OneCall: Single Diversion Portal

Pilot Study Design

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Acronyms and Abbreviations

BLS: Basic Life Support

CARES: Citizen Advocates for Referral and Education Services

CCAC: Community Care Access Center

CMT: Community Medical Technician

CREMS: Community Referrals by Emergency Medical Services

ECLS: Extended Client Lookup System

ED: Emergency Department

EMS: Emergency Medical Services

EMT: Emergency Medical Technician

ER: Emergency Room

FEDU: Frequent Emergency Department Users

FD: Fire Department

GEMS: Grady Emergency Medical Services

MIH: Mobile Integrated Health

MHP: Mobile Health Provider

SFD: Seattle Fire Department

VPSI: Vulnerable Populations Strategic Initiative

Introduction

The following report discusses the rationale, structure, and objectives of the OneCall single diversion portal pilot project. The intention of this report is to plan for the implementation of OneCall, a service meant to be used by EMS responders for information gathering and referrals of low acuity patients to community resources. It is designed to reduce the use of EMS resources by addressing the needs of low-acuity patients who call 911 in King County, Washington. OneCall consists of a partnership between Crisis Connections, Shoreline Fire Department, South King Fire Department Cares, Seattle Fire Department Health One, South King Fire and Rescue, and Valley Regional Fire Authority. This OneCall pilot will be evaluated after it has operated for a 12-month period

Background

Emergency department (ED) visits are increasing in the United States. In 2015 there were 136.9 million ED visits in the US, a 4% increase from 2012 (Giannouchos et al., 2019, p. 421). In addition, the use of the ED by the same individuals is increasing faster than overall average. For example, between 1999 and 2009, visits by repeat ED users increased 83%, while overall US ED visits increased only 30% (Giannouchos et al., 2019). Frequent users of the emergency department (FEDUs[1]) have been identified as a cause of ED overcrowding (Solberg et al., 2016)1. It is estimated that FEDUs make up only 1% to 10% of ED populations, but comprise up to 10% to 34% of ED visits (Giannouchos et al., 2019). Data collected and analyzed by the University of Virginia of ED visits during the year 2012 at a rural Level 1 Trauma Center revealed that 59,629 visits were made by 38,213 patients. Of those, 1,242 were identified as having visited the ED multiple times that year and accounted for 17% of the overall ED visits (Solberg et al., 2016, p. 460). A possible method of reduction in ED visits can be found in how these patients arrive to the ED.

Low-acuity patients and EMS use in King County

The number of visits made by FEDUs are a concern not only for emergency departments, but also for professionals involved in prehospital care delivery. An important commonality between FEDUs is their method of arrival to the ED. In Solberg et al, patients identified as frequent ED users arrived to the ED most often via ambulance, comprising 32% of total transports made to an institutions ED in 2012 (Solberg et al., 2016, p. 460). Because it is already a known point of entry for frequent ED users, EMS may be more effectively leveraged as an avenue to redirect care and to mitigate overuse of emergency services. Further data analysis found some commonalities among FEDUs that could be addressed by changing the method in which they receive care.

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[1] For the purpose of this report, individuals who have visited the ED four or more times in the past year are considered a FEDU.

Characteristics of FEDUs

There are several characteristics common among FEDUs. Research shows that FEDUs have complex medical and social needs in addition to lacking access to regular health care and other resources. According to Giannouchos et al. commonalties include:

- Medicaid or Medicare as primary insurance
- Utilize unemployment benefits
- Have an established primary care provider
- Report their perceived health status as fair or poor
- State their main reason for going to the ED is the seriousness of their particular issue

In a study by Solberg et al., FEDUs had high illness severity scores, higher mortality, and higher rates of chronic disease, further suggesting that FEDUs are medically complex patients in need of adequate and consistent care—care that emergency services are not equipped or designed to provide (Solberg et al., 2016). Overall, FEDUs are able to access some care, but have chronic health conditions requiring frequent health care utilization that is not being addressed through this limited access. Referrals made through OneCall are intended to address this gap in care by giving these patients a method to access consistent care.

Social and Behavioral-Health Factors

FEDUs have several common social and behavior-health factors that further complicate their health care needs. Homelessness, mental illness, substance abuse, and behavioral health disorders were found to be common among the FEDU population (Giannouchos et al., 2019). Of the FEDU population studied through a systemic literature review, mental illness was highly prevalent with rates of mental illness between 62% to 77% of the population. Identified mental illnesses were depression, panic attacks, anxiety, and bipolar disorder (Giannouchos et al., 2019, p. 426). Those FEDUs who are experiencing a behavioral health crisis often are facing several related issues. They need medication assistance, are currently experiencing homelessness, and/or are undergoing another health crisis stemming from socioeconomic disparities.

Homelessness is a leading independent risk factor for utilization of emergency care (Amato et al., 2019, p. 415). In a 2010 retrospective cohort study of patients in an urban EMS system, homelessness was associated with frequent EMS use eight times as frequently as other controls (Tangherlini et al., 2010). In King County, another source of information about this population is the Point-In-Time Count. This activity collects data detailing the needs of individuals experiencing homelessness in order to inform successful intervention. Information is gathered through surveys conducted at a single point in time with individuals experiencing homelessness that are willing to participate. The King County Point-In-Time Count on January 29, 2019, found that 11,199 individuals in King County, Washington, were experiencing homelessness. Sixty-four percent of these individuals reported they were living with a least one health condition. The most frequently reported conditions were psychiatric or emotional (36%), post-traumatic stress disorder (35%), and drug or alcohol abuse (32%). Twenty-seven percent (27%) of respondents reported chronic health problems in addition to these conditions (Count Us In, 2020).

Of the 70% of respondents in the 2018 Point-In-Time Count who indicated that they experienced one or more health problems, only 18.6% indicated that they were able to utilize mental health services, and only 9.7% were receiving alcohol or drug counseling (Marren, 2018). Another study revealed that those living homeless are over seven times as likely to return to the emergency department within 30 days of a visit (Weber et al., 2013). Identified barriers to care for the homeless population in general include: lack of available resources, transportation, knowledge of where to obtain services, and lack of care coordination (Weber et al., 2013). Because of the complex needs of patients experiencing homelessness, a variety of differing care sources are needed to adequately care for them.

The Need for Diversion

Just as the complex needs of FEDUs result in disproportionate use of EDs that cannot ultimately meet those needs, this situation also puts a burden on the EMS system, with similarly and inevitably inadequate results. ED utilization alone is insufficient to deliver the range of services FEDUs often require.

King County EMS serves a population of over 2 million and covers an area of 2,134 square miles (Friedrichsen et al., 2018). It operates through a system of tiered responses according to need to ensure the most appropriate level of care is given. In 2018 Seattle King County Medic One/EMS responded to 268,481 incidents. Basic Life Support (BLS) calls made up 194,179 of those incidents, and of those BLS-only incidents, 65,549 were not transported to an emergency room (Emergency Medical Services 2019 Annual Report, 2019). This means that 30% of EMS responses in 2018 may have been averted if the patient had been put in contact with alternate sources of care.

The City of Seattle utilizes a fire-based EMS system, meaning calls are responded to by a local fire department. Difficulty arises when these first responders encounter an individual experiencing a low-acuity behavioral health crisis (Albright, 2016) and are unable to provide more comprehensive care. These professionals provide evaluation, treatment, stabilization, and, when required, transport. The needs of these low acuity patients with complex medical and social needs go beyond what Medic One/EMS providers can offer. Emergency Medical Services specialize in acute, critical incidents that involve medically stabilizing the patient for transport to a medical facility, not illnesses related to social inequities requiring methodical and time-intensive efforts. Therefore, it becomes essential to explore methods to divert low-acuity patients from utilizing EMS resources as their first point of contact for care. The need to increase system efficiencies and take advantage of existing structures, while reducing the number of low-acuity calls made and responded to by EMS initiated the development of the OneCall pilot study.

Review of Alternative Avenues of Care for low-acuity FEDUs

A review of previous pilots and studies to determine effective measures to address the needs of low-acuity FEDUs and reduce use of EMS resources in King County informed the creation of OneCall. After analyzing programs aimed at reducing EMS usage by FEDUs, a pattern emerged. The factors consistently correlated to improved patient care and reduced burden of care are coordination among case managers, social services, mental health, and transportation services to ensure continuity of care; use of shared data among systems; and, most noteworthy, giving

EMS providers authorization to evaluate and then refer patients to appropriate resources via nurse call line or similar method. Any service area endeavoring to achieve similar goals should benefit from a program that includes these factors. Programs intending to address these patterns that have been implemented across the United States and are known collectively as Mobile Integrated Health (MIH).

Mobile Integrated Health (MIH)

A MIH approach can have a greater impact than episodic care in reducing the number of low-acuity calls handled by EMS by utilizing alternative sources of care outside of emergency services. The purpose of MIH programs is to connect individuals who access the EMS system to appropriate social services and health care providers. MIH programs offer several benefits, most important of which is the ability to meet the patient where they are to aid them in their healthcare decision making. MIH programs utilize strategic partnerships to improve access to care through patient-centered information delivery (Beck et al., n.d.). For example, individuals with asthma who do not have a primary care provider are more likely to call 911 and use EMS resources for their care than individuals who have a primary care provider (Tangherlini et al., 2010). When a patient is aided by programs based on MIH practices, they are informed and more able to make appropriate choices, such as establishing care with a primary care provider to control their chronic conditions.

MIH programs are designed to improve health outcomes for a defined population, such as frequent ED users suffering from disparities in socioeconomic status, by integrating systems of care together. When fewer low-acuity patients rely on emergency services, emergency responders have more availability for high-acuity patients (i.e. patients with life-threatening medical emergencies). MIH programs create stronger collaborations between fire/EMS and community service partners, leading to improved patient outcomes (Roeper et al., 2018).

Examples of MIH Programs and their Outcomes

A 2012 cohort study determined the effects of an EMS-based case management and referral intervention known as the San Diego Resource Access Program (RAP) to reduce EMS, ED, and inpatient visits. The results showed marked reduction in the use of EMS resources through EMS-based case management and referral intervention (Tadros et al., 2012). EMS personnel identified and addressed repeated calls to 911 by referring individuals to the RAP coordinator, who then interfaced with primary care physicians, homeless service agencies, street outreach teams, hospital social workers, case managers, and adult protective services to get individuals the care they needed to maintain their health properly. Clients of this service receive education regarding what situations would require a call to 911, and which situations would be better served through alternative means such as primary care or social services. Links between other services like those that could provide transportation, housing, and mental health services were also provided. The study determined that EMS encounters decreased 37.6%, from 736 to 459, due to the RAP. ED visits were decreased by 28.1%, from 199 to 143 (Tadros et al., 2012, p. 544).

Community Referrals by EMS (CREM) is a similar approach that has been tried by other countries and states with some success. The main purpose of referrals made by EMS in these programs was to connect patients with low-acuity needs such as mental or substance use services to Community Care Access Centers (CCACs). This diverted patients away from the ED, and to sources of care that better serve their particular needs (Verma et al., 2018).

The Hennepin County Medical Center in Minneapolis, Minnesota, in response to the overuse of its emergency department, created the Hennepin County Medical Center's Coordinated Care Clinic. The Coordinated Care Clinic integrates primary care, behavioral health services, care management, and assistance to address social needs into a single location. These services are provided by a clinic-based nurse and social workers specializing in community care. This clinic involves several regional partners – encouraging continuity of care and follow-up care adherence. Following the implementation of this intervention, emergency department usage decreased by 38% (Henkel & McCarthy, 2016).

Grady EMS (GEMS) in Atlanta, Georgia, found that 6% of 911 calls in their operating area were related to mental health. In January 2013, the Grady EMS Upstream Crisis Intervention Group was implemented. As a part of this intervention, instead of an ambulance responding to a call that is mental health related, a team comprising a paramedic and a clinical social worker arrive on scene to assess the patient. From there, telehealth is utilized to connect the patient with a mental health professional. This team can also schedule the patient for mental health appointments or transport them to a psychiatric facility. When not responding to calls, this team visits the homes of frequent emergency department users to help coordinate their care. Following the implementation of the GEMS Upstream Crisis Intervention Group, FEDU's with mental health concerns fell 50% (Munjal et al., 2018).

MedStar Mobile Healthcare in Fort Worth, Texas, created a 911 Nurse Triage line, intended to divert low-acuity patients from the emergency department. Calls made to 911 that qualify as low-acuity are referred to a call center to speak with a specially trained registered nurse, who assists the patient in finding appropriate resources for their specific health need. Since June 2012, 5,175 low-acuity 911 callers have been referred to this program, and 35.7% of those callers had a response other than an ambulance transport to the emergency department. Also, as part of the High Utilizer Program at MedStar, patients who use 911 services 15 or more times in 90 days are referred for its services. Enrollees receive home visits made by MedStar's Mobile Health Providers (MHPs), are connected to available resources, and receive education on how to manage their own healthcare. This program reports that it helped avoid more than 4,800 ambulance transports and 1,917 emergency department visits (Munjal et al., 2018).

King County MIH Models

Past efforts to connect low-acuity patients with alternative sources of care in Seattle have been integral in the rationale for the OneCall pilot. MIH programs currently functioning within the boundaries of King County utilize either of two models. The response model provides services and makes connections at the time of the 911 call and allows for ER diversion. The referral

model provides services and connections after the 911 call through home visits and coordination with multiple providers.

The Community Medical Technician Pilot III was a strategic initiative implemented in King County to address social and behavioral needs in prehospital medical care. Meant to offload low-acuity calls to a responding Community Medical Technician (CMT), the CMT Pilot III project also identified individuals who needed to connect with community-based, health, or social services. For this pilot, three CMT units were utilized: one in partnership with the Puget Sound Regional Fire Authority FDCARES program; one led by the Shoreline Fire Department and also covering the area from Bothell Fire and EMS and Woodinville Fire and Rescue. The last was operated by South King Fire and Rescue and Valley Regional Fire Authority. Though the time spent on scene was longer for BLS units during this CMT Pilot, this was expected due to the nature of patients' needs (Friedrichsen et al., 2018). For example, patients experiencing homelessness or who suffer from mental illness require more time from providers to understand which treatment or aid will most adequately and appropriately address individual patient needs.

Overall satisfaction of patients was high – 97% of those assisted through this pilot responded "very satisfied" and "satisfied" in follow-up surveys. Responders staffing the CMT units also responded favorably. Evaluation of the Community Medical Technician Pilot III brought forth the conclusion that an overarching framework for the CMT and similar programs was needed to provide a method for identifying and assisting "repeat request customers" who utilize the EMS system frequently, and appropriately, refer individuals to community health, mental, and social resources to improve connection and coordination with needed health care (Friedrichsen et al., 2018).Frequent 911 callers with low-acuity needs and patients with complex, long-term disease management needs can be served through the implementation of an MIH program. OneCall is supported by the information gathered from these previously employed programs.

OneCall and Crisis Connections

OneCall is a telephone referral service for EMS providers intended to provide patients with resources outside the traditional 911 response pathway.

Diverting FEDUs successfully requires meeting the patients where they are through an initial interaction with 911 responders. During this interaction, patients begin the process of becoming "tiered". The first responder is able to utilize OneCall to get information for the patient that will enable them to connect with a care coordinator. The care coordinator can then work with the patients to establish them with a care management team. The care coordinator and the patient's care management team work together to act as a safety net to both prevent and treat the patient should another behavioral crisis occur. Once a patient has been tiered, they are informed of the benefits of engaging with care providers without EMS assistance, successfully diverting an EMS response.

OneCall is part of Crisis Connections which allows all individuals in King County experiencing emotional distress or a behavioral health crisis to be connected to a comprehensive database of health and human services available in the state. By dialing 211, individuals speak with a Crisis Connections specialist for assistance in reducing immediate risk of violence to oneself and others. Through this service, individuals in need are able to talk to a professional that can access a safety net of more than 5,000 services and 1,500 agencies ("Crisis Connections").

Figure 1. Response Pathways for ER Diversion

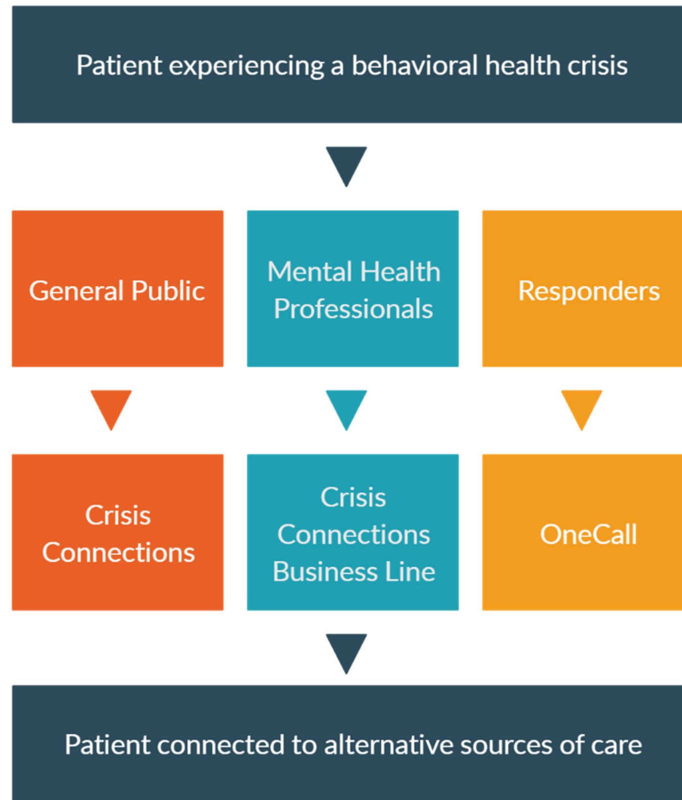


Figure 1 shows the three options to initiate care outside the emergency room for a low-acuity patient experiencing a behavioral health crisis through Crisis Connections. Each option connects the patient to similar sources of care, but the pathway of getting to the care differs based on caller characteristics such as general public, mental health professionals or EMS responders.

Mental health professionals with specialized training are meant to call a separate business line to Crisis Connections, where their specific needs can be better met. These mental health professionals are usually calling from hospital EDs or other healthcare entities on behalf of patients in crisis related to behavioral health, substance abuse, or homelessness.

OneCall is meant to address the specific needs of first responders. OneCall fields inquiries from EMS responders specifically, rather than the patients themselves. Referral options for first responders through OneCall and offered by Crisis Connections include:

- Mental health triage

- Emergency mental health appointments
- Shelter options
- Next-day medication assisted treatment for opioid use
- Problem solving
- Safety planning
- De-escalation

The criteria for referral through OneCall include any low-acuity incident including anyone experiencing a behavioral health crisis, homelessness, or a situation due to social determinants of health within King County. Criteria is based on previous information gathered through the Vulnerable Populations Strategic Initiative (VPSI). The VPSI is a collaboration between Public Health – Seattle & King County, the Emergency Medical Services Division, fire departments, community-based organizations, and the University of Washington with the intention to inform and "ensure that the interface between EMS and vulnerable populations is of the highest quality" (Meischke & Plorde, 2018 p. 3). The VPSI needs assessment found that the majority of the respondents felt that there were challenges to delivering EMS services to individuals specifically experiencing homelessness, mental health conditions, or substance abuse (Marren, 2018). Inclusion criteria will be further assessed throughout the duration of the pilot to determine which patients are best served by the capabilities of OneCall.

Figure 2. OneCall Flow Chart

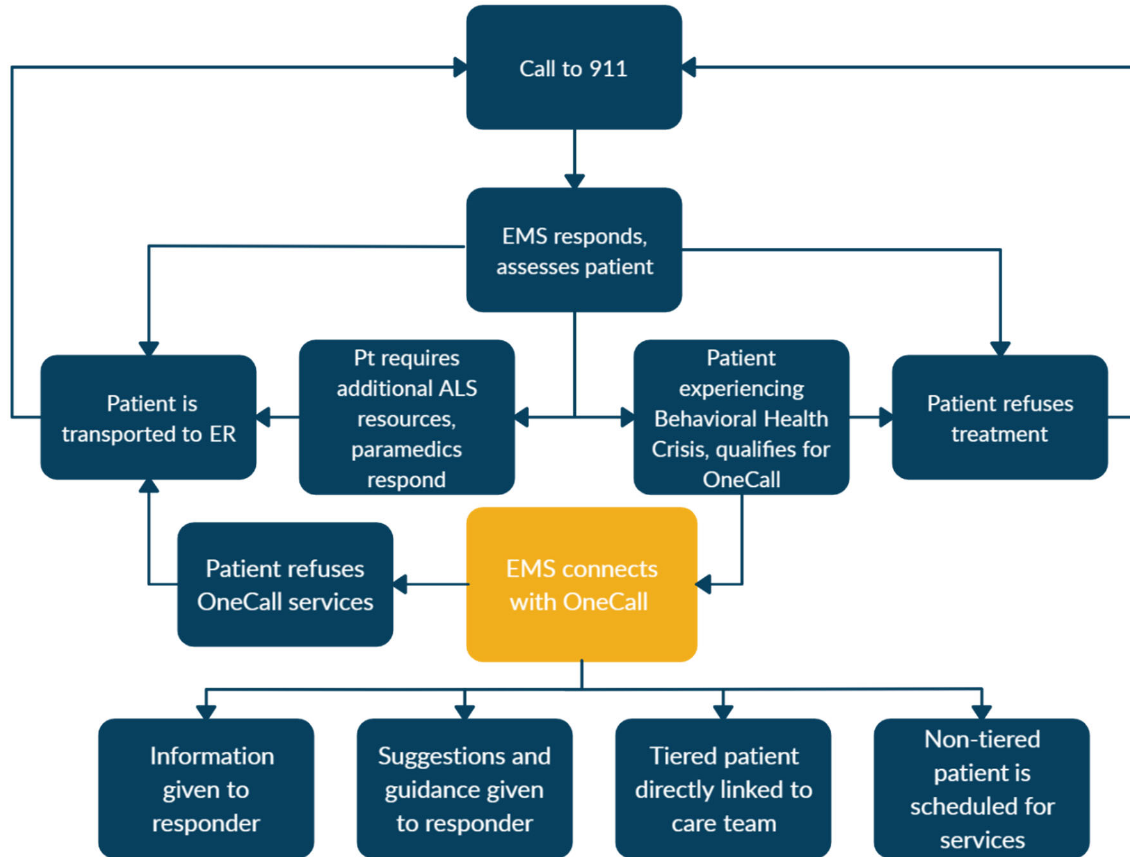


Figure 1 portrays the OneCall pilot process. After an individual calls 911 for help, the dispatcher routes an EMS unit to the scene. From there, EMS assesses the situation and moves forward with the appropriate response. This might be calling for ALS (Advanced Life Support) from paramedics for a critical health condition. If the patient is stable but in need of assistance, such as a patient with suicidal ideation, transport to the emergency room may not be the best option for this patient. If the patient is experiencing a behavioral health crisis, for example, EMS can utilize OneCall to receive aid and information from trained professionals who specialize in mental health to be informed of the next step for the patient. This call to OneCall links the EMS responder to a trained professional at Crisis Connections who is able to access the Extended Client Lookup System (ECLS), and inform the EMS provider if the patient is tiered or of any previous encounters with the patient. From there, Crisis Connections is able to give information

to the EMS provider to better care for the patient or to help the patient establish a connection for further evaluation and care.

A patient who has previously experienced a behavioral health crisis is able to mitigate a future crisis through OneCall by developing relationships with a care management team meant to stabilize their condition. Following an encounter with EMS, should the patient fit the criteria for a low-acuity health condition, they are notified of the benefits of calling 211 rather than 911 in the event that this type of incident happens in the future. Community resources and stakeholders must coordinate systematically to meet this shared vision of reduced reliance on 911 responders for low-acuity care. There are several agencies working towards this goal.

Partnering Agencies:

The OneCall pilot project is a partnership between several fire departments, and Crisis Connections.

Shoreline fire department operates within King County as an independent government agency. Defined as a special purpose district, Shoreline fire department provides fire suppression, emergency medical, and fire prevention services to the approximately 53,000 citizens, and 13 square miles of Shoreline, Washington (Shoreline Fire—About Us, 2020).

Seattle Fire Department and Medic One comprise five battalions containing 33 stations, and as of 2018 is staffed by 1007 uniformed personnel. According to their annual report, Seattle Fire/Medic One responded to 149,844 emergency calls in 2018. In 2019 Seattle Fire launched the Health One program. As part of this program, teams of specially trained firefighters and civilian specialists respond to low-acuity calls to help connect individuals with appropriate services (Schmanke, 2019).

South King Fire & Rescue, headquartered in Federal Way, Washington, comprises five former fire districts serving almost 150,000 citizens and covering almost 41 square miles (South King Fire & Rescue, WA - Official Website—History, 2020).

Valley Regional Fire Authority serves the communities of Algona, Auburn, and Pacific, comprising 80,000 citizens on 37 square miles. VRFA fire fighters work in teams of two or more, staffing fire engines 24 hours a day and responding to all types of emergencies, including aid calls (About Valley Regional Fire Authority, 2020).

Multiple entities came together for the creation of OneCall. In addition to the partnering agencies, OneCall is a culmination of years of research and collective efforts by Seattle King County and the University of Washington.

Goals

It is expected that at scene connecting to OneCall telephone referral service will reduce the number low acuity patients utilizing emergency resources by employing a coordinated network of resources befitting patients non-emergent needs. The goal of the OneCall pilot project is to discover and test the infrastructure needed to successfully deliver services to the community through cohesive and comprehensive referral management.

Increasing the number of individuals enrolled (i.e., “tiered”) in non-acute care services with the intent to decrease dependency on emergency services is key to the success of OneCall. Emphasis is placed on fire departments and mobile integrated health agencies working together to manage patients through referral via phone call to a centralized source of information for King County.

The intention of these EMS-based referrals is to connect patients with behavioral health needs to more appropriate sources of care out of the emergency room, and patients with chronic conditions to stable sources of care, such as a primary care providers. Addressing issues stemming from disparities in social determinants of health through comprehensive care management will reduce the need for emergency services needed by FEDUs.

Methodology

Deliberate steps were taken to inform the development of the OneCall pilot study, including:

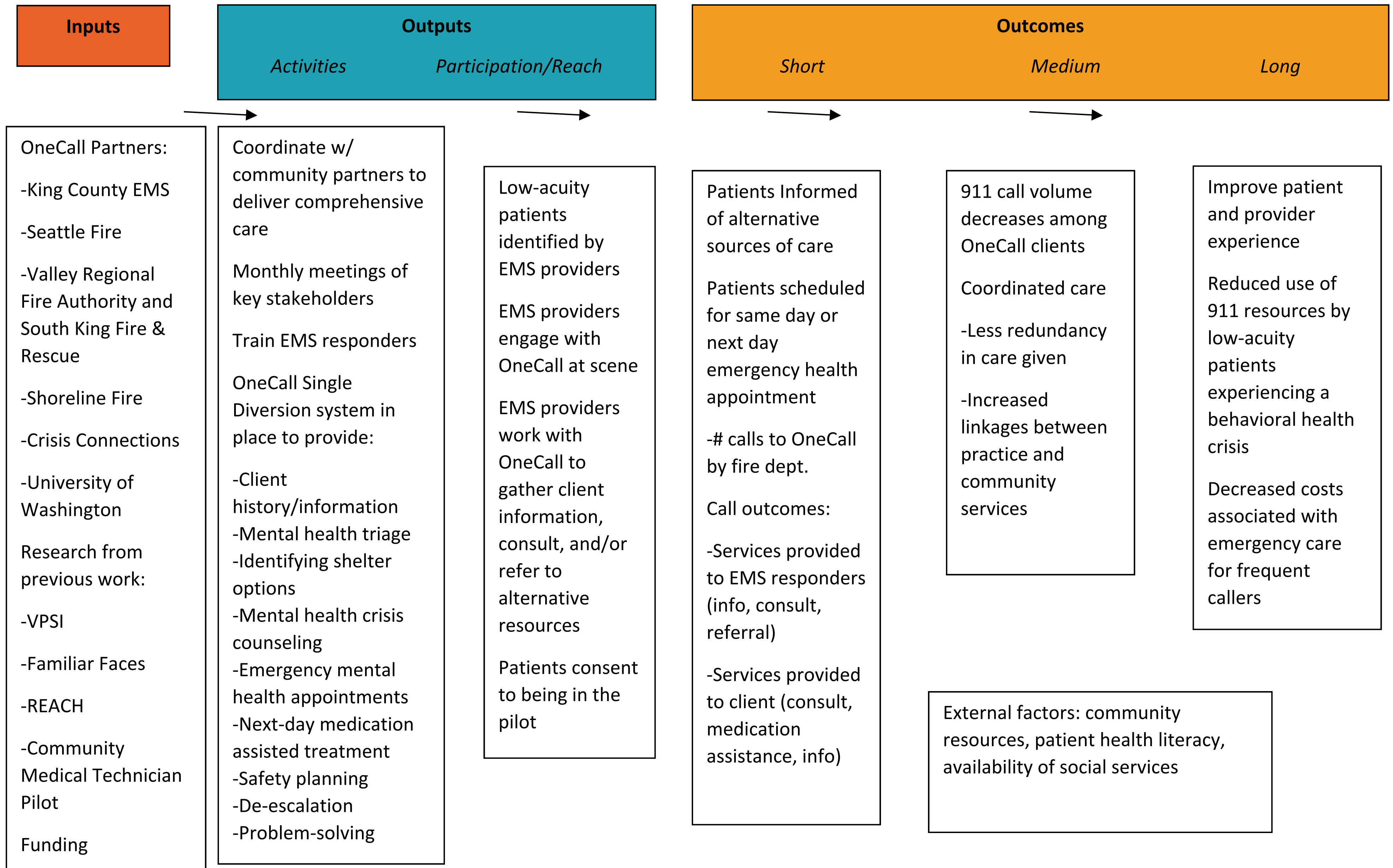
- Identifying crucial data
- Ensuring the proper data could be collected
- Monthly meeting of partners to review progress and adjust processes as necessary
- Regular check-ins with EMS Director to assure objectives are being met
- As-needed meetings with partners for information gathering

Required activities included monthly meetings with key stakeholders, as well as trainings held for each EMS agency. Information for this pilot study report was gathered from previous work done in other areas of the United States; however, the foundation for this pilot is based on the work of the Vulnerable Populations Strategic Initiative (VPSI). OneCall was launched in October 2019 with the intention to hold monthly meetings of pilot partners to address any needed adjustments as well as assess the working inclusion criteria. Based on previous pilots implemented and research done in King County, OneCall established a partnership of streamlined infrastructure among King County EMS, Seattle Fire, Valley Regional Fire Authority and South King Fire & Rescue, Shoreline Fire and Crisis Connections. The pilot was designed to operate for 12 months. This pilot report established the implementation of OneCall; evaluation will be completed following the conclusion of the pilot in October 2020.

Logic Model

The participation of the EMS providers in the OneCall pilot project results in short, medium, and long-term outcomes that culminate into reduced use of 911 resources. The logic model (see Figure 3) shows the implementation process, activities, and expected outcomes for the program. The focus of this paper is on the development and description of the implementation process and implementation outcomes of OneCall.

Figure 3. OneCall Single Diversion Portal Logic Model



Evaluation Objectives

The implementation of OneCall was carefully planned to allow for periodic evaluation as well as the final evaluation to come following the duration of the pilot. This will enable further work to be done to improve health outcomes for the Seattle King County population. Several objectives were set to measure success of OneCall.

- Evaluate the utilization of OneCall for low acuity patients who call 9-1-1 to measure success

Utilize the recorded number of patients identified by EMS responders as eligible for the OneCall referral program on a monthly basis for the duration of the 12-month pilot program, and compare to the number of times OneCall was utilized for similarly characterized patients. King County EMS provides the number of responses made by EMS. OneCall gathers agency call logs and records the number of times each agency calls for assistance. A significant difference in the number of patients identified and the number of calls made to OneCall would indicate that further examination will be required regarding how OneCall can meet the needs of the population in King County. An increase over time in the use of OneCall suggests a successful pilot.

- Assess the frequency and types of information given by OneCall to divert low-acuity patients from utilizing emergency services.

The types of information given by OneCall are categorized and recorded. Researchers will examine the OneCall call log supplied by Crisis Connections to determine the most and least utilized services. This will inform proper allocation of resources and provide insight into the needs of this population.

- Summarize and examine feedback from EMS providers regarding the use of OneCall to recognize any potential areas of improvement.

Using qualitative and quantitative data gathered through interviews with participating care providers from Shoreline FD MIH, South King FD Care, SFD Health One, South King BLS, and Valley Regional BLS, determine if there are areas in need of improvement to facilitate the use of OneCall. Barriers, successes, lessons learned, and recommendations for future projects of this kind should be documented. Data can be examined to illustrate any concerns regarding the OneCall infrastructure as well as opinions on the pilot. Areas in particular to be addressed include ease of use of OneCall and knowledge of OneCall's capabilities.

Overview of Data Sources

King County EMS Data

The overall number of low-acuity calls and other pertinent data in relation to the number of calls and responses made by EMS related to low-acuity behavioral health issues will be provided by King County EMS. Low-acuity refers to a patient either experiencing a behavioral health crisis, homelessness, or health conditions stemming from disparities in socioeconomic status within King County. This data is imperative in comparing the use of OneCall in relation to the number of applicable calls responded to by EMS providers. This data in conjunction with OneCall log data will be useful in identifying process issues and overall knowledge of OneCalls availability.

OneCall Data

Information from each call is gathered by the OneCall staff at Crisis Connections in the Call Log. This log consists of the organization contacting OneCall, the time of the call, any resources identified as missing, and the services provided to the organization appropriately categorized. Data is summarized and sent to partnering organizations monthly as well as utilized at the monthly meetings to assess the use of OneCall.

Organization	**Number of calls**
Shoreline FD MIH	
South King FD Cares	
SFD Health One	

South King BLS	
Valley Regional BLS	
Services provided	
Information only	
Problem solving	
Referred or linked to current treatment	
Referred to new MH treatment	
Resources identified as missing	
Time of call	
8am-noon	
Noon – 4pm	
4pm – 8pm	
8pm-8am	

OneCall Log Categories

Each category has specific criteria to ensure validity during the evaluation stage of the pilot. This data is collected and processed by Crisis Connections on a monthly basis for distribution and discussion during the monthly OneCall meeting of partners.

-Due to information being the main function of OneCall, it is implied in all categories.

Info only
-Information regarding current or past mental health engagement
-numbers to appropriate services given
-call duration is around the 3-minute mark

Problem solving
-complex, critical, or involves time-intensive management
-guidance given
-suggestions for care improvement
-no direct link to existing care management

Referral or linkage to current treatment
-utilized if patient is tiered, established or enrolled in services
-information regarding current care team given
-direct linkage to established care management

Referral to new mental health treatment
-utilized if patient is not tiered, established, or enrolled

-problem solving
-schedule a next-day appointment or direct to specific walk-in agency
-any step taken toward tiering a patient

Conclusions

The creation of OneCall confirmed the need for increased collaborative work between EMS and other sources of care, though COVID-19 did present challenges in its implementation. Careful data collection will be crucial in determining OneCall's validity, especially due to any unforeseen challenges brought by the pandemic. Nonetheless, the impact of increased communication and sharing of ideas has already facilitated the care for patients within King County. OneCall has the potential to become an essential tool for EMS. Going forward, a continued partnership among involved stakeholders will ensure the completion of their shared goal in alleviating patients of low-acuity needs from relying on EMS resources for their care.

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Appendices

Appendix 1: Sample Responder Survey

We want to hear about your experience working with OneCall We do not require your name, only the organization you work with in order to best use the data we collect for quality assurance purposes. Your opinions are important for the betterment and continuation of this service.

Organization name: ____

1. Have you used OneCall when responding to a patient experiencing a behavioral health crisis?
    a. Yes
    b. Sometimes
    c. Never

For the following questions, please indicate one response:

2. I fully understand how OneCall functions and how to use it
    - Strongly Agree
    - Agree
    - Neutral
    - Disagree
    - Strongly Agree

3. I can easily initiate OneCall
    - Strongly Agree
    - Agree
    - Neutral
    - Disagree
    - Strongly Agree

4. OneCall reduced the burden on me and my team
    - Strongly Agree
    - Agree
    - Neutral
    - Disagree
    - Strongly Agree

5. Has OneCall made your job easier? Yes No

Why or why not?

____

____

Please provide any additional feedback regarding the implementation of OneCall:

____

____

Appendix 2: Flyer for Participating Organizations - *Provided by OneCall*

OneCall

for First Responders

206-436-3009

DO NOT GIVE OUT NUMBER TO PUBLIC

Coordinating Diversion Options for Mental Health Crises

De-escalation • Mental Health Triage • Safety Planning

Emergency Mental Health Appointments

Connection to Current or New Mental Health Services

Problem Solving • Patient Information

Questions?

onecall@crisisconnections.org

OneCall Coordinator: 206-461-3210

Appendix 3: Introduction Email for Participating Organizations - *Provided by OneCall*

Subject: New mental health resource (OneCall) launch

We are excited to announce a new service we are piloting to help you better serve patients with mental health needs.

Project overview:
This King County EMS pilot study creates a new linkage between select EMS fire agencies with Mobile Integrated Healthcare (MIH) programs and Crisis Connections' single portal referral service, OneCall, to better connect EMS patients with behavioral health needs to more appropriate resources outside of a hospital ED. The pilot is scheduled to run through October 2020.

What is OneCall?
OneCall is a single phone number you can call 24/7 staffed by mental health professionals, who can provide real-time support to first responders or directly to the patient. OneCall is equipped to support patients who are struggling with:

- Thoughts of suicide
- Anxiety or loneliness
- Symptoms of mental illness
- Alcohol or drug abuse
- Family or relationship difficulties
- Other emotional or mental health challenges

How does it work?
Call OneCall at **(206) 436-3009** when you identify a patient who:

- Is having a mental health crisis; and/or
- Would benefit from additional mental health or substance abuse support outside of the ED; and
- When you feel the patient's needs are outside of your skillset, and/or South King CARES is unavailable to assist (a CARES referral for follow-up is still encouraged)

The mental health professionals at OneCall can help you 24/7 to de-escalate or counsel patients in acute mental health crisis, do safety planning, and connect clients to emergency mental health services, so that you can safely divert patients from the ED and get back into service.

The OneCall number should only be used by first responders, and never given out to the public.

Services include:

- In-the-moment de-escalation and mental health crisis counseling
- Connection to emergency mental health services (next day and after-hours care)
- Consultation, safety planning, and problem-solving
- General resource navigation and connections

The service is live and you can begin calling today. We thank you in advance for trying OneCall as we study the service's benefit to EMS agencies. As a 24/7 service, we hope it will extend and complement the support you receive from South King CARES**.** If you have questions or feedback, please contact the OneCall number or the South King CARES team.