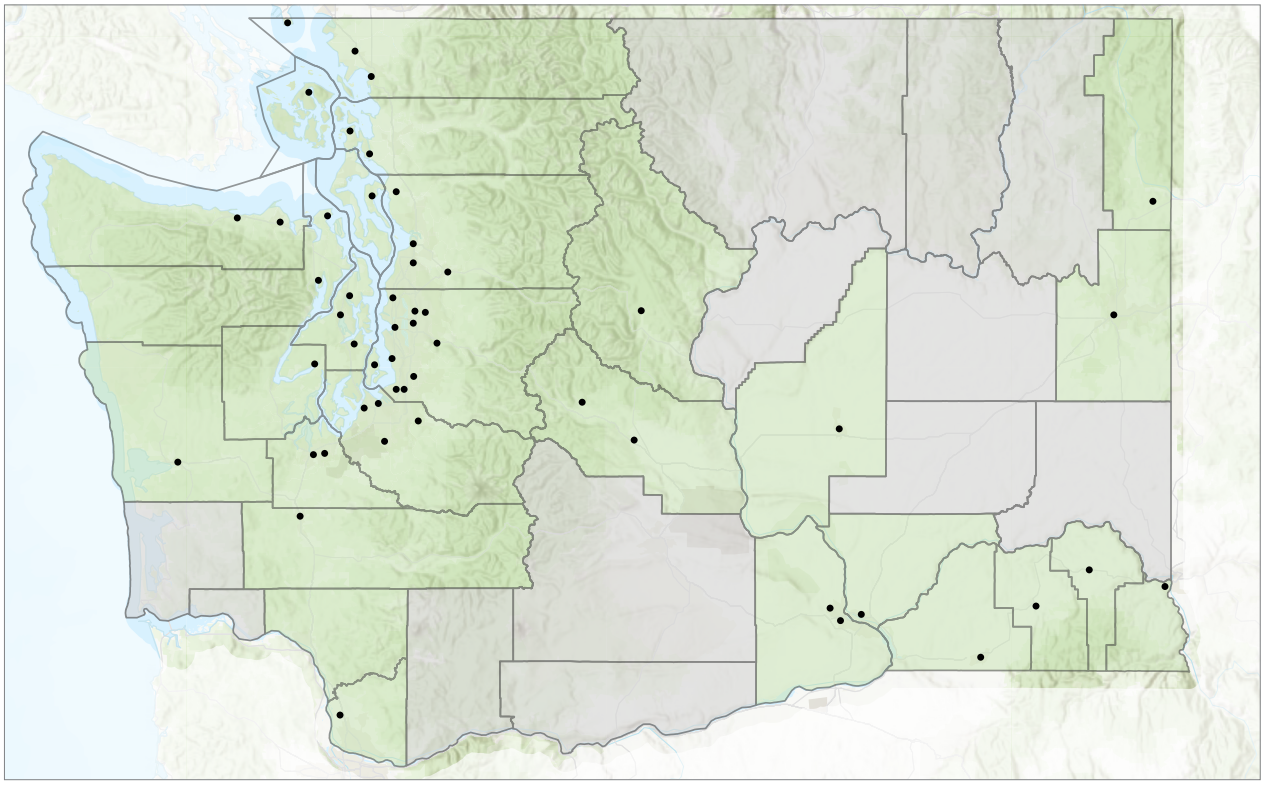
We chose eight programs across the state to examine in closer detail (referred to in the report as case study sites). Our selection criteria included having a positive reputation among other fire agencies, duration of operation and location, and whether in a rural or urban area. (See Appendix B for more about our methodology.)

The 52 CARES programs we identified operate in counties across Washington

The audit identified 52 programs in Washington led by a fire agency. Two-thirds of Washington's counties had at least one program. Notably, King County had 11 programs, and Pierce and Snohomish counties had four programs each. Even many less populous, rural counties, including Columbia, Garfield and Pend Oreille, had a CARES program. The map in **Exhibit 1** shows the location of the 52 programs; **Appendix C** lists all fire agencies that led a program at the time of this audit. However, other counties (shown grayed out in the map) lacked even one program, including Douglas, Stevens and Yakima counties.

Exhibit 1 – Map showing 52 CARES programs in Washington

Active programs as of April 30, 2025



Source: Auditor created from survey results and additional research.

Some programs were partnerships between multiple fire agencies or with other types of community services, such as police and behavioral health organizations. Four of the eight case study sites partnered with other fire agencies. For example, the Clark Regional Fire CARES program works with multiple fire agencies as well as one city employee and a behavioral health specialist. In all, 88 fire agencies participated in the 52 identified programs.

The 52 CARES programs we identified were active as of April 30, 2025. The number will change as new programs start and others close. For example, a few fire agencies were not included in our total because they were only in the early stages of developing a program.

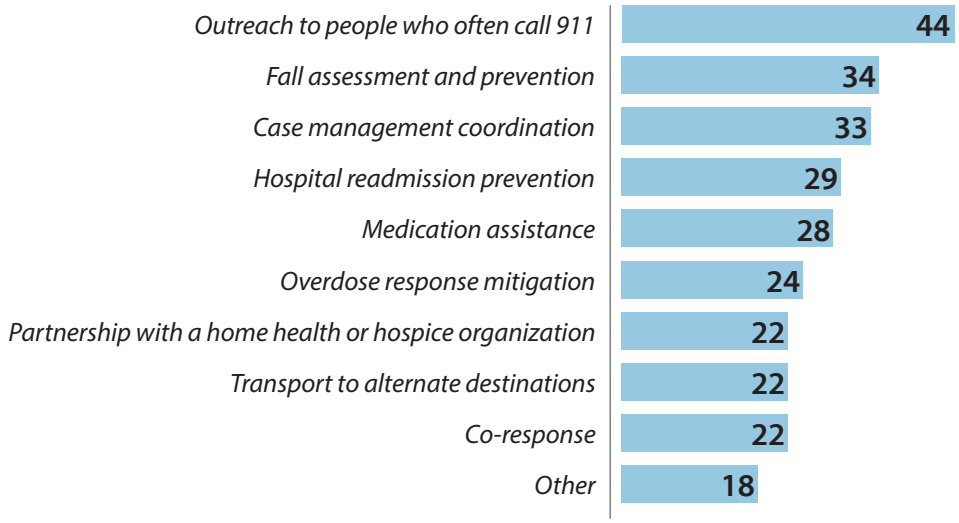
Community needs drive the services programs provide

State law suggests that programs identify people who use the 911 system for nonemergencies and connect them to health care and social services. Program staff at case study sites said they use multiple approaches to find people who may benefit from their services. This includes analyzing 911 call data to identify frequent callers for nonemergencies, referrals from EMS personnel responding to 911 calls, and referrals from hospitals, police and other community organizations.

Since state law imposes no mandatory services, CARES programs have considerable flexibility in the services they do provide, which have been tailored to local needs. Many programs provide similar services to help their patients; they are described in more detail below **Exhibit 2**.

Exhibit 2 – "What types of services does your program provide?"

Survey responses from 48 existing programs; not all answered this question. Respondents could choose multiple answers.



Source: Auditor created using survey results.

- **Outreach to people who often call 911.** Nearly all survey respondents with a program and all case study sites identify people who use the 911 system for nonemergency calls and make efforts to connect them to more appropriate service providers. Program staff refer patients to services directly related to medical needs such as behavioral health services, substance use disorder support, home health care and hospice services. Patients might also be directed to community social support resources to address concerns that contribute to general health and well-being, including housing, food and nonemergency transportation.

  > ***A 63-year-old veteran being treated for cancer was referred to a CARES program for medical and food assistance; he also had trouble keeping up with medical appointments. He had been sleeping on his couch for a long time, which caused him pain due to his cancer treatments and aging, and he expressed the need for a bed. Within 36 hours, CARES program staff were able to locate a hospital bed from one of their community partners and set it up in the patient's home. CARES also provided him with food and dental care resources. In addition, the patient is now compliant with follow-up medical appointments. (Source: Clark Regional Fire CARES program, edited for clarity and length.)***

- **Fall assessment and prevention.** About three-quarters of survey respondents and case study sites said they conduct fall risk assessments. This typically includes visiting the patient's home to assess safety hazards, then installing grab bars or other safety devices to reduce the risk of a fall. The problems sometimes call for less obvious remedies. Staff at one CARES program discovered a patient turned the light on and off by climbing on top of a desk; their solution was a remote to eliminate the daily possibility of a serious fall.

- **Case management coordination.** About three-quarters of survey respondents provide case management services. This includes comprehensively addressing a patient's needs and may require ongoing contact with the patient and coordinating with other organizations. Program staff described providing case management coordination by connecting their patients to available resources in their communities.

  > ***A 54-year-old patient with severe disabilities was referred to the CARES program for additional support. The patient uses a wheelchair and has limited mobility. Frequent episodes of fainting upon standing led to repeated 911 calls and ER visits. The situation became more critical when the patient had a seizure.***
  >
  > ***In response, the CARES team performed multiple home visits to ensure all her needs were addressed. During their home visits, the team identified and mitigated several safety hazards; working with community partners, they provided essential equipment to enhance her safety and independence. The CARES team also coordinated with Meals on Wheels, to ensure the patient received regular, nutritious***

Examples of the services CARES programs provide were drawn from survey responses and case study site interviews.

meals, and a mobile crisis support team, to provide necessary mental health resources. (Source: Clark Regional Fire CARES program, edited for length and clarity.)

- **Hospital readmission prevention.** About two-thirds of survey respondents, including six case study sites, said that they provide services that help prevent hospital admissions or readmissions among their patients. Hospitals refer patients to local CARES programs upon discharge from the hospital to ensure follow-up or ongoing care that minimizes the likelihood of subsequent ER visits or hospital readmission. Such care includes managing prescription medicines or changing a catheter. Again, CARES help can require out-of-the-box thinking. One hospital referred a patient to the CARES program following multiple hospital treatments for heat exhaustion. When CARES team members visited the patient's home, they found a new air conditioner, still in the box on the living room floor. They installed it and the patient had no further repeat visits to the hospital.
- **Medication assistance.** About two-thirds of survey respondents and seven case study sites said that they pick up and deliver prescriptions or help manage medicines for patients who cannot do so themselves. Prescription management becomes particularly important when patients see more than one doctor and are prescribed several medicines but may be uncertain about their uses or the side effects. One CARES program manager said the program's nurses will meet with patients to help them understand what the medicines are treating, the proper dosages and side effects to watch out for.
- **Overdose response mitigation.** About half of survey respondents and six case study sites said that they have programs that respond to opioid overdoses. This can include providing family members or housemates medications that can reverse future overdoses, such as naloxone (commonly referred to as Narcan). To address underlying issues that accompany overdose calls and ER visits, CARES teams can coordinate with sobering centers to have the patient admitted for treatment.

  Community paramedics at a few case study sites said they were also allowed to administer medications like Buprenorphine to treat opioid use disorder directly. One case study site has its community paramedics respond to overdose calls with the 911 crew. If the patient does not need transport to the hospital, the 911 crew is released to return to the station. The community paramedics then assess the patient, offer medication to manage withdrawal symptoms if appropriate, and contact a co-response partner to have a substance use disorder professional respond to the scene. These coordinated activities can lead to the patient receiving a direct placement at a treatment facility.
- **Partnership with a home health or hospice organization.** Almost half of survey respondents partner with organizations that care for people at home, including home health and hospice organizations. Such partnerships often help fill gaps in care delivery, for example by providing night and weekend coverage, or by following up with a health care agency when its patients

call 911 repeatedly. One fire chief said community paramedics will check on patients as needed to help keep them out of the hospital until a more permanent arrangement with a home health nurse can be arranged.

- **Transport to services other than the ER.** About half of survey respondents and case study sites said that they take patients to somewhere other than the ER to receive care when it is appropriate. Examples of alternatives to the ER include an urgent care clinic, an in-patient mental health facility or a sobering center. Taking patients to other facilities can help them get more appropriate care more quickly, while also reducing the number of nonemergency patients waiting in ERs.

  Having this alternative path to treatment can be especially helpful for people experiencing psychiatric or substance use issues. Program managers said their paramedics can perform quick lab tests and physical assessments. If patients meet the criteria, paramedics can bring them directly to an appropriate facility rather than the ER, where they may have to wait hours to be seen. This increases the likelihood patients will enter treatment, since they often leave the ER if the wait becomes too long.

- **Co-response in addressing behavioral health crises.** About half the survey respondents and case study sites said that they work with specialists to help patients experiencing behavioral health crises. One case study site supplied a patient success story that described how CARES staff managed an acute behavioral health crisis.

  > ***A 30-year-old man experiencing suicidal thoughts received timely intervention thanks to the CARES team's community paramedic and behavioral health specialist. His mother, concerned for her son's well-being, called for a welfare check. Upon assessing the situation and recognizing its severity, the CARES team's responders gently encouraged the man to consider inpatient care to receive necessary treatment and support. Their compassionate and nonjudgmental approach played a pivotal role in persuading him to agree to this course of action. As a result, the patient was safely transported to a treatment facility where he could receive the comprehensive care needed to address his mental health challenges. (Source: Clark Regional Fire CARES program, edited for clarity and length.)***

Other services mentioned in the survey results included partnering with licensed care facilities to reduce 911 calls and vaccinating patients. **Appendix D** provides more detailed information about services provided by case study sites.

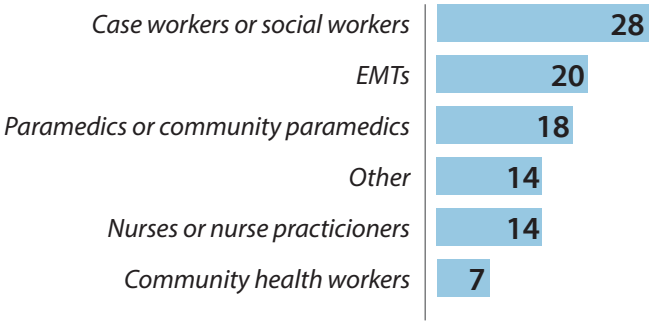
Program staffing depends on the type of services provided

Programs employed people with a variety of professional and practical expertise. According to our survey, these most often included case workers or social workers who can use their training and experience to help patients with complex behavioral health needs. More than 40% of survey respondents employed EMTs

and paramedics, who perform a range of tasks, from checking vital signs to conducting fall risk assessments. One-third of programs engaged nurses and nurse practitioners, who typically visit people in their homes to provide basic home-health treatments. Other program personnel included community health workers, a substance use disorder specialist, a vulnerable adult advocate, a chaplain and other mental health professionals. **Exhibit 3** shows these survey results.

Exhibit 3 – "What types of personnel provide services as part of your program?"

Survey responses from 48 existing programs; not all answered this question. Respondents could choose multiple answers.



Source: Auditor created using survey results.

Staffing models depend on what a program is trying to accomplish, as well as who is available to do the work. We found that almost half of the case study sites partnered with someone outside of the agency. For example, one case study site is located near a university with a social work program, and its program is largely staffed by social work students seeking experience in the field. Such organizational partnerships can help with program staffing traditionally outside the EMS field. Neither state law nor leading practices specify how CARES programs should be staffed.

The photographs below show different ways of staffing programs. Puget Sound Fire's FD CARES program pairs nurses and social workers because they have time and skills to help patients navigate complex medical systems. South County Fire's CARES program is staffed by community resource paramedics and community health workers who respond to needs like behavioral health crises.

Credit: Puget Sound Regional Fire Authority.

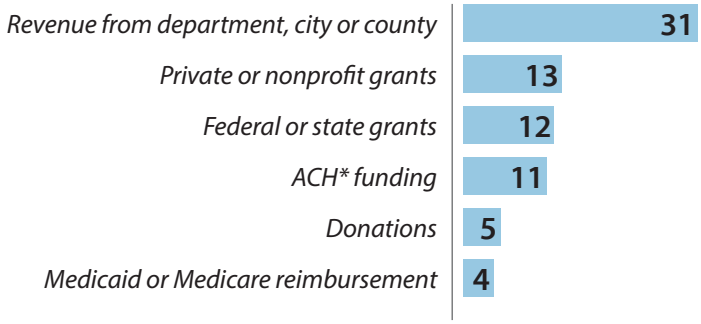
Credit: South County Fire.

About half of survey respondents relied on multiple funding sources, most often local governments and grants

Programs relied on different sources of funding, with the most important being dedicated revenue from local governments. Three-quarters of survey respondents with programs, including six case study sites, received some funding from their fire agency, city or county, as shown in **Exhibit 4**. For more than half of programs, this was their main source of income. In some places, levies approved by voters were a reliable source of local funding. Around half of survey respondents selected only one type of funding source. The remainder selected two or more types, most often a combination of dedicated revenue from local government and grants.

Exhibit 4 – "How is your program funded?"

Survey responses from 48 existing programs; not all answered this question. Respondents could choose multiple answers.



* Accountable Community of Health

Source: Auditor created using survey results.

Grants were the next most common source of funding, drawn from both private and public grantors. More than one-quarter of programs used private or nonprofit grants to fund their work, and a similar number used state or federal grants. In 2024, several grants using funding provided by the Legislature were awarded through the Co-Responder Outreach Alliance (CROA) and the University of Washington School of Social Work's Behavioral Health Crisis Outreach Response and Education center. Some hospitals and public hospital districts have awarded grants to CARES programs in their communities. In addition, the state's nine regional Accountable Communities of Health direct Medicaid funds to organizations and programs working to improve public health. Some Accountable Communities of Health have been instrumental in launching and maintaining CARES programs: a quarter of respondents received funds from their local Accountable Community of Health.

Other sources of funding included opioid settlement dollars, donations and reimbursement from Medicaid. Very few programs received funding through reimbursement from private insurance, by having the patient pay for service, or from a partner organization whose patients were served by the program.

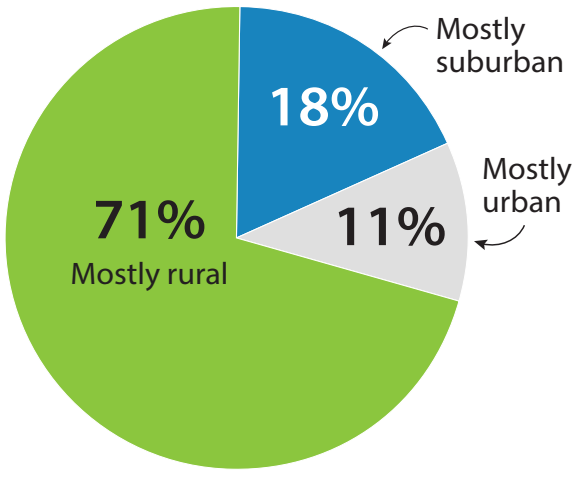
The Puget Sound region has many CARES programs, while other areas of the state need and want one

As the map in Exhibit 1 illustrates, most CARES programs in Washington serve communities around Puget Sound, with more than one-third of existing programs in the large, populous counties of King, Pierce and Snohomish. To identify areas where CARES programs were absent yet needed, we reviewed data on 911 EMS calls, ER visits and access to medical care alongside our survey responses.

Existing CARES programs mostly serve urban and suburban communities

One survey question asked whether the respondent's fire agency led, participated in or was not involved in a CARES program. We then analyzed the responses by the respondents' locations, based on whether they reported serving mostly urban, suburban or rural settings. Over two-thirds of survey respondents served mostly rural areas, as shown in **Exhibit 5**.

Exhibit 5 – "How would you describe the kind of geographic area your fire agency serves?"
257 survey respondents; not all answered this question

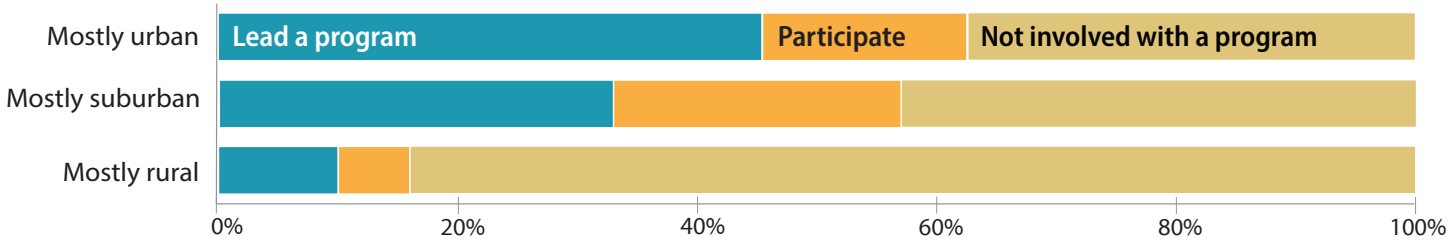


Source: Auditor created using survey results.

Overall, almost one-third (31%) of fire agencies led or participated in a program. As **Exhibit 6** shows, in urban areas (63%) and suburban areas (57%), most responding agencies were already involved with a program. The involvement of rural fire agencies was much smaller: only 16% said they led or participated in a program.

Exhibit 6 – "Do you lead or participate in a program?"

257 survey respondents; not all answered this question



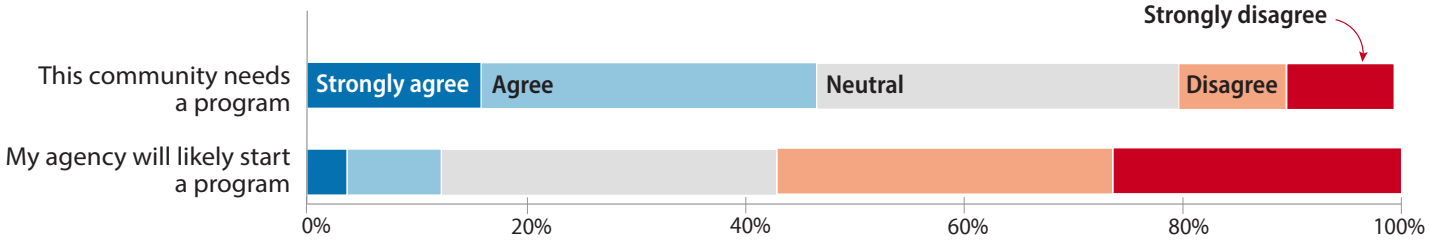
Source: Auditor created using survey results.

Almost half of fire agencies without a CARES program thought their community needed one

The survey identified 178 fire agencies without a program. Nearly half (47%) of these agencies agreed with the statement "This community needs a program," while one-fifth said it did not, as shown in **Exhibit 7**. However, a much smaller percentage of respondents – just 12% – thought their agency would start a program within the next three to five years. More than half (57%) said it was unlikely. Notably, one-third of respondents were neutral on both questions.

Exhibit 7 – Percent of fire agencies without a program that said their community needed one

178 survey respondents; not all answered this question

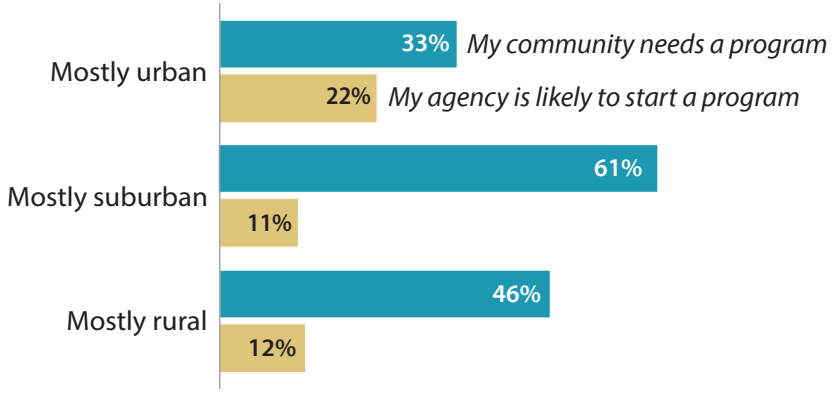


Source: Auditor created using survey results.

The gap between community need and the likeliness of starting a program to address that need was much greater for rural and suburban fire agencies. As shown in **Exhibit 8**, two-thirds of urban respondents whose communities needed a program expected their agency would start one. For rural and suburban agencies, closer to one-quarter expected to start a program. (Only nine urban respondents did not have a program, and of those, three thought their community needed a program while five were neutral.)

Exhibit 8 – Percent of urban, suburban and rural fire chiefs who said their community needs or is likely to start a program

178 survey respondents; not all answered this question



Source: Auditor created using survey results.

While most existing programs in Washington serve urban and suburban communities, many fire chiefs in rural areas saw a need for programs. As one explained:

> ***"Programs have proven very effective in urban areas. However, there is a great need within our rural communities as well. Unfortunately, funding and other challenges have prevented rural programs from starting."***

Other rural fire chiefs said a program would help their community, particularly older residents and those with disabilities who may lack transportation to reach care providers and thus not receive needed follow-up medical care.

Not every respondent thought their community needed a program. Some said their community was too small to make a program worthwhile, or their agency already lacked funding and staff to fulfill its primary mission. In some areas of the state, EMS services are provided by private ambulance companies or other government agencies, and the fire agencies there did not see themselves as taking on this kind of role.

Counties with high rates of avoidable ER use and nonemergency calls, or limited access to primary care, might benefit from CARES programs

To determine which counties are most burdened by nonemergency use of emergency systems, and therefore might benefit from CARES programs, we considered three indicators:

- **Rates of avoidable ER usage.** The Washington State Hospital Association calculates the percentage of ER visits that could have been avoided based on the diagnoses patients receive in the ER. Counties have an average avoidable ER visit rate of 7%. Counties with the lowest rates – under 5% – include Clark and Whatcom; those with the highest rates – just over 10% – include Franklin, Kittitas and Mason.
- **Rates of nonemergency 911 EMS calls.** We calculated this rate using data from the Washington EMS Information System (WEMSIS), a database managed by the Department of Health (DOH) that stores patient care records from ambulance services. The average county has a nonemergency call rate of 9%. The range of call rates was much wider than ER usage rates, from 1% or less in Kittitas and Whitman counties to about 20% in Skamania, Spokane and Wahkiakum counties. Fire agencies may differ in how they enter the data (based on how they were taught to classify it), which could account for some of this variance.
- **Primary Care Health Professional Shortage Areas scores.** The Health Resources and Services Administration at the U.S. Department of Health and Human Services scores counties to identify a shortage of primary care providers. State and federal programs use these scores to determine eligibility for some programs. We included this indicator because communities may rely more heavily on emergency systems for basic medical care when they lack access to primary care. Nine counties qualify as shortage areas, and those with the highest scores are Adams, Ferry, Skamania and Wahkiakum counties.

Six counties were in the top 10 for at least two of these indicators: Adams, Asotin, Kitsap, Mason, Skamania and Wahkiakum. While the other counties have at least one active CARES program, Adams and Wahkiakum do not. The results suggest these two counties might benefit from establishing new programs, whereas the other four might benefit from bolstering their programs or expanding program coverage to other parts of the county. For results of this analysis by county, see **Appendix E**.

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

Results in brief

Fire agencies described barriers to starting or maintaining CARES programs. Insufficient funding forms the most critical barrier to both starting and maintaining programs. Staffing is another barrier. Professional shortages and unfamiliarity with this emerging, interdisciplinary field contribute to program staffing problems. Many rural fire agencies are volunteer-based, making it 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.

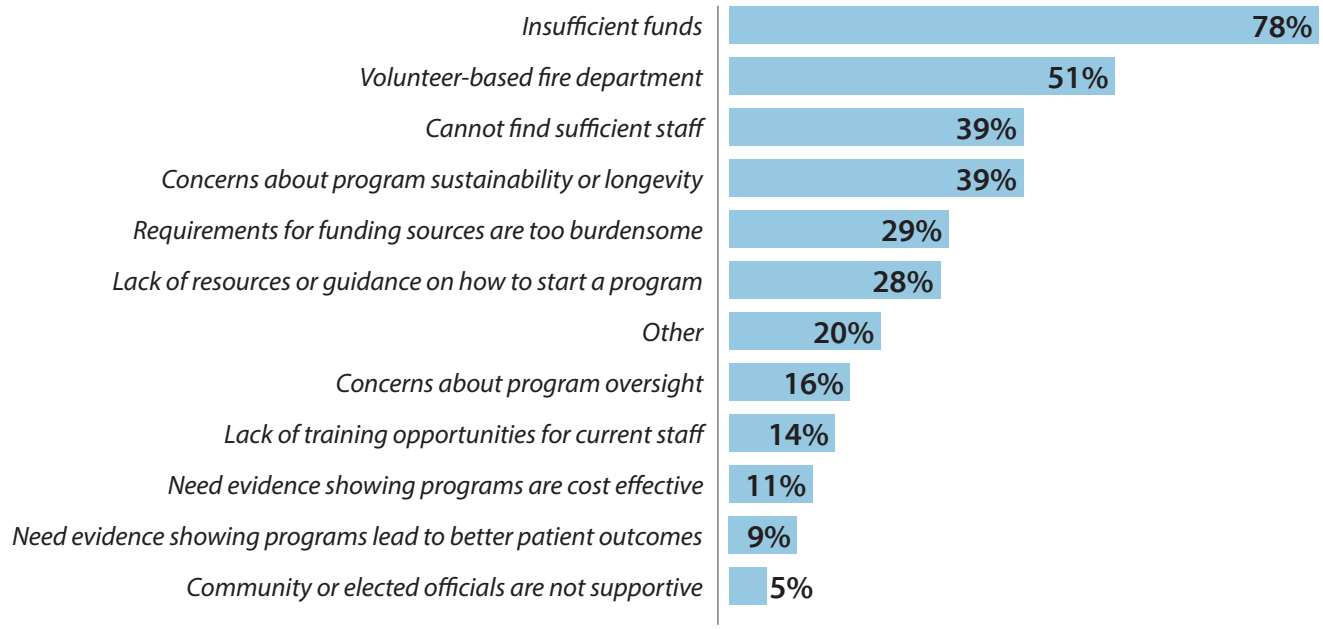
Fire agencies described barriers to starting or maintaining CARES programs

Fire agencies face multiple and often significant barriers to starting a CARES program, as suggested by the 76 survey respondents who said their community needs a program but does not have one. Our survey included questions asking responding agencies about the barriers fire agencies encountered in initiating a program. Those respondents from the 48 agencies that lead a program also described challenges they faced in maintaining their programs. In addition, staff at the eight case study sites provided the most detail about barriers to launching and sustaining their programs.

Some barriers to starting programs and the challenges with keeping them operating are similar, including sustainable funding and staffing. Other issues represent a hurdle to getting a program up and running, from knowing where to begin and obtaining buy-in from leadership to determining the program's scope of practice. The responses from fire agencies without a program but in need of one are shown in **Exhibit 9** (on the following page).

Exhibit 9 – "What reasons prevent you from starting a program?"

76 survey responses from agencies that said their community needed a program.
Percent of respondents choosing each answer; respondents could choose multiple answers.



Source: Auditor created using survey results.

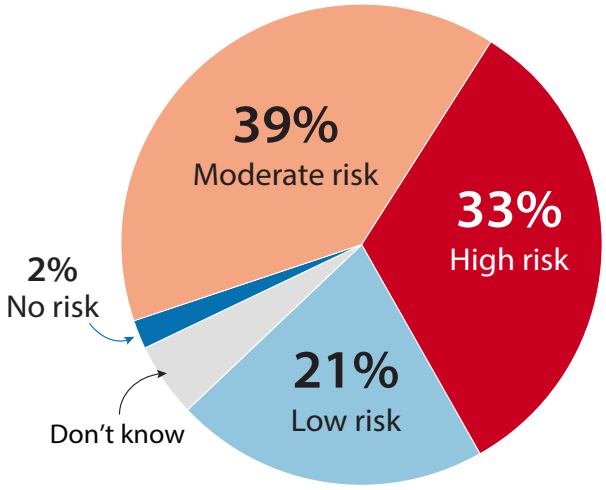
Insufficient funding forms the most critical barrier to both starting and maintaining programs

The most frequently mentioned barrier to starting a CARES program was insufficient funding, cited by 78% of respondents whose community needs a program. Some of these respondents said they already struggle to pay for their existing services and staff or have not yet found a way to fund a program.

Many existing CARES programs were concerned about the sustainability of their funding. Nearly three-quarters of respondents who lead a program said there was a moderate or high risk they would lack sufficient funding in the next three to five years (see **Exhibit 10**).

Exhibit 10 – "Is your program at risk of having insufficient funding 3-5 years from now?"

Survey responses from 48 existing programs; not all answered this question



Source: Auditor created using survey results.

As important a concern as sufficient funding is *stable, predictable* funding. As mentioned in the previous chapter, nearly three-quarters of CARES programs are funded to some extent by their local government, such as the city or county council. These programs are typically funded through levies, which must be renewed by voters, or from the general fund. While funding from a local government can be seen as more predictable in the long term, this can change if:

- The city or county is facing financial difficulties
- Newly elected officials do not view the program as an essential service
- Voters do not renew the levy

Funding from the Accountable Communities of Health and other grants are an essential funding source for some programs, but grants can present their own challenges. Completing grant applications and reporting program outcomes as required can require considerable time and effort on the part of program staff. Program managers noted that grants for CARES programs are often designed to fund new programs, with the assumption that programs will find a more sustainable funding source after the initial grant expires. Ideally, perhaps, the program will secure funding from its local government before the grant expires, but some programs find they must seek and apply for another grant.

> "We have to spend so much time searching and writing grants. It takes away our ability to do the work we are here to do."

In some cases, a fire agency may be unable to embark on a program unless it will be fully paid for through grants. For example, one fire chief said the local government was unwilling to pay for the program, and it thus had to rely upon grants for funding. In this situation, the grant application and award cycle was stressful, as the program would not be certain its annual grant would be renewed. Losing the grant would immediately reduce staff from 14 to three, even though the program has a very positive reputation.

While fire agencies often struggle to fund their CARES programs, they produce substantial savings in other parts of the health care system by preventing avoidable ER visits and hospital readmissions. However, much of the savings accrues to hospitals, insurance companies and Medicaid; this issue is discussed in more detail in the final chapter of this report.

Professional shortages and unfamiliarity with this emerging, interdisciplinary field contribute to program staffing problems

Fire chiefs described many challenges with hiring the professionals CARES programs typically need, especially people with more specialized skills. More than a third of respondents whose community needs a program identified finding sufficient staff as a barrier. Program managers described similar problems in hiring

for these specialized positions. Our audit research looked more closely at the three most pressing areas of concern: paramedics/EMTs, nurses and social workers.

A nationwide shortage of EMTs and paramedics, including in Washington. A 2022 American Ambulance Association study of turnover among paramedics and EMTs found high vacancy rates for part-time EMTs (39%), part-time paramedics (55%) and full-time paramedics (30%). The fire chief at the Seattle Fire Department, the state's largest fire agency, said that, as of December 2024, 11% of its EMT positions and 39% of its 89 paramedic positions were vacant.

The Department of Health (DOH) has taken several steps to address the statewide paramedic shortage. The agency is conducting a statewide study to identify strategies that can help improve recruitment and retention of paramedics. It was awarded a federal grant for this study, which will conclude in 2027. DOH representatives said the agency has recommended various incentives to recruit and retain volunteer EMTs include paying expenses and stipends and offering retirement benefits. DOH representatives also said the EMS workforce more broadly has begun to move away from volunteers to paid, professional employees because people cannot afford to to donate their time, which means funding will remain the primary barrier to recruitment and retention.

Amid a national shortage of nurses, finding those willing to work outside traditional clinical settings. Working at a fire agency is not a common path for either novice or experienced nurses, so a fire agency's first hurdle is to introduce the concept and make it an appealing choice. But in addition to ordinary recruitment issues, the fire agency must also define nurses' role in an untraditional setting.

Fire agency managers we spoke with had varying understanding of what nurses can and cannot do under CARES programs. One noted that the state law lists categories of professionals that may work in these programs but does not specifically mention nurses, and this manager thus believed nurses were excluded from working for CARES programs. In another case, a fire agency hired a nurse but was told by local EMS leadership that the nurse could not provide direct patient care. When asked, DOH representatives said this was a misunderstanding, and they clarified with the fire agency that the nurse could provide direct patient care. The program manager for this fire agency suggested DOH establish a point of contact to continue providing guidance to clarify misunderstandings. However, DOH responded that issuing such guidance would extend beyond its current statutory role and could imply a regulatory oversight responsibility that DOH does not hold.

Fire agencies may also need to clarify a nurse's role in the program with the local firefighters' labor union. One fire chief said the local union raised questions about how the nurses' scope of work in the CARES program differed from the scope of work of emergency services personnel. That fire chief successfully worked through the issue with the union, but also suggested other fire agencies starting a program consult with the International Association of Fire Fighters (IAFF), which is the union for first responders in the United States and Canada. We consulted with an

IAFF representative, who said the union would be happy to provide guidance to help other fire agencies resolve similar issues.

Low awareness of the EMS career path among social workers. Social workers can also be an asset to CARES programs, but – as with nurses – this is not a common career path. Social workers typically receive their training in clinical settings: this is quite different from the work of CARES programs, which can include crisis response. A fire chief at one case study site that employs social workers suggested that social work programs include mobile integrated health and/or CARES programs as part of students' education. Doing so would offer them exposure to this specialized field and workplace.

The University of Washington's School of Social Work is developing training for first responders, behavioral health professionals and project managers working in co-response programs through its Behavioral Health Crisis Outreach Response and Education center. The Center's director hopes to partner with schools of social work across the state to make crisis response training available to social work students and others in similar roles.

Many rural fire agencies are volunteer-based, making it harder to establish and maintain needed programs

Half of all respondents who thought their community needs a program said starting one would be challenging because their fire agency is staffed primarily by volunteers.

Around half the fire agencies responding to the survey were staffed in great part by volunteers. Volunteer-based fire agencies are inherently resource-constrained. Most are based in rural communities with a smaller tax base to financially support their services, so they lack the funds to pay salaries for permanent staff. Rural locations bring other challenges. Because teams must cover wide geographic areas, the cost of driving to visit patients can be high.

We interviewed managers at three rural, volunteer-based fire agencies that had already established CARES programs to learn how they got started. All three programs had received grants from their local Accountable Community of Health, but people-power was just as essential as funding. They emphasized the importance of having an enthusiastic advocate or champion to lead the program and dedicated volunteers to staff it. One described retired first responders as a great resource. Another said volunteers can come from different professional backgrounds as long as they are "passionate about helping, about getting out there and taking care of people."

Rural, volunteer-based fire agencies may be able to participate in a CARES program by working with regional partners. Some survey respondents said their

agency could not lead a program but would participate in one led by a larger fire agency, hospital or other partner. One suggested forming a consortium of local organizations that could use their combined resources to operate a program.

Some fire agencies already work with regional partners. For example, several survey respondents participate in a CARES-like program run by a health organization. Some case study sites also worked with other fire agencies in their regions. Although based in cities, these programs had a larger footprint that included suburban or rural areas.

- The Spokane Fire Department's CARES program works with patients throughout the county, accepting referrals from fire agencies in rural areas.
- Puget Sound Fire contracts with smaller fire agencies in its region to provide CARES services in their communities, sparing them the expense of program infrastructure, such as administrative staff and vehicles.
- Clark-Cowlitz Fire Rescue partners with rural fire agencies to expand CARES services to all of Clark and part of Cowlitz counties. The Southwest Washington Accountable Community of Health runs the program's referral system, which also includes hospitals, clinics, crisis services and police.

A program led by Lake Wenatchee Fire & Rescue, serves a primarily older community, including many retirees. It is staffed by volunteer EMTs who make home visits to prevent falls, drop off medication, and check in with patients after they have been discharged from a hospital. The program's volunteers contribute skills from their other jobs – including social work and nursing – that help strengthen the program.

Volunteer EMTs pay home visits to their patients, checking vital signs and connecting them to primary care physicians. Credit: Lake Wenatchee Fire & Rescue.

Lack of guidance and local support deterred some fire agencies from starting needed programs

Another common barrier, cited by more than a quarter (28%) of respondents whose community needed a program, was the absence of guidance on how to get started. One said,

> ***"We have dedicated and enthusiastic health care providers in my district, volunteer and paid, and they're excited about this kind of thing. We have resources but it is a big commitment. We want to be sure we can plan ahead so we know what is required, what to budget for and how to establish cost recovery mechanisms."***

One reason for this lack of readily available CARES start-up guidance may be traced to Washington's decentralized approach to the program overall. State law establishing CARES did not assign responsibility for overseeing or coordinating the resulting programs to any statewide agency or association. Thus, DOH provides guidance about emergency medical services, while the Washington Fire Chiefs Association provides guidance about legislative updates and available resources. Several national and state organizations have developed guidance on how to establish such programs (several are listed in the Bibliography), but no one has made these resources readily available to fire agencies in Washington.

Another barrier mentioned by fire chiefs at case study sites was lack of support from 911 crews and EMS leaders. One described questions raised at a previous workplace, concerning how a CARES program fit within the fire department's mission. This fire chief went on:

> ***"The barrier was trying to sell an abstract concept – reduce 911 calls and ER use and improve the health of our community – without specifics."***

Another fire chief was initially against a CARES program because fire agency culture depends on standard operating procedures – but it is difficult to write standard operating procedures around the constantly changing work of community paramedics. A third said that the 911 crews were initially apprehensive about the CARES program. However, after the program's nurse was able to intervene with a very complex patient, the 911 crews immediately understood the program's benefits.

Community paramedics are limited in the services they can provide due to absence of statewide expectations

One somewhat unexpected barrier to CARES programs pertains to the role of the county's medical program director. Medical program directors are physician-administrators that provide clinical expertise and leadership to ensure the effective delivery of medical care. In EMS and CARES programs, EMTs and paramedics operate under the license of the county's medical program director.

Individual medical program directors have significant influence over CARES programs, including:

- **Determining if fire agencies can start a CARES program.** In some counties, experienced medical program directors may be more open to new ideas; in other counties the medical program director may be new or not willing to approve a fire agency running a CARES program.
- **Determining what services CARES programs can provide.** While the state has established a statewide scope of practice for many medical

professionals, including nurses, home care aides and EMTs, it has not done so for community paramedics. This means the scope of what community paramedics can do is determined entirely by county medical program directors. In practical terms, this means that community paramedics in some counties can administer antipsychotics like Invega and medications to manage opioid use disorder like Buprenorphine while those in a neighboring county cannot.

As another example of the influence medical program directors have on specific services offered by CARES programs, when the Legislature considered amending state law to allow transport to alternate destinations, nonpartisan analysts at the Washington State Board of Health wrote:

> **"Each medical program director may have a different comfort level with EMS transporting patients directly from the field to facilities other than EDs [emergency departments] … some regions have not seen any MPDs [medical program directors] authorize and develop protocols for transport to these alternate facilities. A patchwork of authorization exists in other regions, where some MPDs have authorized transport to facilities allowed under current DOH guidance and others have not."**

Some states have established statewide expectations for their community paramedics, which helps address issues of regional variance. Several, including California, Colorado, Maine and Minnesota have codified in state law the specific services community paramedics may provide. While their specific scopes of practice differ, each describes what any community paramedic in the state is authorized to do, whether monitoring chronic diseases, gathering diagnostic data or transporting patients to alternate destinations. Rather than enshrine its permission in law, Delaware required its Division of Public Health to develop standards for the state's community paramedicine programs. In either case, these state-level practices address issues of regional variance because they apply equally to community paramedics across the state.

CARES programs tracked their performance, but lack of centralized coordination contributed to gaps in meeting state requirements

Results in brief

State law requires programs to track two performance measures: reductions in 911 calls and in ER visits. About half of surveyed programs tracked both reductions in 911 calls and ER visits as required in state law. Reasons for not tracking required metrics suggest a lack of centralized coordination.

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.

While programs tracked a variety of performance measures, only half fully met the requirements of state law

State law requires CARES programs to track two performance measures

State law does not impose many requirements on CARES programs, but it does require they measure their performance. Since 2013, CARES programs must track two metrics annually: avoidable ER visits and any reduction in the repeated use of 911. State law also suggests measuring any cost savings for Medicaid, but this is not mandatory. The law did not establish a regular process for reporting these performance measures – only that they can be reported to the Legislature or local governments upon request.

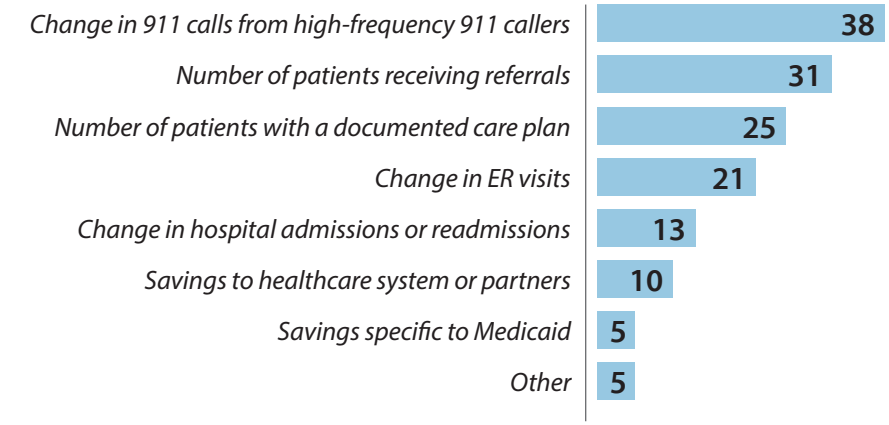
Programs used a variety of measures to track their performance

Nearly all survey respondents, including all case study sites, collected and analyzed data to gauge performance of their CARES programs. Survey respondents tracked the change in 911 calls among high-frequency callers, the number of patients receiving referrals, and the number of patients with a documented care plan.

Exhibit 11 provides more information about CARES performance measures.

Exhibit 11 – "Does your program assess program outcomes using any of these approaches?"

Survey responses from 48 existing programs; not all answered this question; respondents could choose multiple answers.



Source: Auditor created using survey results.

Some case study sites used specialized software to serve their patients and track their own performance. One program developed multiple dashboards to manage their patient caseload: one for people who were not enrolled in their CARES program but were frequent 911 callers, the second for enrolled patients. These two dashboards allowed the program to identify potential enrollees and to monitor whether current patients continued to call 911. (Case study site performance measures are briefly described in Appendix D.)

Time and effort spent complying with grant metrics took time and attention away from patients

The administrative time and skills needed to comply with grant requirements, including tracking performance measures, deterred some fire agencies from launching needed CARES programs. Almost one-third of respondents whose community needed a program said that the activities required by funding sources would be too burdensome. And when programs stitch together funding from multiple grantors, the administrative burden can become significant indeed.

Generally speaking, each granting organization has specific requirements for its grants, which may include performance measures that the program must track and report on. While some measures may overlap for similar grants, they often differ. For example, Port Angeles' CARES program uses grant funds from four sources, including a hospital, a state association, CROA and its region's Accountable Community of Health. Each organization has different requirements for their grants, which means someone at Port Angeles' program must take care to track them individually. Programs tracked performance measures in different ways

depending on the tools they had available, such as specialized software or simpler spreadsheets.

Each grantor will also then have its own reporting requirements programs must fulfill. Some case study sites produced numerous reports with slightly different information, to meet the reporting requirements of various funders.

These administrative tasks of documenting and reporting measures might be performed by administrative staff, but in many CARES programs, the work could easily fall to a care provider. This can limit staff time to meet patient needs. For example, program managers at a rural, primarily volunteer fire agency said their one full-time employee spent most of her time on documentation, which included entering the same information into multiple software programs.

About half of surveyed programs tracked both reductions in 911 calls and ER visits as required in state law

While 38 of the 42 survey respondents who answered this question tracked the change in 911 calls from high-frequency callers, only half of survey respondents and case study sites tracked the change in ER visits (as shown in Exhibit 11).

Among the case study sites, the programs that fully met the state requirements frequently resorted to laborious, manual tracking methods, such as looking up their patients one by one in medical records and counting the number of ER visits. However, one program manager used specialized software that measured the average number of 911 calls and ER visits for CARES patients before and after they were enrolled in the program.

Reasons for not tracking required metrics suggest a lack of centralized coordination

Program managers at case study sites offered several reasons why they did not track the performance measures required for CARES programs. Some were unaware of the requirements in law and focused on tracking performance measures required by their grant funding. Others did not have enough time to spend on data analysis because they were busy helping patients; furthermore, data analysis was not their area of expertise. Managers also said the limitations with their software would make tracking reductions in 911 calls challenging.

Ideally, a program could find itself at a point when the measure of repeat 911 callers becomes moot. Program managers said if their 911 crews are quick to identify people who could benefit from their CARES program, the patients will no longer generate a pattern of repeat 911 calls to track. They added that a useful time to track reductions in 911 calls is when the program is still new, because those diminishing numbers demonstrate the value of the program to potential funders.

Program managers also said there were limits to how effectively they could track a reduction in ER visits. While CARES staff can count the number of times their fire agency takes patients to the ER, they cannot know the number of times their patients went to the ER by other means unless they have access to medical records. This report discusses CARES programs' access to medical records in the next chapter.

Some of the reasons why programs did not track the two required metrics might be explained by the absence of centralized coordination. Compared to the central, statewide oversight and support of EMS, community paramedicine programs lack centralized guidance or support. Washington lacks a statewide agency or organization that can ensure all programs are aware of legal requirements, provide assistance dealing with technical issues, and advocate for possible changes to legal requirements.

Changes in a national database should make it easier to systematically measure CARES program success

The national database used to collect, store and share EMS data will soon include performance measures for community paramedicine and mobile integrated health. The database, known as the National EMS Information System, or NEMSIS, will include about 25 data elements related to CARES-type programs. These data elements were developed in consultation with state EMS data managers and other experts and are expected to be available in 2025. Individual state EMS data managers will then decide whether to require EMS departments in their state to track these performance measures.

The changes in NEMSIS will allow for more standardized data collection and analysis, both within and across CARES programs, if adopted at the state level in Washington. For example, such changes would allow each encounter with CARES program patients to be documented and analyzed over time. This standardization could also lead to more consistency in the performance measures required by grants and so reduce costs associated with collecting data.

California's EMS agency is already using its state's NEMSIS database to produce reports with standard performance measures for its community paramedicine programs. Programs there submit quarterly reports on the number of patients enrolled in their programs and demographic information and can also produce reports through California's NEMSIS to analyze their data. Program managers at California's EMS agency said they also used the same dataset to identify active programs.

If Washington chooses to adopt the new NEMSIS performance measures, DOH could perform similar tasks. This would facilitate the agency's communication with active CARES programs across the state as well as between individual programs.

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

Results in brief

Insurers and hospitals could partner with CARES programs, supporting them with a portion of the savings they generate. CARES programs can generate substantial savings for private insurance companies, Medicaid and hospitals.

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 unable to do so. The consequent inability to track frequent ER users hinders programs' ability to demonstrate their value.

Insurers and hospitals could partner with CARES programs, supporting them with a portion of the savings they generate

Fire agencies typically institute CARES programs to make better use of their own resources and benefit their communities. These programs can also provide significant benefits to insurers and hospitals. By reducing avoidable ER visits and transportation – two major contributors to costs – they produce savings for health care systems as long as there is sufficient demand to outweigh program salary and start-up costs. As it stands, costs that would have been borne by hospitals and insurers – both private insurance companies and Medicaid – are shifted instead to fire agencies. For Washington's health care system to benefit more widely, by encouraging more fire agencies to step into this work, hospitals and insurers may need to consider an appropriate redistribution of the money they have saved due to these programs.

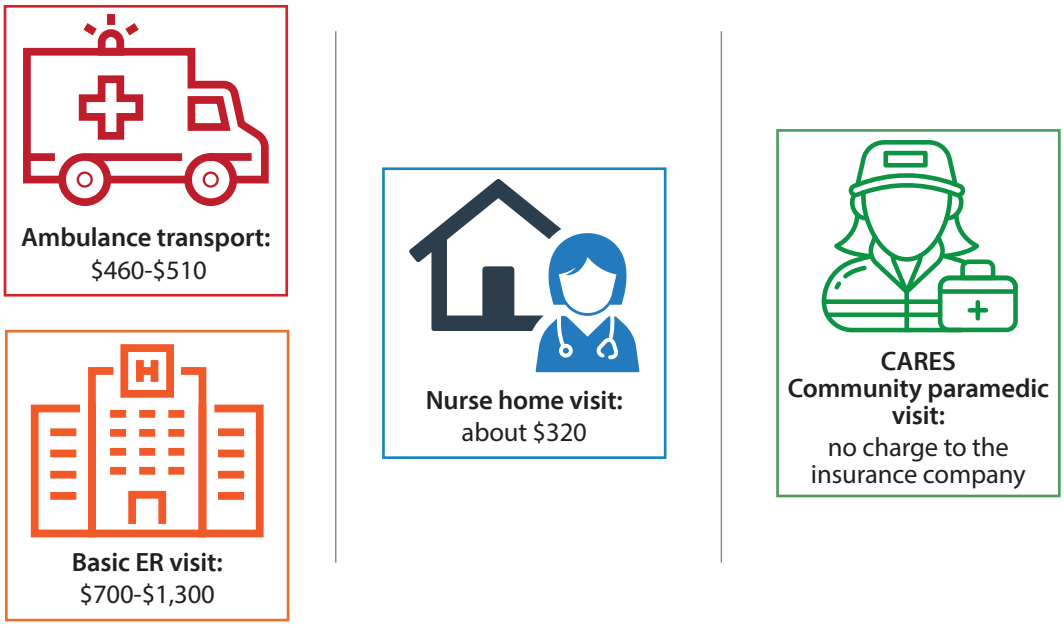
CARES programs can generate substantial savings for private insurance companies

Insurance companies pay providers large sums when someone experiencing a nonemergency goes to the ER. In 2023, Washington insurers typically paid between $460 - $510 for a basic ambulance trip. For an ER visit – using King County as an example – one typical insurance company would have paid another $700-$1,300,

and that is before the cost of any care or treatment the patient received. (Note that the actual costs to insurers varies greatly depending on the specifics of patients' insurance plans and the agreements insurers negotiate with medical systems.)

Insurance companies save significant amounts of money when care is provided through other options. One cost-saving option is to send a home health agency nurse to the patient's home, which would likely cost the insurance company about $320. But if a nearby fire agency sends a community paramedic to the patient's house, both the ambulance ride and ER visit are safely averted, and the insurance company would pay nothing. **Exhibit 12** illustrates these three scenarios affecting a typical insurer's costs.

Exhibit 12 – An ambulance trip and ER visit cost a typical insurance company far more than the alternatives



Source: Auditor analysis based on information from Washington Healthcarecompare.com, the Office of the Insurance Commissioner, Public Employee Benefits Board, Dispatch Health.

Some states now require insurance companies to reimburse services provided by CARES-type programs. In 2023, both Illinois and California required private insurers to reimburse fire agencies for services provided by those states' programs. In 2024, West Virginia mandated that its insurance companies pay for emergency medical service transport to locations like in-patient mental health centers just as they would transport to an ER.

Washington has taken initial steps in this direction. The Legislature directed the Office of the Insurance Commissioner to analyze the cost, potential savings and total net costs or savings of requiring insurance coverage of services provided by CARES programs. The Commissioner's report is due to the Legislature on October 1, 2025. Earlier in 2025, Washington's Legislature considered mandating insurance companies pay for emergency medical service transport to locations other than the ER, but the proposal did not pass.

Our survey produced only one CARES program that was reimbursed by private insurance companies for services provided to its clients.

CARES programs can also produce savings for Medicaid

As they do for private insurers, CARES programs can also save money for the state's Medicaid program. In many communities, a majority of CARES patients are insured through Medicaid. One fire chief said Medicaid insures 12% of his city's overall population, but about 90% of patients served by the fire agency's CARES program. State law suggests (but does not require) CARES programs estimate the value of Medicaid dollars that would have been spent on ER visits had the program not been in place.

Washington's Medicaid program, administered by the Health Care Authority, financially supports CARES programs through three different efforts:

- **Accountable Communities of Health.** These independent, regional organizations play an integral role in Washington's Medicaid Transformation Project. Some of the Accountable Communities of Health have supported CARES programs, through grants and with technical assistance, but the level and type of support varies by region. For example, while Greater Health Now has financially supported CARES programs across southeast Washington, in some regions the Accountable Community of Health has minimal involvement.
- **Ground Emergency Medical Transportation (GEMT).** Established in 2015, this voluntary program makes supplemental payments to EMS agencies for providing this type of transportation to Medicaid patients. Any fire agency that does so is eligible to establish an agreement with the Health Care Authority. In fiscal year 2023, 144 EMS agencies participated in GEMT reimbursement, which pays for at least 50% of their unreimbursed costs, including direct costs for provided services and indirect costs such as administration and training. GEMT reimbursement is not specific to CARES programs, but some case study sites used GEMT reimbursement to help pay for their CARES programs.
- **Treat and Refer.** Established in 2017, this voluntary program reimburses fire agencies for some services provided by their CARES programs, such as treating patients on the scene and then referring them to behavioral health providers. Any fire agency with a CARES program is eligible to establish an agreement with the Health Care Authority. In fiscal year 2024, 10 CARES programs received reimbursement through Treat and Refer. The current reimbursement rate for an ambulance arriving on the scene but not transporting the patient is $115.34.

The audit found these efforts have met with varying degrees of success, in terms of financial support for CARES programs. In our survey, only 10% of existing CARES programs reported receiving reimbursement from Medicaid or Medicare. Fire

chiefs at case study sites said they have tried – but no longer seek – reimbursement from the Treat and Refer program because the low reimbursement rate does not justify the time it takes to request reimbursement. However, one quarter (26%) of existing programs reported receiving grants from their region's Accountable Community of Health.

In addition to the financial support, program managers at one case study site described their Accountable Community of Health as "fantastic, steadfast partners" for their program. It supports the program's vision and wants to enable the community paramedics to focus on their work: the accountability reporting it requires is not regarded as burdensome. It also offered management advice concerning the community paramedics and helped this program gain access to other programs' policies and protocols.

CARES programs can also generate savings for hospitals

In the same way that health insurance providers save money thanks to the activities of CARES programs, hospitals also benefit financially as well as practically through the reduction of nonemergency patients crowding their ER departments. Benefits include:

Reducing avoidable ER visits. Some avoidable ER visits are paid for by patients and private insurance, but the vast majority are paid for by Medicaid, Medicare or a combination of both. According to the Washington State Hospital Association, seven out of 10 hospital patients in Washington are insured through Medicaid or Medicare. Both programs reimburse hospitals at rates below the actual cost of care, with Medicaid currently reimbursing about 85% of actual costs. This means hospitals are likely to lose money on most avoidable ER visits.

By comparing survey results with a list of Washington hospitals with the highest rates of avoidable ER visits, we found most of these hospitals had a CARES program nearby. Other hospitals on the list were close to a fire agency that might consider starting a program. By partnering with and helping support a fire agency, hospitals could reduce avoidable ER visits and so save money.

Reducing readmissions. The Affordable Care Act created incentives to reduce hospital readmissions, introducing financial penalties for hospitals with relatively high rates of Medicare readmissions. The Centers for Medicare and Medicaid Services evaluates the frequency with which Medicare patients return within 30 days and lowers future payments to hospitals that had a greater-than-expected rate of return. Hospitals are thus deeply invested in reducing readmissions.

Some readmissions are unavoidable, but hospitals can reduce their readmission rates by reducing medical complications during patients' initial hospital stays, clarifying patients' discharge instructions, and coordinating with other care providers. CARES programs cannot help address the first issue, but they are well suited to supporting hospitals in the other two.

State law suggests that CARES programs partner with nearby hospitals to reduce readmissions. This was indeed a core service of almost two-thirds (64%) of survey respondents and three-quarters (75%) of case study sites. For example, when patients are discharged from the hospital and cannot be seen by someone from a home health agency promptly, community paramedics can bridge the gap and provide timely support.

Hospitals could partner with local CARES programs and financially support their work

The gains in improving readmission rates and reducing overcrowding in their ER departments are but two of the ways active partnerships with CARES programs can benefit hospitals. Successful CARES programs replace high-cost ER visits with low-cost home visits, while also shifting those costs from hospitals to fire agencies. Hospitals could rebalance some of the financial burden by redirecting a portion of what they would have spent on avoidable ER visits and penalties related to high rates of readmission to their local CARES program.

Some hospitals have already taken steps to do so, as some case study sites described strong financial support from nearby hospitals. The fire chief at one site said their CARES program brought a conservative estimate of cost savings to the nearby hospital's CEO, and in the course of a ten-minute meeting, the CEO decided to continue supporting the program for another four years. The program manager at another case study site said their CARES program initially applied to the county for a start-up grant, which the county rejected. An employee with a nearby hospital submitted the same grant application to the hospital instead, and the fire agency received twice as much as initially requested.

Some programs lacked access to medical records, limiting their ability to address patient needs and demonstrate program value

When treating patients with high use of health care resources, access to medical records between health care organizations is vital. Complete and accurate medical records promote patient safety and quality of care, ensuring patients get the right care at the right time, and they also facilitate coordination along the continuum of care. Access to medical record systems also facilitates ready communication with doctors and other providers serving the same patients, as everyone can use the same internal message system.

> "I couldn't do my job without access to medical records. The 911 crews see what is happening in the moment, but I can go back and see what's happening historically… I want to have that information prior to calling the patient [for the first time]."

CARES programs cannot always rely on patients to provide accurate medical histories. Some patients may be dealing with memory issues, substance use, psychiatric concerns or other medical issues that prevent them from communicating important information. Other patients may move frequently and not have a primary care provider for a CARES team to consult with. For example, one fire chief said the medical records showed that in one year, a patient had more than 100 visits to various ERs around the I-5 corridor.

However, some case study sites cited barriers to accessing medical records for their patients. The fire chief at one case study site described getting access as a "herculean effort," requiring four years of ongoing communication with the hospital and a very tech savvy community paramedic. In addition, three case study sites had no access to patients' medical records, and one program manager described this lack of access as one of the biggest barriers the program faced. A community paramedic at one of these sites said another provider's data breach resulted in the nearby hospital removing everyone's access. Fire agencies and the local hospital systems must have a good working relationship for the CARES program to have permission to access the hospitals' medical records systems, which may not always be the case.

The Emergency Department Information Exchange offers a partial solution

While the best solution to these and other problems would be to improve CARES program access to medical records, the Emergency Department Information Exchange offers a partial solution. The statewide Emergency Department Information Exchange system captures information about frequent users of emergency services. Through its data-sharing arrangements, it facilitates the development of care plans and supports case management. Thirteen of the 52 CARES programs already have access to the exchange. The programs send lists of active patients to the exchange, then receive notifications about those patients. Some CARES programs have partnered with organizations that sponsored program access to the exchange; others pay between $5,000 and $10,000 a year. While the exchange does not provide as much detail as actual medical records, nor does it allow program staff to message patients' doctors and care teams, the data it does offer is better than having no information about an individual patient at all.

The consequent inability to track frequent ER users hinders programs' ability to demonstrate their value

Aside from its requirement in state law, tracking ER visits offers programs a concrete way to demonstrate their value to hospitals, insurance companies and the Medicaid program. Programs can and do count the number of times they transport patients to ERs, but without access to medical records, they do not know how many times patients went to the ER on their own.

Gaps in performance measurement make it harder to demonstrate program success. Performance measurement has many purposes, including improving programs, providing accountability and guiding strategic decisions. It also helps officials evaluate which resources and activities are likely to produce the best outcomes. In addition, good performance measurement helps programs formulate and justify budget requests and allows elected officials and Washingtonians to see the results of the funding they provided. Finally, outcome data can be used to help secure grant funds, and tracking outcomes can give potential funders greater confidence that any money they provide will be – or has been – well spent.

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

For the Legislature

Pending the results of the Office of the Insurance Commissioner's study, due to the Legislature on October 1, 2025, to help address issues related to a lack of sustainable funding, as discussed on pages 26-27, we recommend the Legislature:

1. Amend state law to require private insurance companies to develop ways to reimburse services provided by CARES programs

To address concerns about CARES programs as discussed on page 28, and regulatory barriers and the lack of centralized coordination as discussed on pages 31-32 and 35-36, we recommend the Legislature:

2. Convene a workgroup or advisory committee for CARES implementation across Washington. This group should include representatives from a wide range of CARES programs, both large and small, serving various regions of the state. The group could also include other interested parties, such as the Department of Health (DOH), the Washington State Fire Chiefs Association, the Co-Response Outreach Alliance and Washington's 10 behavioral health administrative service organizations. Responsibilities of the workgroup would include:
    - Drafting statewide guidance for CARES protocols
    - Determining if Washington should recognize community paramedics as a distinct category of providers, with additional training and a scope of practice established through law and/or regulation
    - Determining standard measurements for different types of programs across the state and encouraging program funders to work within this measurement framework. As the workgroup determines these standard measures, we strongly recommend that it consider the community paramedicine/mobile integrated health program performance measures developed by NEMSIS, when they become available.
        - The workgroup should also consider whether the Legislature should update the performance measurements required by state law.
    - Determining if DOH's role in supporting CARES programs should be expanded.
        - This could include establishing a point of contact to clarify misunderstandings, such as perceived barriers related to nurses working at fire agencies, and sharing relevant guidance with CARES programs.

For the Washington State Association of Fire Chiefs

To address challenges faced by small rural fire agencies that want to establish CARES programs, as discussed on pages 29-30, we recommend it:

3. Continue to encourage regional partnerships, including with area hospitals, the Accountable Communities of Health, and Washington's 10 behavioral health administrative service organizations

Some barriers can be overcome by centralizing available resources. We recommend the association compile the following information and make it readily available to all fire agencies:

To address challenges in obtaining support from leadership, including concerns around mission drift and uncertainty about cost effectiveness/patient outcomes, as discussed on pages 30-31, we recommend it:

4. Continue to promote the benefits of CARES with fire agencies

To address challenges using data to demonstrate program value, as discussed on pages 34-36, we recommend it:

5. Share available guidance on using data to demonstrate value

To address lack of guidance on how to start a program, as discussed on pages 30-31, we recommend it:

6. Make relevant guidance readily accessible

For the International Association of Fire Fighters

To facilitate mobile integrated health programs hiring nurses, as discussed on pages 28-29, we recommend it:

7. Provide guidance to address union concerns related to nurses working at fire agencies

While only a limited number of fire agencies choose to employ nurses, we recommend the association make this guidance available to all fire agencies and provide a copy to the Washington Fire Chiefs Association so it can be included with other related resources.

For the Washington State Hospital Association

To address issues related to a lack of sustainable funding, as discussed on pages 26-27 and pages 40-41, we recommend it:

8. Encourage hospitals to partner with nearby CARES programs, and to the extent feasible, redirect a portion of the savings generated through reduced ER visits back to the programs

To address challenges related to a lack of patient information, as discussed on pages 41-42, we recommend it:

9. Provide guidance and encouragement for hospitals to share relevant patient medical records with the CARES programs

For the University of Washington School of Social Work

To increase the number of social workers and other human service professionals serving in CARES programs, as discussed on page 29, we recommend it:

10. Work in partnership with schools of social work across the state to make crisis response training available for bachelor's and master's level social work students. Options could include:
    - Advanced behavioral health skills training working with community paramedicine/mobile integrated health programs for all social work students and other human service professionals
    - A certificate for students in master's programs, introducing a variety of practices across the crisis response continuum, incorporating relevant skills training

For CARES programs in Washington

To address lack of access to patients' medical records, as discussed on pages 41-42, we recommend:

11. CARES programs consider requesting access to the Emergency Department Information Exchange

Agency Response

Note: All audited agencies are invited to send a formal response to the final draft of the audit report, to be incorporated in the published report. In this instance, the Bellingham Fire Department and the Walla Walla Fire Department did not do so.

Clark-Cowlitz Fire Rescue Statement of Support for Audit Findings and Recommendations

Clark-Cowlitz Fire Rescue supports the audit's findings and recommendations. With over 5 years of experience operating Mobile Integrated Health (MIH) programs, we have the data, outcomes, and success stories that demonstrate the vital role fire-based teams play in filling a critical gap in care for vulnerable populations. These programs are not only helping community members survive-but thrive.

Clark-Cowlitz Fire Rescue has developed a regional program with partners that have aligned missions in service to vulnerable populations. Through these partnerships and a collaborative holistic approach, we have been part of substantial impacts across our community. Our efforts with local hospitals to avoid unnecessary admissions helped Clark County lead the State with the lowest percentage of avoidable Emergency Department visits according the State Association of Hospitals. Additionally, we have reduced our responses to fall patients by 50% and improved our response capacity, unit availability, and resource utilization while improving the lives of vulnerable populations.

Meeting People Where They Are

First responders are often the first professionals to see a person in their own environment. We have a unique window into the social, medical, and behavioral health needs that too often go unseen. Fire/EMS personnel regularly encounter the "forgotten ones"-community members whose needs are not met by current systems, not due to lack of compassion, but because existing medical and behavioral health structures rarely meet people in their homes, in their current environment.

First responders have the ability to:

- Recognize what is missing for someone to have a stable, sustainable life.
- Walk alongside individuals from the moment of crisis through the steps of recovery and change.
- Serve as advocates, ensuring people are connected to care and supported until they are safe, thriving, and healthier.

Closing Gaps in Emergency and Medical Systems

The 911 and emergency department systems were designed for acute emergencies. When individuals in crisis present to the ER, they are often stabilized, provided short-term answers, and sent home with a list of next steps. For someone already struggling, this process can result in becoming lost in the system.

Our MIH teams help to address these system issues by:

- Meet clients in their home environment with a wide array of assessment and tools to assist them and connect them to resources.
- Providing an alternative response to help keep costly and limited emergency response resources available for acute response needs.
- Addressing Critical needs in real time.
- Connecting people directly to resources such as housing, food, behavioral health, and ongoing medical care with an ability to follow-up and ensure clients are not lost in the system.

Our mission began with reducing unnecessary 911 and ER use among high system utilizers. While we have successfully decreased 911 and ER use, the greater outcome is more important: community members are now safer, healthier, and more stable. Our program has also expanded to provide specialized response to acute behavioral health needs in the 911 and 988 systems for improved service and follow-up care.

The Power of Collaboration with Law Enforcement and Other Agencies

Equally important to our mission is the ability to collaborate with local police departments and community partners. These partnerships allow us to leverage the strengths of multiple agencies to provide comprehensive care.

Our partnerships with Law Enforcement, local hospitals, our Area Agency on Aging and Disabilities (AAADSW), along with Carelon, our BH-ASO, and our Accountable Community of Health (SWACH) has facilitated collaboration and program efficiencies to avoid duplicated services and braid funding for more holistic and comprehensive services.

This collaboration has created strong partnerships for a standardized regional approach to address complex needs of our most vulnerable populations.

Supporting the Mental Health of First Responders

Firefighters and paramedics care deeply about the people they serve. Yet, when they encounter individuals in crisis repeatedly-transporting them to the ER only to see them return to the same unsafe circumstances-this can create feelings of helplessness, guilt, and moral injury.

Without the tools to provide long-term solutions, firefighters are left with a single option: transport to the ER. Over time, this cycle can lead to **burnout, trauma, and compassion fatigue**.

Adding CRP/MIH/CARES teams changes this dynamic:

- Firefighters now have a resource to connect people with real solutions, providing a sense of closure and confidence that appropriate follow-up care will be provided.
- They see positive outcomes—clients placed in safe housing, connected to care, and stabilized.
- This restores hope and reinforces the purpose that brought them into public service.

By empowering firefighters with effective tools and support teams, we not only improve community outcomes but also protect the **well-being and resilience of first responders**.

Documented Outcomes

Our data consistently shows:

- Significant decreases in 911 and ER utilization in our service area.
- Improved health, safety, and stability for individuals once lost in the system.
- Significantly reducing falls related calls and subsequent injury.
- Prevented emergencies by identifying risks early and intervening before injury, sickness, or trauma occurs.
- Enhanced outcomes with a diverse team with varied backgrounds to ensure social determinants of health are addressed alongside medical needs.
- Efficient and impactful results over a large service area through collaboration with law enforcement and community partners.
- Improved morale and mental health among firefighters and law enforcement officers, who can now see the long-term positive change for those they once felt powerless to help.
- Impact with successful intervention and referral to services and improved health of clients with Substance Use Disorder, including opioid use.

Audit-Identified Recommendations

The audit reinforces the very barriers and opportunities we have seen in practice:

1. **Funding and Cost Recovery** - Sustainable funding streams are necessary for CRP/MIH/co-response programs to continue meeting needs and reducing reliance on 911 and Hospital Emergency Departments. Emphasizing the efficiency and effectiveness of these comprehensive programs is key to sustainability in a complicated healthcare landscape.
2. **Mental Health and Social Determinants of Health** - There is an urgent need to expand direct, face-to-face behavioral health and CHW support, addressing the social determinants of health that drive repeated crises.
3. **Guidance and Training for First Responders** - State-level guidance is needed to support first responders with education, training, and relationships with community-based services that make long-term change possible.

4. **FIRE/EMS protocol change** – changing protocols to allow Paramedics/EMT's and CRP/MIH to easily transport to alternate appropriate destinations and care.
5. **Legislative change** – requiring insurance companies and other funding sources provide funding for CRP/MIH programs, expanding education to Fire Departments on behavioral health and alternate care.
6. **Collaborating services and recognizing FIRE EMS as providers** – Allowing Fire/EMS, Police Departments, mental health providers, medical providers and other medical resources the ability to communicate on a system-wide platform of care.

Conclusion

The reliability of and culture around 911 and emergency services will continue to draw people needing diverse services that are better served outside of traditional emergency response resources. Fire and EMS programs like CRP, MIH, and co-response strengthened by Community Health Workers, Social Workers, and Behavioral Health Specialists efficiently fill a critical gap in direct person care for our most vulnerable populations. Collaboration for these programs is key to ensure efficient and consistent service delivery that is aligned to address common objectives across diverse organizations in the public and private sectors.

What began as an effort to reduce 911 and ER overuse has evolved into a proactive system of care that predicts and prevents crises before they occur or provides an effective tailored response when they do occur. By meeting people where they are, supporting the well-being of first responders, and working side by side with law enforcement and other community partners, CRP/MIH/co-response teams transform lives and strengthen the entire community.

CITY OF PORT ANGELES
WASHINGTON, U. S. A.
Fire Department

August 25, 2025

Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit report, "*Reducing Nonemergency Use of Emergency Systems.*" We sincerely appreciate the comprehensive evaluation conducted by your staff. It was an honor to participate in this important audit and we are grateful that the Port Angeles Fire Department's Community Paramedic Program was included among the agencies interviewed.

We support the report's findings and commend the State Auditor's Office for recognizing both the positive impact and the ongoing challenges associated with CARES programs across the state. The recommendations outlined in the report, particularly those focused on sustainable funding models, centralized coordination, and improved access to relevant patient information, will enhance the long-term sustainability of these programs.

As a smaller fire agency serving a diverse and rural community, we have seen firsthand the value of our Community Paramedic Program in addressing complex social and medical needs that extend beyond the scope of traditional emergency medical services. What makes our program especially impactful is its adaptability. Whether responding to opioid overdoses, conducting post-hospital discharge follow-ups, or connecting unsheltered individuals with health and housing resources, our program continually adapts to meet emerging community needs. Our paramedics routinely partner with local healthcare providers, behavioral health agencies, and social service organizations to deliver proactive, cost-effective care that reduces unnecessary emergency room visits and over utilization of 9-1-1 emergency services.

We strongly support the formation of a statewide workgroup to establish standardized protocols, program reporting metrics and provider credentialling for CARES programs. The Port Angeles Fire Department would welcome the opportunity to contribute to this important initiative by sharing our experiences as a rural agency implementing innovative mobile integrated healthcare with limited resources.

Thank you again for the opportunity to contribute to this performance audit and for your commitment to reducing nonemergency use of emergency medical systems through CARES programs.

Respectfully,

Derrell Sharp
Fire Chief
Port Angeles Fire Department

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PUGET SOUND REGIONAL FIRE AUTHORITY
INTERNATIONALLY ACCREDITED FIRE AGENCY

Professionally and compassionately helping people.

August 19, 2025

Puget Sound Regional Fire Authority appreciates the thorough performance audit conducted by the Washington State Auditor's Office regarding Community Assistance, Referral, and Education Services (CARES) programs. We have reviewed the findings and are in agreement with the audit's conclusions.

CARES programs represent an essential and innovative approach to addressing non-emergency 911 calls while reducing unnecessary emergency department visits and improving community health outcomes. The audit correctly identifies significant implementation barriers, particularly the lack of sustainable funding mechanisms, staffing challenges, technology and integration issues, and insufficient centralized coordination at the state level. These obstacles disproportionately impact rural and underserved communities, limiting their ability to establish and maintain effective CARES programs.

Puget Sound Fire supports the principles and objectives outlined in the audit. Our FD CARES program exemplifies how regional collaboration, multidisciplinary teams, and strategic partnerships can enhance both program impact and operational efficiency. We endorse the audit's recommendations to:

- Develop sustainable funding models, including exploration of reimbursement pathways for CARES services
- Establish coordinated statewide technical assistance, performance measurement standards, and training protocols
- Foster partnerships among fire agencies, healthcare providers, and insurance carriers to distribute program costs and benefits equitably

We commend the State Auditor's Office for recognizing the demonstrated value of CARES programs across Washington and for providing actionable recommendations to strengthen these services statewide. Puget Sound Fire remains committed to collaborating with local, regional, and state stakeholders to ensure CARES programs continue serving as a cornerstone of Washington's integrated public safety and community health infrastructure.

Respectfully,

Brian Carson
Fire Chief

Toni Troutner
Governance Board Chair

Administration
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Serving the communities of Covington, Kent, Maple Valley, SeaTac, Tukwila, Fire Districts 37 & 43

South Snohomish County Fire and Rescue (SCF)

Statement of Support for Audit Findings and Recommendations

South County Fire is in strong support of the audit's findings and recommendations. As a Fire/EMS department with over 12 years of experience operating Community Resource Paramedic (CRP) and Mobile Integrated Health (MIH) programs, we have the data, outcomes, and success stories that demonstrate the vital role fire-based teams play in providing this necessary care. These programs are not only helping community members survive but also thrive.

South County Fire started 12 years ago supporting 50 people and decreased their 911 and ER use by over 50% in just a few months of care. We see our caseloads increase each year and will serve over 3,000 people in need in 2025. Each year the numbers continue to rise exponentially.

Meeting People Where They Are

First responders are often the first professionals to see a person in their own environment. Fire and EMS personnel regularly encounter the "forgotten ones," community members whose needs consistently fall through the cracks. Their struggles are not overlooked because first responders lack compassion, but because today's medical and behavioral health systems are not designed to meet people where they live. Rarely do these systems step into someone's home or engage with them in the environment where the crisis is actually unfolding. As a result, responders often witness the same individuals cycling through emergencies without ever receiving the long-term support they truly need.

We have a unique window into the social, medical, and behavioral health needs that too often go unseen. Fire/EMS personnel regularly encounter the "forgotten ones," community members whose needs are not met by current systems. This is not due to a lack of compassion, but because existing medical and behavioral health structures rarely meet people in their homes, in their current environment.

First responders have the ability to:

- Recognize what is missing for someone to have a stable, sustainable life.
- Walk alongside individuals from the moment of crisis through the steps of recovery and change.
- Serve as advocates, ensuring people are connected to care and supported until they are safe, thriving, and healthier.

Closing Gaps in Emergency and Medical Systems

The 911 and emergency department systems were designed for acute emergencies. When individuals in crisis present to the ER, they are often stabilized, provided short-term answers, and sent home with a list of next steps. For someone already struggling, this process can result in becoming lost in the system.

CRP/MIH teams fill this gap. We ensure that:

- Critical needs are identified and addressed in real time.
- People are connected directly to resources such as housing, food, behavioral health, and ongoing medical care.
- Compassionate follow-up continues until the individual is firmly linked to long-term support.

Our mission began with reducing unnecessary 911 and ER use among high utilizers, individuals calling multiple times a year or even multiple times a day. While we have successfully decreased 911 and ER use, the greater outcome is more important: community members are now safer, healthier, and more stable.

The Essential Role of Community Health Workers (CHWs)

A critical part of our success has been the integration of Community Health Workers (CHWs) into our CARES team. CHWs provide culturally competent, relationship-based support that bridges the gap between emergency responders, healthcare providers, and the community.

For example, in 2023, five individuals alone generated approximately 300 calls to 911. After adding CHWs to our CARES team, we saw dramatic results:

- Within the first year, call volumes for these individuals dropped by 50%.
- By the first seven months of 2025, all five had been placed in safer environments, connected with appropriate care, and their 911 use dropped to nearly zero.

This outcome clearly demonstrates the power of CHWs in providing stability, advocacy, and ongoing follow-up that ensures long-term success for high-risk individuals.

The Power of Collaboration with Law Enforcement and Other Agencies

Equally important to our mission is the ability to collaborate with local police departments and community partners. These partnerships allow us to leverage the strengths of multiple agencies to provide comprehensive care.

One significant example involved an elderly woman discovered by police officers living in a collapsing home filled with trash and rats. The conditions were unsafe and life-threatening. Historically, cases like this have dragged on for months or even years without resolution. But through close coordination between Fire/EMS, CRP/MIH staff, and law enforcement, an unprecedented outcome was achieved:

- **Temporary housing was secured within just a few days.**
- **Permanent, safe housing was arranged in less than two weeks.**
- She was immediately connected to ongoing medical care, food assistance, and long-term supportive services.

The speed of this coordinated response is virtually unheard of in traditional systems. In a matter of weeks, a woman once living in isolation and danger was moved into a safe, stable, and supportive environment where all her basic needs are now met.

This case demonstrates the extraordinary power of co-response and agency collaboration. By working together, agencies accomplished in days what typically takes months or years, ensuring no one fell through the cracks and setting a new standard for how quickly lives can be transformed.

Supporting the Mental Health of First Responders

Firefighters and paramedics care deeply about the people they serve. Yet, when they encounter individuals in crisis and repeatedly transport them to the ER only to see them return to the same unsafe circumstances, this can create feelings of helplessness, guilt, and moral injury.

Without the tools to provide long-term solutions, firefighters are left with a single option: transport to the ER. Over time, this cycle can lead to burnout, trauma, and compassion fatigue.

Adding CRP/MIH/CARES teams changes this dynamic:

- Firefighters now have a resource to connect people with real solutions.
- They see positive outcomes such as clients placed in safe housing, connected to care, and stabilized.
- This restores hope and reinforces the purpose that brought them into public service.

By empowering firefighters with effective tools and support teams, we not only improve community outcomes but also protect the well-being and resilience of first responders.

Documented Outcomes

Our data consistently shows:

- Significant decreases in 911 and ER utilization among enrolled clients.
- Improved health, safety, and stability for individuals once lost in the system.
- Prevented emergencies by identifying risks early and intervening before injury, sickness, or trauma occurs.
- Enhanced outcomes through CHW integration, ensuring social determinants of health are addressed alongside medical needs.
- Life-changing results made possible by collaboration with law enforcement and community partners.
- Improved morale and mental health among firefighters, who can now see the long-term positive change for those they once felt powerless to help.

Audit-Identified Recommendations

The audit reinforces the very barriers and opportunities we have seen in practice:

1. Funding and Cost Recovery: Sustainable funding streams are necessary for CRP/MIH/co-response programs to continue meeting needs and reducing reliance on 911 and ERs.
2. Mental Health and Social Determinants of Health: There is an urgent need to expand direct, face-to-face behavioral health and CHW support, addressing the social determinants of health that drive repeated crises.
3. Guidance and Training for First Responders: State-level guidance is needed to support first responders with education, training, and relationships with community-based services that make long-term change possible.
4. FIRE/EMS Protocol Change: Changing protocols to allow Paramedics/EMTs and CRP/MIH teams to transport to alternate appropriate destinations and care.
5. Legislative Change: Requiring insurance companies and other funding sources to provide funding for CRP/MIH programs, and expanding education to Fire Departments on behavioral health and alternate care.
6. Collaborating Services and Recognizing Fire/EMS as Providers: Allowing Fire/EMS, Police Departments, mental health providers, medical providers, and other medical resources the ability to communicate on a systemwide platform of care.

Conclusion

The reality is clear: 911 and emergency departments will continue to receive calls from people whose true needs are not medical emergencies but access to resources, housing, food, mental

health care, and social support. Fire/EMS programs like CRP, MIH, and co-response, strengthened by Community Health Workers and supported by strong interagency collaboration, are uniquely positioned to fill this gap.

What began as an effort to reduce 911 and ER overuse has evolved into a proactive system of care, one that predicts and prevents crises before they occur. By meeting people where they are, supporting the well-being of first responders, and working side by side with law enforcement and other community partners, CRP/MIH/co-response teams transform lives and strengthen the entire community.

Response to Audit Findings

August 29, 2025

Lori Garretson, MPA
Senior Performance Auditor
Office of the Washington State Auditor

Dear Ms. Garretson,

On behalf of the Integrated Medical Services Program, I want to thank you for the time and attention devoted to the recent audit. We greatly appreciate the thoughtful observations and recommendations provided, as they offer valuable guidance for strengthening our operations, accountability, and overall community impact.

In response to the findings, we have taken deliberate steps to enhance program governance, data management, compliance, staff development, and evaluation practices. Governance has been reinforced through the creation of an oversight structure that brings together EMS leadership, public health representatives, and community partners. Decisions are consistently documented to ensure transparency and accountability.

To address documentation and reporting concerns, we have implemented an electronic case management system that standardizes and improves the accuracy of records. Staff training in documentation practices has been strengthened, and performance data will be shared with stakeholders on a regular basis to provide a clearer picture of outcomes and progress.

We also recognize the importance of strict compliance with grant and funding requirements. To ensure accuracy and accountability in this area, we are working directly with the Fire Department Financial Office to review expenditures and conduct regular reconciliations. By coordinating closely with the department's financial team and aligning our processes with state and federal guidelines, we will ensure responsible use of public resources and sustained program integrity.

Staff training and certification are critical to the success of the program. To that end, we have placed a renewed emphasis on training as it relates specifically to Integrated Medical Services. Supervisors will continue to be responsible for verifying completion, and periodic audits of staff files will ensure compliance with certification standards and readiness to serve the community effectively.

We are committed to maintaining transparency by reporting on our progress in the annual Fire Department Report. This commitment reflects our dedication to accountability and continued service to the community.

Thank you again for your careful review and for supporting the continued success of the Integrated Medical Services Program.

Respectfully,

Anne Raven
Administrative Battalion Chief of Medical Services

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September 4, 2025

Honorable Pat McCarthy
Washington State Auditor
PO Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy, Pat

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit report, "Reducing Nonemergency Use of Emergency Systems".

We are grateful to have been included as a case study site and for you shining a light on the work all the programs provide. We believe the findings are accurate, as it pertains to each district and what each district chooses as their area of focus. We aren't in favor of the recommendation regarding billing private insurance, even with it being optional, as well as placing the onus on the fire department to decrease the ED visits, simply for the purpose of saving the insurance money. We can appreciate the collaboration with hospitals and insurance case managers however, expanding our services into case management is not something our department is seeking to do, especially considering there is no identified funding to support the work.

The program West Pierce supports, is focused on more than just frequent callers. Our program works to acquire and provide resources to people prior to them becoming a frequent caller. Providing direct care is not the key to being successful in this arena, but rather short-term, focused intervention. This strategy has produced highly effective outcomes throughout our community.

The goal of our program has always been to decrease dependence on the fire department and not be a long-term option for case management. We can also appreciate that each district/department is unique and needs a program which suits their specific demographics' needs. Additionally, we believe as long as each district will have the flexibility to choose which recommendation best fits them then we are in agreement with the recommendations.

We have staff that are interested in participating in the workgroups that develop from these recommendations.

Sincerely,

Jim Sharp
Fire Chief

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.**
2. Identify services that can be reduced or eliminated	**No.**
3. Identify programs or services that can be transferred to the private sector	**No.**
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**No.**
5. Assess feasibility of pooling information technology systems within the department	**No.**
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**No.**

I-900 element	Addressed in the audit
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**Yes.** This audit recommended that state law be amended to require private insurance companies to develop ways to reimburse for services provided under their CARES programs.
8. Analyze departmental performance data, performance measures and self-assessment systems	**Yes.** This audit surveyed CARES programs' performance measures and reviewed additional performance measures from the eight case study sites.
9. Identify relevant best practices	**No.**

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in *Government Auditing Standards* (July 2018 revision) issued by the U.S. Government Accountability Office. 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.

The mission of the Office of the Washington State Auditor

Our mission is to promote accountability and transparency in government. We provide the people of Washington with independent examinations of how state and local governments use public funds and develop strategies that make government more efficient and effective. . The results of our work are widely distributed through a variety of reports, which are available on our website and through our free, electronic subscription service. We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program. For more information about the State Auditor's Office, visit www.sao.wa.gov.

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Appendix B: Objectives, Scope and Methodology

Objectives

The purpose of this performance audit was to identify existing CARES programs across the state and to determine what prevents fire agencies from establishing needed programs. The audit addresses the following objectives:

1. Where are Community Paramedicine/Mobile Integrated Health programs located, what types of programs exist, and how are they funded?
2. Where are programs underrepresented and needed, and what factors prevent fire departments/districts from establishing programs?
3. What opportunities exist to systematically measure program success?

For reporting purposes, we organized the audit results into four key findings. The messages relate to the original objectives as follows:

- Fire agencies operate more than 50 CARES programs, but many more communities could benefit from a program (pages 13-24) – This finding addresses Objective 1.
- CARES programs encounter many barriers, most significantly the lack of sustainable funding (pages 25-32) – This finding addresses Objective 2.
- CARES programs tracked their performance, but lack of centralized coordination contributed to gaps in meeting state requirements (pages 33-36) – This finding addresses Objective 3.
- Insurers, hospitals and fire agencies can support each other in reducing nonemergency use of emergency systems (pages 37-43) – This finding addresses Objective 2.

Scope

This audit focused on identifying programs intended to reduce the use of emergency services for nonemergency uses. The audit only focused on programs led by fire agencies. This includes community paramedicine, mobile integrated health, CARES and co-response programs where the lead agency is a fire agency. We did not include programs led by other types of agencies, such as police departments or nonprofit organizations. We also did not include programs run by fire agencies that focus only on emergency response (such as Medic One) or outreach to the general population (such as school visits or car seat checks). The audit period was calendar year 2024.

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this audit report during our fieldwork period (January through April 2025), with some additional follow-up work afterward. We have summarized the work we performed to address each of the audit objectives in the following sections.

Objective 1: Where are Community Paramedicine/Mobile Integrated Health programs located, what types of programs exist, and how are they funded?

Surveyed fire agencies

We surveyed all fire agencies in Washington to identify existing CARES programs. Because there was no available list of all the state's fire agencies, we compiled one using data from online sources and an internal State Auditor's Office system that includes all government agencies we audit. We found that many fire agencies use multiple names (for example, a district name and a department name) or merged with another agency in recent years. We initially invited 431 fire agencies to participate in the survey, but 30 were no longer in operation or did not provide EMS services, resulting in a total of 401 potential respondents.

We collected survey responses from January 13 to February 14, 2025, using an online survey, as well as a shorter telephone survey for fire agencies we could not reach by email. We received responses from 257 fire agencies (213 online and 44 by phone), for a response rate of 64%. This number does not include duplicate responses from the same fire agency or responses where we could not determine which agency completed the survey, because we removed these records from the dataset before analysis.

Fire chiefs made up the vast majority of survey respondents. We invited fire chiefs to complete the online survey, as well as some fire commissioners, while allowing them to delegate to someone else in their office if needed. For the phone survey, with its shorter set of questions, we generally spoke with whoever answered the phone, whether they were the chief or not.

As part of the survey, we asked about whether the fire agencies had a CARES program, the services their program provided, how they staff their programs and how the program was funded.

Conducted case study of eight fire agencies

To gain a better understanding of how CARES programs operate, we selected eight programs to study in depth. We made a judgmental selection of fire agencies based on recommendations from fire agencies and health care organizations. We sought to include programs that had been operating for at least a few years and were located around the state. We chose this approach because we did not know the entire population of CARES programs statewide when we selected the eight programs. The fire agencies with CARES programs that we selected represent about 15% of the state's programs (eight of 52 total). The results of this case study review cannot be projected to the entire population because each CARES program is structured differently. The selected fire agencies were:

- Bellingham Fire Department
- Clark-Cowlitz Fire Department

- Port Angeles Fire Department
- Puget Sound Regional Fire Authority
- South County Fire (a regional fire authority serving South Snohomish County)
- Spokane Fire Department
- Walla Walla Fire Department
- West Pierce Fire & Rescue

The case study included structured interviews, in which we asked the selected agencies about their program's services and funding sources. We also reviewed program documentation, such as strategic plans, annual reports and presentations, to corroborate information provided. We also asked the fire agencies to provide a list of their funding sources, but we did not review any financial statements.

Literature review

We conducted a broad-based literature review that informed many aspects of this audit, including:

- Online resources about community paramedicine, mobile integrated health and co-response programs, including definitions and typical services, staffing, funding and performance measures. This research informed our survey design and questions.
- Articles and studies on program effectiveness, outcomes and impacts

Objective 2: Where are programs underrepresented and needed, and what factors prevent fire departments/districts from establishing programs?

Surveyed fire agencies

As part of the survey described above, we asked fire chiefs without a CARES program whether they believed their community needed a program, whether they were interested in starting a program and how likely they were to start a program in the next three to five years. We also asked whether they faced any other barriers, which might include a lack of support from public officials, funding, staffing and insufficient guidance on how to start a program.

Interviewed rural fire agencies

Because most of our case study sites served urban areas, we specifically interviewed several fire agencies in rural areas. Three, with mostly volunteer staff, described operating a program despite the challenges. We interviewed:

- Garfield County Fire District #1
- Lake Wenatchee Fire and Rescue
- Quilcene Fire Rescue

Two fire agencies without an active program shared their perspectives on the barriers to starting and maintaining a program. We interviewed:

- Camano Island fire and Rescue
- Toledo Fire Department

Conducted data reliability tests of EMS calls and ER visits

The Department of Health provided data on all EMS calls from the Washington Emergency Management Services Information System (WEMSIS) from April through December 2024. Data reliability work included tests for blank fields and illogical values, duplicate response categories and outliers. We found that the dataset's completeness varied by field, but the fields we needed for our analysis were 99% complete. We found this dataset sufficiently reliable to use for our analysis.

The Washington State Hospital Association (WSHA) provided data on avoidable ER visits. This was summary-level data that WSHA owns, collects and analyzes. WSHA also defines an "avoidable" ER visit using a list of diagnostic codes from the Oregon Health Authority. We tested whether county rates fell within a reasonable range. We found this data source sufficiently reliable to use for our analysis.

Analyzed data of county-level nonemergency, low acuity EMS calls

We calculated the percentage of nonemergency, low acuity EMS calls by county. (Low acuity is defined as requiring minimal patient care.) To do so, we filtered a dataset from the WEMSIS of more than 960,000 records to only include records in which the final patient acuity field showed non-acute or low acuity and the "response mode to scene" field showed nonemergent or, for a small number of records, "already on the scene." We applied additional filters to exclude certain types of services, like hospital-to-hospital transports, and certain incident location types, like places of businesses and medical facilities. We then analyzed the resulting 76,000 records by county.

Analyzed data of county-level avoidable ER visits

We calculated the percentage of avoidable ER visits for each hospital or medical facility. WSHA provided monthly rates of avoidable ER visits for 95 medical facilities, November 2023 through October 2024. We calculated a 12-month average for each facility, then ranked the facilities to see which had the highest rates of avoidable ER visits. For the top 10 medical facilities, we used our program map, survey results and internet searches to determine if the facility was based in a city that already had a CARES program and, if not, whether the local fire chief (or other survey respondent) had expressed interest in starting a program.

Conducted case study of eight fire agencies

As part of our case study with fire agencies as described above, we asked program staff to describe barriers they had faced in establishing or maintaining their CARES programs, including to what extent funding was a barrier.

Researched how other states addressed barriers for these programs

We reviewed a database maintained by the National Conference of State Legislatures and conducted other online research to find relevant legislation in other states. Through this work we identified laws and practices in other states that could help address barriers for Washington's CARES programs.

Objective 3: What opportunities exist to systematically measure program success?

Surveyed fire agencies

As part of the survey described above, we asked fire agencies with CARES programs whether they measured their performance and, if they did, which performance measures they used. We asked them about a variety of performance measures, including those required in CARES legislation: reductions in both 911 calls and ER visits. For those that did not measure their performance, we asked what prevented them from doing so.

Conducted case study of eight fire agencies

As part of our case study with fire agencies as described above, we asked CARES program staff about the performance measures they used and how they tracked this information (for example, using specialized software, spreadsheets, etc.).

Interviewed EMS data managers

We interviewed employees at California's EMS agency and the National Emergency Management Services Information System (NEMSIS) to better understand how Washington could systematically measure the performance of CARES programs.

Work on internal controls

Internal control is significant within the context of Objective 3, which is focused on performance measurement. We did not identify any internal controls at the state level to ensure CARES programs are aware of required performance measures and how to track and report them. We therefore recommend the Legislature convene a statewide workgroup for CARES program implementation across Washington.

Appendix C: List of CARES Programs in Washington

The audit identified 52 CARES programs across Washington, using a state-wide survey of fire agencies, internet research and consultation with experts in Washington's CARES programs. Existing programs listed below. Information was current as of April 15, 2025.

County	Fire agency
Asotin	Clarkston Fire Department Rescue One
Benton	Benton County Fire District #4
Benton	Richland Fire and Emergency Services
Chelan	Lake Wenatchee Fire and Rescue
Clallam	Clallam County Fire District #3
Clallam	Port Angeles Fire Department
Clark, Cowlitz	Clark-Cowlitz Fire Rescue
Columbia	Columbia County Fire District #3
Franklin	Pasco Fire Department
Garfield	Garfield County Fire District #1
Grant	Moses Lake Fire Department
Island	Camano Island Fire and Rescue
Grays Harbor	Aberdeen Fire Department
Jefferson	East Jefferson Fire and Rescue
Jefferson	Quilcene Fire and Rescue
King	Bellevue Fire Department
King	Eastside Fire and Rescue
King	King County Fire District #2
King	Kirkland City Fire Department
King	Puget Sound Regional Fire Authority
King	Redmond Fire Department
King	Seattle Fire Department
King	Shoreline Fire Department
King	South King Fire
King	Valley Regional Fire Authority
King	Vashon Island Fire and Rescue

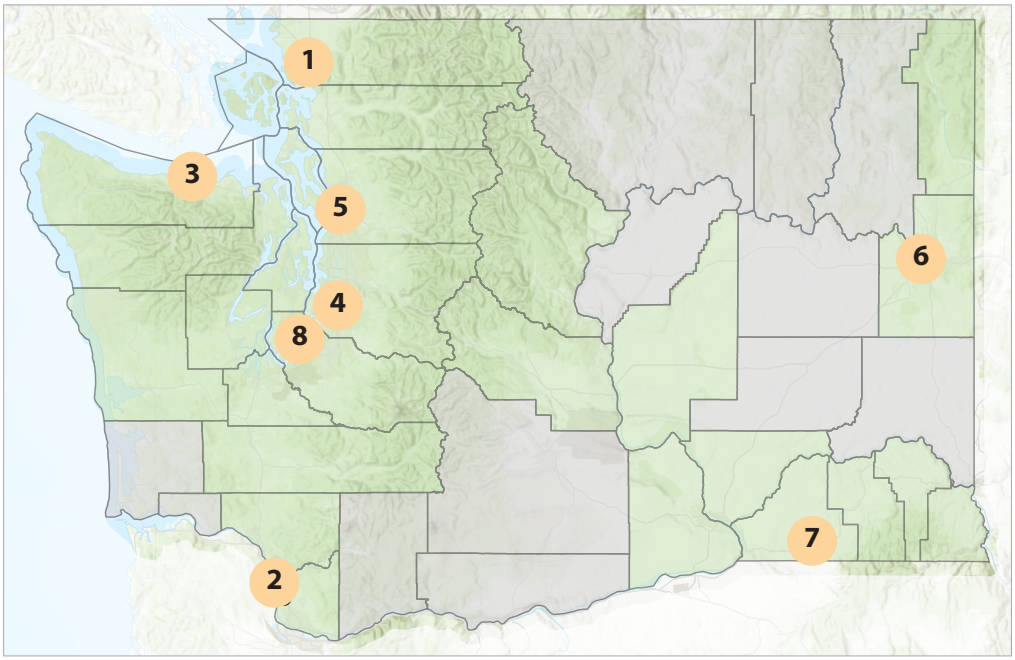
County	Fire agency
Kitsap	Central Kitsap Fire and Rescue
Kitsap	Poulsbo Fire Department
Kitsap	South Kitsap Fire and Rescue
Kittitas	Kittitas County Fire District #1
Kittitas	Kittitas County Fire District #6
Lewis	Riverside Fire Authority
Mason	North Mason Fire
Pend Oreille	South Pend Oreille Fire Rescue
Pierce	Central Pierce Fire and Rescue
Pierce	East Pierce Fire and Rescue
Pierce	Tacoma Fire Department
Pierce	West Pierce Fire and Rescue
San Juan	Orcas Island Fire and Rescue
Skagit	Anacortes Fire Department
Skagit	Skagit County Fire District #13
Snohomish	Everett Fire Department
Snohomish	North County Regional Fire Authority
Snohomish	Snohomish Regional Fire and Rescue
Snohomish	South County Fire
Spokane	Spokane Fire Department
Thurston	Lacey Fire District #3
Thurston	Olympia Fire Department
Walla Walla	Walla Walla Fire Department
Whatcom	Bellingham Fire Department
Whatcom	Whatcom County Fire District #5
Whatcom	Whatcom County Fire District #7

Appendix D: Case Study Program Profiles

This appendix contains case studies for the eight selected CARES programs studied in depth as part of this audit. We selected these programs based on a variety of factors including having a positive reputation among other fire agencies, being in operation for more than two years and their location. The information is drawn from program documents and testimonial evidence from program staff.

Each case study includes information on these topics:

- When and why the program was started
- Program goals
- Services provided
- Patient information, including how the program selects patients and the number served
- Staffing levels and skills
- Funding and community partners
- Measuring success
- Barriers and challenges encountered
- Program sustainability



Map #	Program name	Lead fire agency	Page
1	Community Paramedic Program	Bellingham Fire Department	72
2	Clark Regional Fire CARES Program	Clark-Cowlitz Fire Rescue	75
3	Community Paramedic Program	Port Angeles Fire Department	78
4	FD CARES Program	Puget Sound Regional Fire Authority	81
5	Community Paramedic Program	South County Fire	84
6	CARES Community Assistance Response Team and Behavioral Response Unit	Spokane Fire Department	88
7	Community Paramedic Program	Walla Walla Fire Department	92
8	Connected CARE Program	West Pierce Fire & Rescue	95

Bellingham Fire Department Community Paramedic Program

Areas served: City of Bellingham, Whatcom County

When and why program started

Bellingham Fire Department's community paramedic program started as a pilot program in 2015. The city's leadership had identified a need to assist frequent 911 callers. At that time, the most frequent 911 calls came from facilities like adult family homes; paramedics responding to calls often had to educate facility staff about appropriate use of the 911 system and alternatives to calling 911. A year or two after the program started, the program shifted its focus from facilities with high numbers of 911 calls to people in the general public who frequently called 911.

The program focuses on connecting patients to appropriate medical and behavioral health services. It has also begun piloting services to address opioid-related responses.

Program goals

- Reduce the number of frequent 911 callers
- Address patients' medical needs
- Connect patients to appropriate resources
- Improve public health and advance injury and illness prevention

Services provided

- Connecting patients with appropriate medical and behavioral health care, including working with designated crisis responders and alternative response teams at Compass Health
- Picking up, delivering and administering medications to people who lack transportation to do so
- Transporting people who do not need an ambulance to destinations other than a medical facility
- Decreasing the risk of hospital readmission through services like fall risk assessments
- Recently started piloting services to address opioid-related crisis response

Staffing

- Two community paramedics
- Two case managers
- One crisis responder employed by Compass Health

Bellingham Fire Department provides additional administrative and oversight support. In addition, Fire District 7 has one community paramedic and a case manager.

Who selects patients and what criteria do they use

Number of patients served in 2024: 114

Patients may be eligible to receive services from the community paramedic program if they are:

- Identified as a frequent 911 caller. The program identifies frequent 911 callers using several criteria, including how often they call in a short period (such as four or more calls a month or 12 or more calls a year). They use a dashboard that shows patient names, call counts and the reasons for the calls, which can help staff determine if the program can meet their needs.
- Referred from Bellingham Fire Department's 911 crews. Even if these patients do not meet the threshold of 12 calls a year, the fire department will likely have repeat 911 calls from these patients, so these calls are considered high priority.
- Referred from local community agencies and other fire districts
- Identified as a risk for hospital readmission. This includes patients who were recently discharged from the hospital and need assistance with transportation to follow-up appointments, medication use or fall risk assessment.

Each community paramedic has a caseload of about 20 patients at any given time. Patients no longer need the community paramedic program when they have no unwarranted calls to 911 for three months.

Community partnerships

Through the GRACE program Whatcom County Health Department supplies case managers, who connect patients to appropriate services.

Funding

- Whatcom County EMS Levy
- Whatcom County Health Department (covered mostly by the Behavioral Health Fund)
- City of Bellingham
- Ground Emergency Medical Transportation (GEMT)

Sustainability

The city and county councils strongly support funding this program. For example, funding to respond to the opioid crisis has increased. The fire department will continue to fund the program through the duration of the EMS levy, so it is funded through at least the next five years. After that, the fire department could continue to use city and county funding, or rely only on city funding. The fire chief supports the CARES program and is committed to finding funding for it. One challenge for the program is whether it can expand services to other groups such as nursing home residents.

Measuring success

The program currently measures:

- Number of patients
- Number of patients by program
- Number of EMS incidents
- Number of transports
- Number of behavioral health calls
- Number of overdoses
- Frequent 911 callers not yet enrolled in a/the program

The program uses two dashboards:

- A dashboard for unenrolled, frequent 911 callers. If someone made 12 or more calls over a one-year period, that person will be contacted by a community paramedic.
- A dashboard for active patients that shows the last time a community paramedic visited the patient and the last time the patient called 911.

Bellingham Fire Department does not currently track any reduction in emergency room use. Managers said they are still determining other performance measures to include.

Barriers and challenges

- The quality and quantity of available services is a barrier to the program's success. Program managers believe their community paramedicine program and others can only be as successful as the "wraparound" programs around them. This means they rely on the medical community and housing to make their program work: if these services do not exist or are limited, community paramedicine's success is also limited. A lack of those services makes it more difficult for the program to operate successfully.
- The initial training that medics and EMTs receive does not cover the social work aspect of the work they do as community paramedics. As a result, the fire department partners with case managers through the county's GRACE program. As community paramedics, they need appropriate training and an appropriate scope of work to operate this program successfully.

Clark Regional Fire CARES program

Areas served: Clark County and part of Cowlitz County

When and why program started

The CARES program started in 2020 after an internal conversation about how the county could better serve people who called 911 frequently, including patients being discharged from hospitals who have a high likelihood of readmission. The Southwest Washington Accountable Community of Health provided initial funding for a paramedic and a social worker. The program also provided vaccinations and food service during the pandemic.

Program goals

- Use resources more efficiently by connecting people in need to the right nonemergency services and health care
- Reduce demand for and improve the availability of emergency response and hospital care
- Improve public health by reducing risk of injury and complications from medical conditions
- Improve public health by addressing the opioid crisis

Services provided

The CARES program's acute response team responds to behavioral health crises. The CARES program follow-up care team help patients with many medical and social needs, including:

- General medical care and connection with a primary care physician
- Health supportive services and chronic disease management
- Help obtaining health insurance coverage
- Medication management, including filling prescriptions
- People with serious or unstable health conditions who are at risk of hospital readmission
- Behavioral health support and crisis intervention
- Substance use disorder support
- Food or utility assistance
- Housing assistance and homeless outreach
- Hospice and advanced directive assistance
- Domestic abuse and child abuse response
- In-home care and family caregiver service referral

Staffing

Acute response team

- One behavioral health specialist employed by Sea Mar (two rotating staff)
- One paramedic (17 rotating staff)

Follow-up care team

- Two paramedics
- One registered nurse
- Three community health workers

Support staff

- One administrative assistant
- One CARES program manager
- One fire chief officer

Several fire agencies in the region have hired staff to support the CARES program, including Clark Cowlitz Fire Rescue, the Camas-Washougal Fire Department, Clark County Fire District 3 and the city of Battle Ground.

Who selects patients and what criteria do they use

Number of patients served in 2024: CARES acute response team: 372, CARES follow-up care team: 525

The CARES program's acute response team receives referrals from the operations crews at Clark Cowlitz Fire Rescue and Fire District 3, and local law enforcement. The CARES program's follow-up care team receives referrals from participating fire agencies, hospitals, community partners and police.

The CARES follow-up care team uses criteria to determine whether they can help a patient referred to them, including:

- At-risk older adults, such as those at high risk of experiencing a fall or who are disabled with little or no support at home
- Patients deemed high-risk of hospital readmission under hospital discharge criteria
- Other target patients living in the CARES program service area

Community partnerships

- A Caring Closet
- Area Agency on Aging and Disabilities of Southwest Washington (AAADSW)
- Battle Ground Police Department
- Clark County EMS Medical Program Director
- North Country EMS
- Ridgefield Police Department
- Sea Mar

- Southwest Washington Accountable Community of Health (SWACH)
- Woodland Police Department

Funding

- Southwest Washington Accountable Community of Health (SWACH)
- Area Agency on Aging and Disabilities of Southwest Washington (AAADSW)
- Legacy Salmon Creek
- PeaceHealth Southwest Medical Center
- Carelon Behavioral Health
- Co-Responder Outreach Alliance (CROA) grant

Sustainability

CARES program managers noted there was significant funding for pilot programs, but less for long-term funding. Grant funding is typically not a predictable or long-term source of funding.

Measuring success

CARES program managers prioritize data collection based on their partners' requests; each partner requests slightly different information, including:

- Number of referrals
- Sources of referrals
- Reasons for referrals
- Number of home visits
- Outcome of patient contact
- Number of fall risk assessments and hazards mitigated
- Emergency service repeat responses and types of responses
- Hospital readmissions

Barriers and challenges

- Recruiting professionals in social services and nursing to work within the fire service, because it is not a traditional workplace for these professions.
- Stakeholders ask for different performance metrics in different formats, even though they have similar goals. CARES program managers would like to see this streamlined.
- Funding for these programs is typically unpredictable, as most funding is geared toward pilot programs or short-term grants.

Port Angeles Fire Department Community Paramedic Program

Areas served: Clallam County

When and why program started

The Port Angeles Fire Department Community Paramedic Program was established in 2019 to fill important health care gaps in the community, focusing on people facing behavioral health issues, substance use disorders and chronic medical conditions.

The department began with a one-year pilot program staffed by one firefighter. After the pilot program was deemed highly successful, it received a grant that provided funding for two paramedics for two years. That same year, the Clallam County behavioral health advisory board provided additional funding for a third staff member for two years from the 1/10th of 1% sales tax designated to fund behavioral health and substance use disorder programs.

Program goals

The three primary objectives of the Community Paramedic Program are to:

- Decrease the public's overuse of 911 emergency services
- Reduce the overuse of the local ER
- Improve overall health and wellness of those who frequently call 911

The broader program goals include the following:

- Provide more health care to the community
- Work to effectively divert patients from the Olympic Medical Center ER
- Reduce hospital readmissions
- Reduce the public's use of 911 for nonemergency services
- Monitor chronic illness, targeting high-risk patients and frequent 911 callers
- Connect patients to appropriate medical and social services
- Respond to nonurgent 911 calls for service

Services provided

- Medication management
- Safety assessments
- Medical equipment assistance and training
- Chronic disease management
- Work with hospice agencies to provide at-home care
- Identify alternative destination and treatment paths for patients with psychiatric crises and substance use disorders

- Wound management
- Patient, community and family education
- Connecting patients with primary care
- Checking vital signs and EKGs, collecting lab samples, and giving vaccinations to unhoused and homebound patients
- Assisting patients with nutrition, substance use disorder, behavioral health, older adult services, transportation, legal concerns, housing and health care coverage
- Post-overdose response

Staffing

- Two community paramedics
- Two community EMTs

Who selects patients and what criteria do they use

Number of patients served in 2024: 382

Most of the program's referrals are from fire and EMS employees; the balance come from doctors or other agencies that cannot fulfill the patient's social or medical need. Nearly all its referrals are for patients facing behavioral health or substance use disorder crises.

Community partnerships

The Community Paramedic program works with more than 100 different agencies. The main part of its program is connecting people to resources. Some of its partners include:

- REdisCOVERY program
- Recovery, Salish Empowerment, Advocacy and Linkage (REAL) Teams
- Reflections team
- Olympic Medical Center
- North Olympia Health Network
- Clallam County Health Department

Funding

- Olympic Medical Center
- Olympic Community of Health Computer Grant Expanding the Table grant
- Clallam County Department of Health and Human Services – Behavioral Health Tax
- Opioid Settlement Funding
- Co-responder Outreach Alliance (CROA) Grant (expires June 30, 2025)
- Association of Washington Cities grant
- Ground Emergency Medical Transportation (GEMT)

Sustainability

Program managers are concerned about funding, as multiple grants for the program will expire soon and it is unclear whether the city of Port Angeles will subsequently fund those positions. The program managers have been successful in securing funding for vehicles and other aspects of the program, but finding sustainable funding for the community paramedics' wages and benefits has been more challenging.

Measuring success

The program currently measures:

- 911 call reduction
- Number of patient encounters including number of:
    - Contacts by the office of community paramedicine
    - Referrals received
    - Referrals initiated
    - Patients
    - Patients with intense case management
- Patient demographics
- Referrals to other service providers
- Type of procedures it performs
- Drug overdose data including the number of:
    - Responses to overdose calls
    - Warm handoffs that result in overdose patients entering treatment programs. (A warm handoff occurs between two health care providers in the patient's presence as one provider transfers patient care information, explains why the other provider can better care for a particular condition, and emphasizes the team approach to care.)

The community paramedicine program formerly tracked patients' ER visits when it was funded by the North Olympic Health care Network because it was an important metric to the network. However, because current funders do not ask for it, program staff have chosen to limit their access to sensitive patient data.

Barriers and challenges

- Lack of training in behavioral health, including for de-escalation and substance use disorder crisis response
- Lack of expertise to collect and analyze data, which is key to conveying the value of the program to funders

Puget Sound Regional Fire Authority FD CARES program

Areas served: As of April 2025, the Puget Sound Regional Fire Authority's FD CARES program covers the areas served by Puget Sound Fire, which are the cities of Covington, Kent, Maple Valley, SeaTac and Tukwila, as well as fire districts 37 and 43.

In addition, the FD CARES program provides services under contract for the Renton Regional Fire Authority, Enumclaw Fire Department, Skyway Fire Department, Renton Police Department and Kent Police Department.

When and why program started

The FD CARES program started in 2014 to help the fire department respond more effectively to frequent 911 callers. The program began with one person visiting frequent callers at home, offering resources and asking questions to see what the fire department could do to better address the caller's needs. The goal was to connect people with services and resources or fix problems such as fall hazards to reduce the actual need for 911 calls. In 2015, the FD CARES unit officially commenced service.

Program goals

The initial goal of the FD CARES program was to connect frequent 911 callers to appropriate resources or help address problems such as fall hazards. Program staff soon realized that if the program was truly effective, the number of repeat 911 calls would effectively disappear.

The main goal of the program is now to help people navigate through complicated medical systems and social services by connecting them with nurses and social workers who have the time and necessary skills to help.

Services provided

The FD CARES program is primarily staffed by registered nurses and social workers. Registered nurses can navigate the patient's complex medical needs with their care providers and help them with:

- Medication management
- Vaccinations
- Wound care

Social workers help connect patients with resources to address:

- Housing and food insecurities
- Drug and alcohol rehabilitation
- Behavioral and mental health issues

Staffing

- Nine registered nurses
- Nine social workers
- One intake care coordinator
- One uniformed captain
- One medical program director (contracted position)
- One substance use disorder specialist (contracted position)

Who selects patients and what criteria do they use

Number of patients served in 2024: 2,448

If fire crews respond to a call and find that a person does not need emergent care, they ask the dispatch center if an FD CARES unit is in service. If an FD CARES unit is available, it is dispatched; if not, the responders note an FD CARES referral in the electronic care report. The intake coordinator receives all the referrals and sends out an FD CARES unit within 48 hours of the referral. FD CARES also receives referrals from the police department and Valley Medical Center. Most referrals come in from the field, but hospitals also supply some referrals.

Community partnerships

The FD CARES program works with senior centers, the local health department, King County departments and school districts.

Funding

- King County Medic One Levy
- Puget Sound Regional Fire Authority general fund
- Interlocal agreements with local fire departments

The King County Medic One levy started in 2018; the program was previously paid for from the county's general fund.

Sustainability

Program managers are generally not worried about program funding because leadership has supported the program primarily through the King County Medic One levy and general funds. The FD CARES program is the fastest growing, highest demand program at the Puget Sound Regional Fire Authority, and FD CARES can establish contracts with other fire departments when those municipalities want its services.

Measuring success

The program currently measures:

- The number of 911 calls
- How long nurses and social workers spend with the patient
- What services nurses and social workers provided or connected patients with
- The location the patient called from

The program has not been tracking a reduction in 911 calls because it receives referrals after the patient has called once or twice. They also have a transient population, so they may see someone once or twice and then the person moves to another nearby city. This could be another reason why there would not be repeat 911 calls. Program managers would like to have a regional database, to better track how their patients use other nearby service providers.

Program managers said the patient success stories show the program is working and they share these anecdotes with public officials.

Barriers and challenges

The main challenge of the program is recruiting qualified people to do the work. It would be great if colleges made mobile integrated health training part of nurse and social worker clinical rotations, so students are aware of paramedicine as a potential career path.

While Puget Sound Regional Fire Authority leadership has made FD CARES a core service, paid for through the Puget Sound Regional Fire Authority general fund, a lack of long-term sustainable funding is a challenge.

South County Fire Community Paramedic Program

Areas served: Cities of Edmonds (under contract), Lynnwood, Mill Creek, Mountlake Terrace, Brier and unincorporated areas in southwest Snohomish County.

When and why program started

In 2013, the South County Regional Fire Authority noticed an increase in 911 calls related to behavioral health and other health problems the fire department was not trained to manage. These calls affected its standard fire operations because they diverted paramedics and vehicles away from actual emergencies such as motor vehicle accidents.

The department started a pilot program with one community paramedic and found that calls from frequent 911 callers decreased by 50%. The program was officially established with funding from the Verdant Health Commission.

Program goals

The broad program goals are to:

- Reduce the burden on emergency response and health care systems by addressing nonemergent needs
- Expand access to behavioral health services, including opioid use disorder treatment
- Improve health equity through targeted interventions for underserved populations

The objectives to accomplish these goals include the following:

- Reduce avoidable emergency room visits and hospital readmissions by 50%
- Enhance patient access to care through home visits, telehealth and community outreach initiatives
- Improve chronic disease management for underserved populations by providing personalized, proactive care plans
- Reduce overdose fatalities and recidivism by providing harm reduction and treatment access
- Build sustainable partnerships with local health care providers, payers and community organizations to ensure long-term viability

Services provided

24/7 Community Response Paramedic Acute Crisis Response. Community resource paramedics meet with patients at home to address needs including:

- Behavioral health crises
- Social determinants of health
- Preventable at-risk older adult falls
- Care after hospital discharge

Care Coordination. Community health workers meet with patients to address needs relating to:

- Substance use disorder
- Mental and behavioral health challenges
- Domestic violence
- Homelessness
- Older adult care
- Hoarding
- Food insecurity
- Medication adherence

Coordinated Overdose Response by EMS program. Community resource paramedics and health workers address the opioid crisis by:

- Providing Narcan Leave-Behind kits
- Having paramedics administer medication for opioid use disorder during 911 calls
- Coordinating care with other service providers
- Following up with patients

Community Resource Outreach and Education. Community resource paramedics and health workers host pop-up events, attend conferences and conduct public education sessions. These events cover a range of topics, such as emergency preparedness, substance use disorder prevention, fall prevention for at-risk older adults, and how to navigate local health and social services.

Facilities and Falls Prevention. A community resource specialist evaluates residents' environments in both assisted living facilities and the broader community to identify potential hazards and offers practical solutions, such as installing grab bars, rearranging furniture, improving lighting and recommending mobility aids.

Staffing

- Deputy chief of EMS
- Two community resource paramedic captains
- Four, 24/7 community resource paramedics
- One day position community resource paramedic
- Four community health workers
- One community resource specialist
- One administrative assistant

Who selects patients and what criteria do they use

Number of patients served in 2024: 2,257

Initially, the fire crews referred someone to the community paramedic program after responding to 911 calls multiple times – twice in a week or three times in a month. Now that the community paramedic program is staffed 24/7, 911 calls are triaged to determine which are the most critical before the community paramedic responds to a call.

Community partnerships

- Police departments
- Other fire agencies
- Detox centers
- Hospitals
- Behavioral health centers
- Assisted living facilities and senior centers
- Disability services
- Social service agencies providing food and housing assistance

Funding

- South County Fire
- Verdant Health Commission
- North Sound Accountable Community of Health (ACH)
- Co-Responder Outreach Alliance (CROA)

Sustainability

Program managers worry about the sustainability of their funding sources. They spend so much time researching and applying for grants that it takes time away from patient care.

Measuring success

The program currently measures:

- Number of patients served
- Reduction in the number of 911 calls
- Reduction in avoidable trips to the ER
- Reductions in time saved by not having to respond to nonemergency calls
- Cost savings associated with fewer emergency transports, hospital admissions and departmental expenses

Program managers said they measure the patient outcomes every six months for about 1,000 patients. The information is reviewed for each individual patient, which is time-consuming.

Barriers and challenges

- Instability of grant funding cycles
- Outdated protocols for paramedics that do not allow them to administer specific medications to patients

Spokane Fire Department CARES Community Assistance Response Team and the Behavioral Response Unit

Areas served: Spokane County

When and why program started

In 2007, the Spokane Fire Department's fire chief approached the Eastern Washington University School of Social Work because the department was experiencing an increasing need for "social service assistance." At first, the EMS chief supervised social work students from the university doing their practicums, so the program did not have any paid staff. It originally focused on helping older adults with activities of daily living and general health care.

In recent years, the CARES Program has seen an increase in behavioral health and substance use disorder crises, but providing services to older adults is still a significant element of the program. The fire department also has a Behavioral Response Unit, which is dispatched by 911. While the CARES teams are not dispatched by 911, the Behavioral Response Unit refers patients to the CARES Program for follow-up.

Program goals

The primary goal of the CARES Program is to improve the public's quality of life and reduce unnecessary use of the emergency health care system by addressing social factors that affect health.

The primary goal of the Behavioral Response Unit is to stabilize patients facing a behavioral health crisis and escort them to the most appropriate form of care, diverting them from the ER when appropriate.

Services provided

- Assess patients' social service needs
- Develop plans for connecting patients with community resources that address their needs
- Advocate on behalf of patients
- Ensure patients have connections to help them improve their quality of life

Some examples of patient needs for referral include:

- Food, shelter and clothing
- Medication maintenance assistance
- Older adult care
- Emotional/crisis support
- Health care referrals
- Nonemergency transportation

The **Behavioral Response Unit** assesses patients' physical and behavioral health to determine if they should go straight to a mental health or substance use disorder treatment center, instead of an overcrowded ER. The unit has a mobile lab for paramedics to quickly perform a mental health assessment, contact an appropriate facility, and check the patient's vital signs and other lab values, such as blood alcohol content using a breathalyzer, as part of determining if someone is cleared for admittance. If patients meet the health criteria, unit staff can bring them directly to the facility rather than wait for clearance from ER physicians, making it more likely patients will receive needed care. The Behavioral Response Unit can also administer buprenorphine to help manage withdrawals after overdoses.

The fire department also runs a **Nurse Navigation program**, in which eligible 911 calls are transferred to a nurse who either gives self-care advice or helps the patient schedule a telehealth or urgent care visit. As of January 2025, the Spokane Fire Department plans to have the Nurse Navigation program also refer patients to the CARES Program for follow-up.

Staffing

CARES team:

- Three paid social workers
- Fifteen student volunteers
    - Eleven studying social work
    - Four studying nursing

Behavioral Response Unit:

- One paramedic
- One licensed mental health counselor (employed by Frontier Behavioral Health)

Who selects patients and what criteria do they use

Number of patients served in 2024: CARES team: 628, Behavioral Response Unit: about 400

Any fire district in Spokane County can refer to the CARES Program. Historically, most referrals have been from the Spokane Fire Department and the Spokane Valley Fire Department. The new Behavioral Response Unit now refers a large number of people to the CARES Program. While CARES teams can respond to calls, they are not dispatched by 911.

The CARES program manager plans to preemptively look at 911 call trends to identify frequent callers.

Community partnerships

- Aging and Long-Term Care of Eastern Washington
- Nonprofits like Meals on Wheels
- Spokane Treatment & Recovery Services (STARS)
- The Spokane Regional Stabilization Center

Funding

- City of Spokane EMS Funds
- City of Spokane Opioid Settlement Dollars
- Spokane Valley Fire Department
- Innovative Co-Response Program Grant

Sustainability

Program managers said they are concerned about the sustainability of funding, noting that grants are temporary. While they are still using funds from opioid settlements, this funding is at the discretion of the mayor and city council. Program managers would like to explore more sustainable funding options and ways to show the value of their work. They are now doing more public speaking, training and networking to improve their chances of obtaining more grant funding.

Measuring success

The **CARES Program** currently measures:

- Number of referrals
- Referral sources
- Referral outcomes
- Number of 911 calls pre- and post-CARES intervention
- Number of home visits
- The concern level of the referrals to prioritize patient follow-up (no concern, low concern, moderate concern, high concern)
- Average response time, resolution time and time spent
- Number of volunteer hours
- Referrals by zip code
- Reasons for referral
- Patient demographics

The **Behavioral Response Unit** currently measures:

- Number of patient contacts
- Number of diversions from the emergency room

Barriers and challenges

- Neither the CARES Program nor the Behavioral Response Unit can transport patients to places other than the ER because the fire department is not a transport agency.
    - Program managers are considering updating the contract with the ambulance company to allow for transport to other locations; however, reimbursement rates are lower for transport to treatment facilities, compared to an ER.

- If the Behavioral Response Unit medically clears someone for transport to an alternate destination, it is harder to get reimbursed because the transport is no longer considered medically necessary. As a result, patients are still often transported unnecessarily to the ER.
- The CARES Program is not new and so no longer has access to startup funding. Also, the program addresses any patient need – not just behavioral health – which further limits the types of funding it can pursue.
- The CARES Program does not have access to records at hospitals or other care facilities.
- The Behavioral Response Unit faces the same significant shortage in paramedics as other places in Washington and across the nation.
- The CARES program manager has limited capacity to build necessary relationships with other service providers.
- The co-response model sometimes faces political opposition and lacks community support, especially in areas with a lower tax base.

Walla Walla Fire Department Community Paramedic Program

Areas served: City of Walla Walla

When and why program started

The program started in late 2020 to address frequent 911 callers and high utilizers of the Walla Walla ER. The fire department started a pilot program with funding from Providence St. Mary Medical Center, because both shared an interest in reducing avoidable trips to the ER.

Program goals

Mental Health response

- Fully implement anti-psychotic injectable program by the year 2024
- Reduce mental health 911 response by 30% by the year 2028

Opioid Crisis response

- Fully implement "Narcan Leave-Behind" program by the year 2024
- Reduce opioid overdose responses by 30% by the year 2028

Fall Risk Reduction

- Fully implement this program by end of 2023
- Reduce fall-related EMS calls by 30% by 2025
- Reduce repeat patient calls for falls by 50% by 2028

Services provided

- Implementing an anti-psychotic injectable program
- Opioid crisis response
- Fall risk reduction
- Connecting patients to appropriate medical and social services

Staffing

- One paramedic
- One EMT
- One community RN nurse
- One social worker

Who selects patients and what criteria do they use

Number of patients served in 2024: 336

Most patients are referred to the CARES program through the fire department's paramedics. The paramedics record patients' information using tablets when they are out on service calls, which includes a mandatory question about whether a CARES referral is needed. Records are shared with the community resource navigator and with an EMT or nurse if the referral has a medical component.

Program staff can also review patients' call frequency and medical history and generate a list of patients who frequently call 911; the community paramedic team then reaches out to these patients. Program staff also receive direct calls from social service providers and calls from police through dispatch.

If there are no active referrals at the time, the community paramedic will outreach by meeting with people in the wider community.

Community partnerships

Program managers said they work with almost every social service in town. They also partner with Greater Health Now, the local Accountable Community of Health. Its staff want to learn from the community paramedics' work as they provide funding and guidance on how to operate the community paramedic program.

Funding

- Greater Health Now
- Walla Walla County Behavioral Health (county tax)
- Co-Responder Outreach Alliance (CROA) grant
- Opioid abatement settlement

Sustainability

Funding for the program is available for at least the next few years; funding from Greater Health Now is likely sustainable into the future, and the Behavioral Health funding was recently approved for an additional three years. However, the grant from the Co-Responder Outreach Alliance expires in 2025. Program managers said they will continue to apply for grants as they come around.

Measuring success

The program currently measures:

- Number of service calls
- Number of ER trips it helps avoid (new in 2025)
- Patient demographics
- Types of services provided

One challenge the program has in measuring success is that the data in its current system only goes back two years, so it is difficult to measure trends over time. Program managers also said if the 911 crew recognizes that the patient likely needs the CARES program, they divert many unnecessary 911 calls before they happen, which means these calls also cannot be tracked.

Barriers and challenges

Community paramedic programs need strong advocates and leadership support to get off the ground, someone with the vision to see that this program can work. This type of work is not well defined, varies by community and does not follow set procedures like the fire service usually does.

Another challenge to establishing the program is recruiting qualified people to work in expanded or nontraditional capacities. For example, the community paramedic program did not initially have a clearly defined way to allow nurses to use their skills in an EMS setting.

West Pierce Fire and Rescue Connected CARE Program

Areas served: Cities of University Place and Lakewood, Town of Steilacoom (contracted)

When and why program started

West Pierce Fire and Rescue was part of a mobile integrated health pilot program, with five other fire districts in Pierce County, in collaboration with the NW Physicians Network. This program provided case management referrals and services for frequent 911 callers, fire/EMS, ER and hospital services. After the pilot program ended, West Pierce Fire and Rescue considered several different models for community paramedicine and mobile integrated health, and concluded the program should focus on helping connect patients with existing community resources, rather than providing direct services. West Pierce Fire and Rescue's Connected CARE Program started in 2022.

Program goals

- Empower residents of West Pierce to manage their health care, behavioral health and social needs by helping them access proper community resources, which helps to reduce the number of frequent 911 callers
- Improve patient health outcomes and reduce these callers' reliance on the 911 system and ERs by providing short-term, intervention-focused case management

Services provided

The Connected CARE program manager coordinates with local service providers and connects patients with these services. Activities include:

- Provide education to patients on chronic medical conditions, as needed
- Provide referrals to patients for transportation, food, social services, substance use disorder services, Veterans Administration services, health care access and behavioral health resources
- Provide home visits to patients as needed
- Coordinate with other services such as medical providers, home health and hospice, and care facilities
- Help 911 crews, while on scene, to problem solve and coordinate care for patients needing assistance with nonemergent issues
- Provide ongoing education to 911 crews on available community resources

Staffing

One RN care manager as the Connected CARE program manager

Who selects patients and what criteria do they use

Number of patients served in 2024: 384

Firefighters and paramedics on emergency calls refer patients to the Connected CARE program when they identify people who may benefit from the program. The program serves anyone who needs help connecting to appropriate resources, whether or not they frequently call 911 for nonemergent reasons. Examples of referrals include patients who:

- Frequently call 911 for nonemergent hospital transports
- Live alone and need additional resources due to their declining health
- Have complex social and medical conditions for which traditional fire department resources are inadequate
- Have behavioral health challenges and do not know how to navigate the local health care system

Community partnerships

- Lakewood Police Department
- Pierce County Aging and Disability Resources
- Department of Social and Health Services
- Adult Protective Services
- Child Protective Services
- Other fire agency CARE programs in Pierce County

Funding

- EMS levy
- Ground Emergency Medical Transportation (GEMT)

Sustainability

Fire department leaders are not worried about funding to keep the program going because they use GEMT, which is now built into the program's system. The challenge will be in securing funding to expand it.

Measuring success

The program currently measures:

- Number of 911 calls before and after referral
- Number of ER visits before and after referral
- Number of referrals per month
- Reasons for referrals
- Referral status
- Patient demographics

The program manager also reviews monthly, department-wide data that tracks the number of times emergency responders assist someone with behavioral health needs. This data is used to better understand what the emergency responders encounter on 911 calls so they can educate the responders on the resources available to address specific situations.

Barriers and challenges

Fire department leaders needed measurable data to justify starting the program. While no one actively opposed the program, leaders had to show that it would be useful and meet long-term community needs.

Appendix E: Nonemergency Data by County

This appendix lists the results of the county-level analysis described on page 24 of the report. The first column shows the number of fire agencies that lead or participate in a CARES program, as determined by the auditors. High results in the other columns may suggest a greater need for CARES programs.

Text in bold shows the three highest results for each category. Highlighted cells show the ten highest results. For example, the table shows Adams County is high in all three indicators, while Asotin, Kitsap, Mason, Skamania and Wahkiakum counties are high in two.

County	Number of fire agencies with a CARES program	Percent of 911 EMS calls that were nonemergencies with low acuity	Percent of ER visits that were avoidable	Primary care health professional shortage area
Adams	0	14.6%	8.1%	**15**
Asotin	1	13.4%	8.3%	
Benton	2	11.4%	8.3%	
Chelan	1	9.8%	7.3%	
Clallam	3	12.0%	5.7%	
Clark	2	13.5%	4.6%	
Columbia	1	3.6%	7.2%	
Cowlitz	1	15.0%	6.0%	
Douglas	1	11.7%	7.7%	
Ferry	0	1.6%	6.2%	**17**
Franklin	1	9.9%	**11.3%**	
Garfield	1	2.8%	5.5%	12
Grant	1	5.6%	7.0%	
Grays Harbor	2	1.2%	8.5%	
Island	1	2.9%	6.5%	13
Jefferson	4	9.6%	5.9%	
King	**19**	3.6%	5.9%	
Kitsap	5	11.9%	8.6%	11
Kittitas	3	0.2%	**10.7%**	
Klickitat	0	3.0%	6.4%	
Lewis	2	6.8%	5.2%	
Lincoln	0	2.9%	6.7%	9
Mason	3	18.2%	**10.3%**	

County	Number of fire agencies with a CARES program	Percent of 911 EMS calls that were nonemergencies with low acuity	Percent of ER visits that were avoidable	Primary care health professional shortage area
Okanogan	0	2.4%	6.9%	
Pacific	0	8.2%	7.1%	
Pend Oreille	1	5.4%	8.8%	
Pierce	**5**	3.1%	7.6%	
San Juan	1	10.2%	6.7%	
Skagit	4	11.3%	6.4%	11
Skamania	1	**19.5%**	5.1%	**15**
Snohomish	4	5.7%	5.3%	
Spokane	2	**22.3%**	5.7%	
Stevens	0	11.3%	6.7%	
Thurston	3	5.6%	5.8%	
Wahkiakum	0	**20.5%**	6.5%	**15**
Walla Walla	2	14.4%	6.7%	
Whatcom	**9**	12.0%	4.9%	
Whitman	1	1.0%	7.0%	
Yakima	0	6.8%	8.4%	

Sources:

- The percent of 911 EMS calls that were nonemergencies and low acuity cases, as categorized by first responders. Fire agencies may differ in how they enter the data (based on how they were taught to classify it), which could account for some of this variance. **Source:** Calculated by auditors using 2024 data from the Washington EMS Information System, which is managed by the Department of Health.
- The percent of ER visits that were avoidable. **Source:** Washington State Hospital Association.
- Primary Care Health Professional Shortage Areas (HPSA) scores. **Source:** Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services (HHS)

See Appendix B for more information about these sources.

Bibliography

This bibliography contains several resources used during the audit that readers may find helpful.

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