REACH/EMS
Pilot Study Design

A Vulnerable Populations Strategic Initiative (VPSI) of
King County Emergency Medical Services (EMS)

In partnership with REACH and Puget Sound
and Renton Regional Fire Authorities

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Definitions

Homeless: Patient primarily sleeps in any of the following places: outside, tent, tiny house, abandoned building, car, recreational vehicle (RV), shelter, transitional housing, couch surfing/doubled up, or motel.

Outcome: Successful engagement with a service through a referral by a case manager

Risk score: Number of 9-1-1 calls in the last 30 days multiplied by the number of 9-1-1 calls in the last 12 months.

Service plan: Collaborative document prepared by a patient and their case manager that represents a patient's goals and the steps that will allow the patient to reach those goals.

Unstably housed: Patient or provider is not confident that the patient will be able to maintain residency in a safe place over the next 12 months.

Acronyms & Abbreviations

BLS: Basic Life Support

CARES: Community Assistance Response (Spokane) or Citizen Advocates for Referral and Education Services (Bellevue)

CHS: Center for Human Services

CM: Case Manager

CMT: Community Medical Technician

EMS: Emergency Medical Services

EMT: Emergency Medical Technician

ER: Emergency Room

FD: Fire Department

MSW: Master of Social Work

PHSKC: Public Health – Seattle & King County

PSF: Puget Sound Regional Fire Authority

Renton Fire: Renton Regional Fire Authority

RV: Recreational Vehicle

SUV: Sport-Utility Vehicle

VPSI: Vulnerable Populations Strategic Initiative

Introduction

The Division of Emergency Medical Services (EMS), Public Health – Seattle & King County (PHSKC) works to reduce inequities in access to health services and health outcomes, particularly for populations with limited English proficiency, older adults, and people experiencing homelessness, mental illnesses, and/or chemical dependencies, through their Vulnerable Populations Strategic Initiative (VPSI).[1] This pilot project is an effort to improve access to medical and social services for high-need patients who are homeless or at risk of homelessness. This will be done through the development of a referral pathway linking patients receiving EMS from Puget Sound Regional Fire Authority (PSF) and Renton Regional Fire Authority (Renton Fire) to REACH, a nonprofit providing street-based case management services. As the availability of affordable housing declines in King County[2] and other areas nationally,[3] it is critical to consider innovative approaches to connect some of our most vulnerable neighbors to the services they need and deserve.

Background

Patient Population

Nationwide, organizations coordinate Point-in-Time Counts in which they estimate the number of people who are sheltered or unsheltered in their communities on a single night in January. According to Seattle/King County's Point-in-Time Count, there were 12,112 people experiencing homelessness, of whom 6,320 were unsheltered, on January 26, 2018. After the Point-in-Time Count, peers and service providers surveyed a representative sample of 898 people experiencing homelessness in the county, of whom 98% said that they would move into safe, affordable housing if it were offered to them.[4] People of color in King County are more likely to be homeless, and, if homeless, are more likely to be unsheltered. The United Way of King County calculated that people who are Black or African American in King County are about five times and people who are American Indian, Alaska Native, Native Hawaiian or Other Pacific Islander are about four times as represented among people experiencing homelessness than in the general King County population. Racial inequities in homelessness reflect not only an affordable housing shortage, but also historic and ongoing structural racism in our region.[5]

The majority (61%) of Point-in-Time survey respondents were men, 35% were women, 1% were transgender, and 3% were gender non-conforming. While less than 5% of the general Seattle-Tacoma-Bellevue region identifies as lesbian, gay, bisexual, or transgender, 18% of Point-in-Time survey respondents identified as lesbian, gay, bisexual, queer, questioning, pansexual, or "other." A minority (2%) of respondents were under 18, 22% were aged 18-24, 57% were aged 25-50, and 20% were 51 or older.[4]

Unhoused people disproportionately experience physical and behavioral health issues, which can lead to, result from, or be exacerbated by homelessness. For many people, experiencing homelessness is incredibly stressful and traumatic, which can worsen mental health symptoms and strengthen chemical dependencies.[6,7] The majority (70%) of participants in the Point-in-Time Count indicated that they experienced one or more health problems, of which the most common were psychiatric or emotional conditions (44%), posttraumatic stress disorder (37%), and drug or alcohol abuse (35%). However, only 18.6% indicated that they were accessing mental health services and only 9.7% indicated that they were receiving alcohol or drug counselling.[4]

The majority (69%) of Point-in-Time Count respondents reported barriers to getting help or accessing services within the community.[4] Traditional medical and social services are not designed to be accessible for unhoused people. People experiencing homelessness often have a hard time scheduling an appointment, qualifying for services, and making it to an appointment. Many service providers require photo identification and income verification, items that are challenging to acquire and easy to lose. Transportation can be a barrier, with transit costing money, and not all places being easily accessible by public transit. There are often competing needs – such as needing to acquire food or move camp locations – that can take priority over a scheduled appointment. Finally, frontline staff may be unwelcoming or even refuse to serve people with poor hygiene or with

challenging behaviors resulting from mental illness and/or substance use. These experiences can make people experiencing homelessness resistant to interfacing with services in the future.[8]

The burden of untreated physical and behavioral health issues leads to significant morbidity and mortality for people experiencing homelessness. A recent study in Boston found that the mortality rate for people who sleep outside was three times greater than for people who sleep in shelters, and ten times larger than for the overall Massachusetts population.[9] In 2017, the King County Medical Examiner investigated the deaths of 169 people presumed to be homeless, representing just a fraction of the total number of unhoused people who died in the county last year.[10]

Community Context

This project will take place in the service areas of Renton Fire and PSF. Renton Fire serves the City of Renton and King County Fire Districts 25 and 40, an area of 43.3 square miles with a population of more than 125,000.[11] PSF, previously the Kent Fire Department Regional Fire Authority,[12] currently serves Covington, Kent, SeaTac, and portions of unincorporated King County, totaling approximately 60 square miles and a population of over 182,000.[13] It is currently merging with Maple Valley Fire & Life Safety.[14]

The majority of people experiencing homelessness in King County sleep in the City of Seattle, which is also where most resources and research are clustered.[4] Less is known about people experiencing homelessness in other parts of the county. Some outreach workers are wondering if encampment sweeps in Seattle may be inadvertently pushing people who sleep outside to set up camps south of the city, in areas such as Kent and Renton, which have fewer services for people experiencing homelessness. According to the most recent Point-in-Time Count, 15% of unsheltered people slept in Southwest King County, an area that includes the Renton and PSF jurisdictions.[4]

Many currently housed people in the Renton Fire and PSF jurisdictions have a hard time affording their rent, and may be at risk of homelessness. Gentrification is spreading south from Seattle, as illustrated by the 12.68% rise in median home prices from August 2017 to August 2018 in Southwest King County.[15] In Kent,[16] 6 in 10 households are cost burdened, as are 4 in 10 in Renton[17] and SeaTac,[18] and 3 in 10 in Covington[19] and Maple Valley.[20] Across Kent, Renton, SeaTac, Covington, and Maple Valley, 2,779 households are overcrowded, and at least 748 lack adequate kitchen or plumbing facilities.[16–20] Individuals and families struggling to make ends meet can face similar barriers to accessing services as people experiencing homelessness.[21,22] Unfortunately, inability to engage in services can lead to worsening of physical and behavioral health conditions, and ultimately prevent someone from staying housed.

Role of Emergency Medical Services

A 2014 VPSI needs assessment of King County fire department (FD) personnel (N = 698) found that the majority of respondents felt that there were challenges to efficient delivery EMS services frequently or all of the time to patients who are homeless, have a mental health condition, or are

under the influence of alcohol or drugs. Similarly, most respondents indicated that they experienced communication challenges frequently or all of the time with patients who have a mental health condition or are under the influence of alcohol or drugs. When asked what population was most difficult to serve, respondents indicated this was patients with limited English proficiency and/or from different cultures, followed by patients who were homeless and/or intoxicated, then by mental health patients.[23]

A substantial number (29%) of King County EMS cases in which there is a Basic Life Support (BLS) response do not result in transport to a hospital or other facility, suggesting the call was low-acuity, or not medically urgent. Frequent dispatch of BLS for low-acuity calls can result in longer response times for BLS during time-critical emergencies. Calls that are low-acuity or are related to behavioral, not physical, health concerns are often frustrating for EMS personnel, who are trained to respond to medical emergencies, and often lack resources for patients with unmanaged chronic conditions or who are experiencing mental health crisis or acute intoxication.[23] Unfortunately, calling 9-1-1 is the only option for support for many community members who are not having their needs met by friends, family, or other service providers.[24]

Current strategies used by EMS for low-acuity cases include referring callers to a nurse line, dispatching Community Medical Technicians (CMTs) instead of BLS, and providing taxi vouchers for patients needing transport to a hospital so that the BLS unit can return to service sooner. A CMT – who is a firefighter/emergency medical technician (EMT) with some limited additional training – responds to calls in a sport-utility vehicle (SUV), instead of a fully outfitted ambulance or fire truck, and can educate the patient about local services.[25]

Additionally, EMS supports regional efforts to more efficiently meet the needs of low-acuity callers, such as the FD CARES program.[26] The FD CARES division of PSF was created to support high utilizers with unmet physical health needs.[27] Similar to the CMT program, an FD CARES unit responds to the scene when dispatchers identify a call as low-acuity. FD CARES also conducts "proactive" visits in which they will outreach with patients who have been high 9-1-1 utilizers or referred by other firefighters/EMTs. FD CARES units are SUVs and are staffed with a firefighter/EMT and a nurse. They are able to spend more time with patients than a typical first responder and work to address the underlying issues causing the patient to call 9-1-1. For example, FD CARES may install a fall prevention device for an older adult with multiple falls, or work with a patient to reengage with their primary care provider.

FD CARES staff are often challenged by patients who are homeless, particularly those with unmanaged substance use and/or mental health concerns. This led to PSF reaching out to REACH, who has experience working with this population, about the possibility of a partnership, which has since expanded to include Renton Fire and is receiving EMS support. This project fits within the vision of mobile integrated health shared by EMS and the participating fire departments. Under this ideal, EMS provides value-based mobile health services as part of a fully integrated network of social and medical service providers.[26]

REACH, founded in 1996, is a program of Evergreen Treatment Services, a large nonprofit that provides medication assisted treatment for people with opiate use disorder.[28] REACH provides

street-based outreach and case management services for people who sleep outside, most of whom use substances. REACH's approach is client-centered, with staff working with clients to work towards their own goals in ways that feel possible for the client at the stage they are in their recovery. In 2017, REACH served nearly 3,400 clients, visiting over 1,000 encampments, and successfully moving nearly 200 clients into transitional or permanent housing.[29]

Literature Review

National Interventions

Nationally, efforts to connect similar patient populations from emergency medical services to case management have been effective. In one pilot study from Ann Arbor, Michigan, emergency rooms (ERs) referred high ER users to a case manager who would work to connect them with longer-term resources and services. Of the 24 referrals made, 18 were considered eligible, and 10 were found through outreach efforts and agreed engaged in case management services. Of the 18 eligible referrals, 10 were homeless, all had a history of alcohol dependence, and 8 had another substance use disorder. For the 10 patients who received case management services, emergency medical service use decreased by 58% ($P<0.03$) in the year following referral compared to the year before, while there was no change for the 8 control patients.[30]

Another study conducted in San Francisco focused on emergency room high utilizers, among whom 67% were homeless. A total of 53 patients were connected with a case manager who provided intensive, wrap-around services. Data were compared for the twelve months before and after case management enrollment for each patient. The median reduction in ER visits pre- to post-intervention was 5 ($P<0.01$), and the median increase in outpatient medical visits was 1 ($P<0.01$). The median reduction in hospital costs was $2,406 ($P<0.06$).[31]

Washington State Interventions

In Washington, other fire departments have initiatives to connect social workers to EMS patients with unmet social, behavioral, and physical health needs. In 2008, the Spokane Fire Department founded the Community Assistance Response (CARES) program (unrelated to the FD CARES program). In the CARES program, EMS providers refer patients to the CARES Team Manager who assigns Master of Social Work (MSW) students from Eastern Washington University to conduct outreach. CARES Team members conduct a social service needs assessment, develop a plan to connect the patient to services, and advocates on the clients' behalf. In 2017, the CARES team received 289 referrals and successfully closed 145 cases. Patients who received services from CARES utilized emergency medical services 63% less compared to before the intervention.[32] The Bellevue Citizen Advocates for Referral and Education Services (CARES) program also follows this model.[33] Similar programs exist nationally, though myself and partners are not aware of any programs in which a fire department has partnered with an existing non-profit organization to provide social services specifically for patients experiencing homelessness.

This pilot will be part of the EMS VPSI. In one past VPSI project, EMS hired Center for Human Services (CHS) MSWs to work with the Shoreline Fire Department (Shoreline FD). Shoreline FD staff screened their records 2-3 times a week to generate a list of 9-1-1 callers with a primary or

secondary clinical impression of behavioral/psychiatric disorder or substance/drug abuse. The MSW initially outreached to patients by phone, but, due to low success rate, expanded to have office hours and to also conduct home visits with a CMT. Sixty-two patients were contacted by phone, of which eleven agreed to receive services. Office hours generated zero patient contacts, and only four patients were reached in person through home visits, but all four agreed to reach services. Fire department crews and MSWs felt that low success rates were largely due to the delay between the EMS interaction and initial outreach by the MSW, and felt that the ideal program would have round-the-clock staffing to immediately reach eligible patients identified by EMS in the field.[34]

This pilot will generally not provide in-the-moment referral and follow-up. However, it will have a number of key differences from the Shoreline pilot that may enhance its success. First, the inclusion criteria will be different as this program requires participants to be homeless or unstably housed. In the Shoreline pilot, 9% of patients were homeless, and the MSWs did not do any street outreach, which is necessary to reach folks who don't have a "home" to visit or a working phone. Additionally, the Shoreline pilot did not attempt to follow-up with patients who refused services initially.[34] In contrast, REACH has a long history of successfully outreaching with people who sleep outside, particularly those who are initially resistant in receiving services.

REACH has demonstrated experience working with the target population of this pilot and also partnering with emergency services. Law Enforcement Assisted Diversion (LEAD) is a criminal justice diversion program in which people in Seattle who are engaged in low-level drug trade and sex work can choose to engage in REACH case management as an alternative to prosecution. The program was developed in the context of concerns about racial disparities in the criminal justice system and the sentiment that recidivism is a self-perpetuating cycle and incarceration is counterintuitive to prevent crimes associated with poverty. Having a criminal history and cycling in and out of jail makes it extremely challenging to obtain and maintain legal employment, housing, and engagement with medical and mental health services. As an alternative, LEAD case managers use trauma-informed, strength based, harm-reduction principles and work with participants to meet their own goals, such as by facilitating linkage to housing, mental health and substance use treatment, health care, and job services. LEAD evaluators have determined that the program reduces recidivism rates, saves money, improves participant housing and employment outcomes, and is viewed as beneficial by participants.[35]

The REACH/EMS pilot seeks to take a similar approach, with EMS instead of law enforcement being the referring agency. There will be significant differences, however, including that the REACH/EMS pilot is much smaller in scope and will be less rigorously evaluated.

Methods

The below Program Procedures and Evaluation Plan were developed through a collaborative, iterative process with key stakeholders. Inclusion criteria and referral pathway were designed to maximize the potential of the REACH staff person, reduce burden on EMS systems, and provide better care for people experiencing homelessness and housing instability. The evaluation plan was designed with careful consideration of what data points would reflect our goals and would be reasonably possible to obtain. Specific steps informing the methods development included:

- Completion of the Northwest Center for Public Health Practice training modules "Developing an Action Plan" and "Data Collection for Program Evaluation"
- Review of all past VPSI reports and other relative literature
- Facilitation of eight meetings with 6-10 representatives from EMS, Renton Fire, PSF, and REACH
- Bi-weekly meetings with Michele Plorde for status updates and troubleshooting, and as-needed meetings with other partners
- Ride-a-longs with PSF, FD CARES, and REACH staff to observe day-to-day operations of front line staff
- Meetings with REACH and EMS database experts

Program Procedures

Note: In this and following sections, "EMS" refers to first responders from Renton Fire and the FD CARES division of PSF.

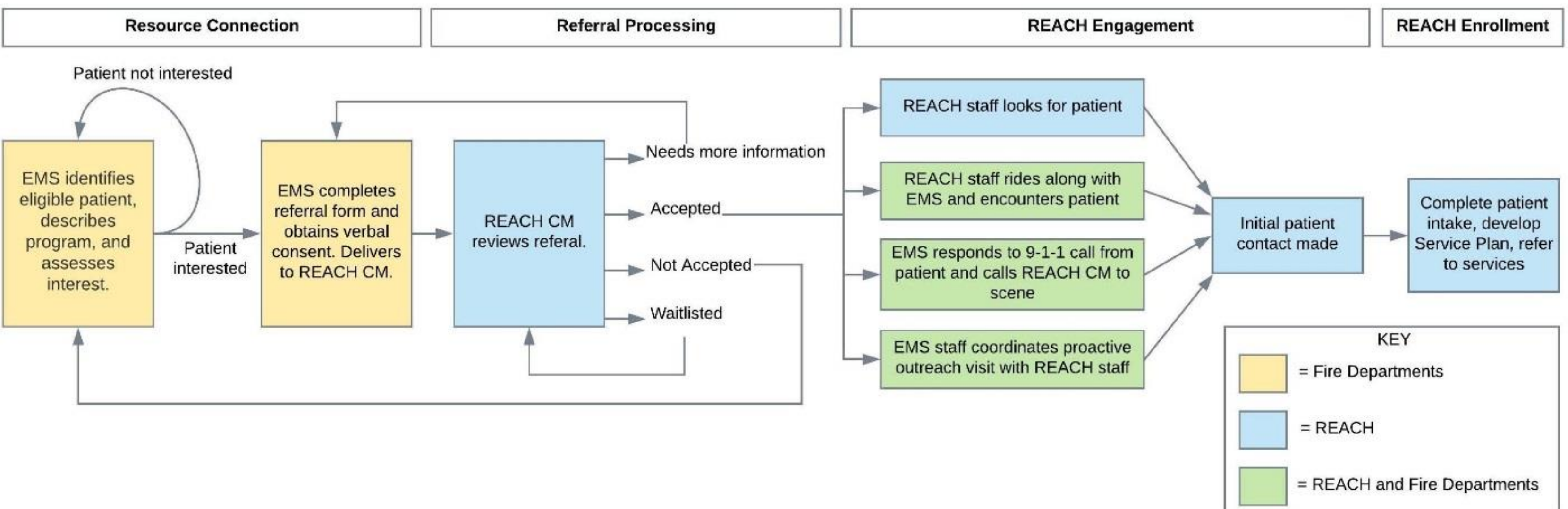
Resource Connection to REACH

When EMS encounters a potentially eligible patient in the field, they will determine if they are homeless or unstably housed. This will be done by asking the patients questions such as, *Where do you sleep at night? Are you worried that in the next year you could lose your housing? Are you on the lease here?* If responding to the patient's place of residence, the EMS provider can also make a subjective assessment about whether the patient is likely to maintain residency. If the person is homeless or unstably housed, and does not reside in permanent supportive housing, an adult family home, a skilled nursing facility, or another care facility, the EMS provider will initiate a conversation about the pilot program with the patient and determine if patient is open to speaking with the REACH case manager (CM). For example, the EMS provider could say, *I know a case manager named [REACH CM name] who works with people having a hard time with [specific issue]. Would you be interested in talking with them about this?*

If the patient expresses interest in outreach by REACH CM, EMS staff will complete the referral form with patient. EMS will ask for verbal consent to share the completed referral form with the REACH CM. If said consent is given, it will be noted on the referral form and initialed by the provider, and the referral form will be delivered in person to the REACH CM. If consent is not given, the referral form will not be shared with the REACH CM until consent is received. If the patient is not interested

in meeting with the REACH CM, EMS will continue asking the patient about their interest in receiving additional support during future encounters.

Figure 1. Referral pathway flow chart



Referral Processing

The REACH CM will decide whether to accept, reject, waitlist, or ask for more information for each referral they receive from EMS. The REACH CM will indicate their decision on the referral form, which they will photocopy and return to the referring agency.

If patient does not meet eligibility criteria, or REACH CM feels the patient would not benefit from REACH services, the REACH CM will reject the referral. Reason for rejection will be noted on the referral form. The REACH CM can also provide the EMS referrer with suggestions for more suitable resources for the patient. If the referral form is incomplete or the REACH CM needs more information on the client to assess their eligibility or need for REACH services, REACH CM will detail the information needed on the referral form.

If the patient does meet the eligibility criteria and may benefit from REACH services, the REACH CM can accept the referral if they have capacity to add the patient to their caseload. If the REACH CM has more referrals than they have capacity to accept, they will prioritize patients who have the highest needs and the most vulnerability, as reflected by their risk score, 9-1-1 utilization over the prior 12 months, and other information on the referral form. The REACH CM may also care conference with referring providers to determine which patients to prioritize. REACH CM will "waitlist" patients who are eligible and may benefit from REACH services, but who they do not have capacity to add to their caseload at the time they receive the referral.

REACH Engagement

After the REACH CM accepts a patient referral, they will attempt to make initial contact with the patient. Although the REACH CM may contact the patient through a cold call or visit, the initial outreach effort will ideally occur through a warm handoff coordinated by the referring EMS agency, which could occur in a number of ways. If a 9-1-1 caller is identified as a referred patient, the EMS provider can contact the REACH CM to meet the patient while EMS is at the scene. EMS can also coordinate a proactive outreach visit, in which they and the REACH CM try and meet with the patient without 9-1-1 being called. Finally, the REACH CM can participate in a "ride-a-long" in which they respond to 9-1-1 calls with EMS and may encounter eligible patients. If EMS staff introduce the REACH CM to the patient in person, such as in the scenarios just described, the handoff will be classified as "EMS present." The handoff will be classified as "EMS not present" if EMS staff were not physically present when the patient and REACH CM met.

REACH Enrollment

After the REACH CM has first met the patient, they will work to build a relationship with the patient, develop a Service Plan, and connect the patient with resources and services. A Service Plan is a representation of a patient's goals and the steps that will allow the patient to reach those goals. All accepted referrals will first be designated with "outreach" status in the REACH database. This indicates that the REACH CM is trying to engage the client, but the client is not actively engaged in a Service Plan. Once the REACH CM is regularly meeting with the client and has a Service Plan that

the client is engaged with to their capacity, the patient status will be designated as "active." Once a patient has achieved active status, they will be considered enrolled with REACH case management. See Appendix 2 for a complete description of REACH client designations.

Evaluation Measures

Evaluation Objectives

1. Determine whether enrolled patients increase their engagement with community-based services and decrease their utilization of emergency medical services when enrolled in the pilot program.
REACH data will be used to compare what services patients reported receiving during initial intake to their "outcomes" while working with the case manager (outcomes are defined as successful engagement with a service). Each service designated as an outcome but not listed during the intake process will represent a new service for that patient. EMS data will be used to look at 9-1-1 utilization for patients while they are actively enrolled with REACH, during the prior 12-month pilot period, and after they stop engaging with REACH. If we see a decrease in 9-1-1 utilization and an increase in the number of services a patient receives during the pilot period, this may suggest that the patient is shifting to use more appropriate services.

2. Examine whether patients, front line staff, and leadership feel that the program is effective and identify areas for improvement.
An evaluator will survey patients to obtain both qualitative and quantitative data on how they feel the program has benefited them and what changes they suggest. The evaluator will interview front line staff and leadership from REACH, Renton Fire, and PS Fire to gain their perspective on if the program benefited their organizations and patients, and to identify opportunities for improvement.

3. Establish whether there is a need to continue and grow this service.
If results are positive for the first two evaluation objectives, this would suggest that the intervention may be effective. If after the 12 month pilot period enrolled patients still need support, or if the REACH case manager has been receiving an ongoing stream of referrals, this would suggest a need to continue the service. If after the 12 month pilot period there remains a significant population of waitlisted patients that have not been accepted, this would suggest a need to grow the service.

4. Deepen understanding of the characteristics of people experiencing homelessness and housing instability in Southwest King County and document assets and resource gaps in the community.
The data obtained from referral forms, the REACH database, and the EMS database can be used to better characterize the demographics and needs of people experiencing homelessness and housing instability in Southwest King County. Interviews with service providers can give qualitative information about what services in the area they rely on, and what services are limited. This is important given that the majority of research and programs in King County are concentrated in the Seattle area.

5. Assess if the program is implemented equitably.
Every stage of the referral process should be assessed for equity. Various populations to be compared are shown in Figure 2 below. For example, since people of color are more likely to experience homelessness than the general population, an equitable program would contain a greater proportion of people of color within the “referred patients” pool than within the “all patients” pool. Process measures, such as the number of hours of case management services a patient receives, and outcome measures, such as the number of successful referrals, should also be compared between demographic groups to determine if the program benefits were equitable for enrolled patients. Finally, comments from patient surveys and key informant interviews can provide qualitative perspective on program equity.

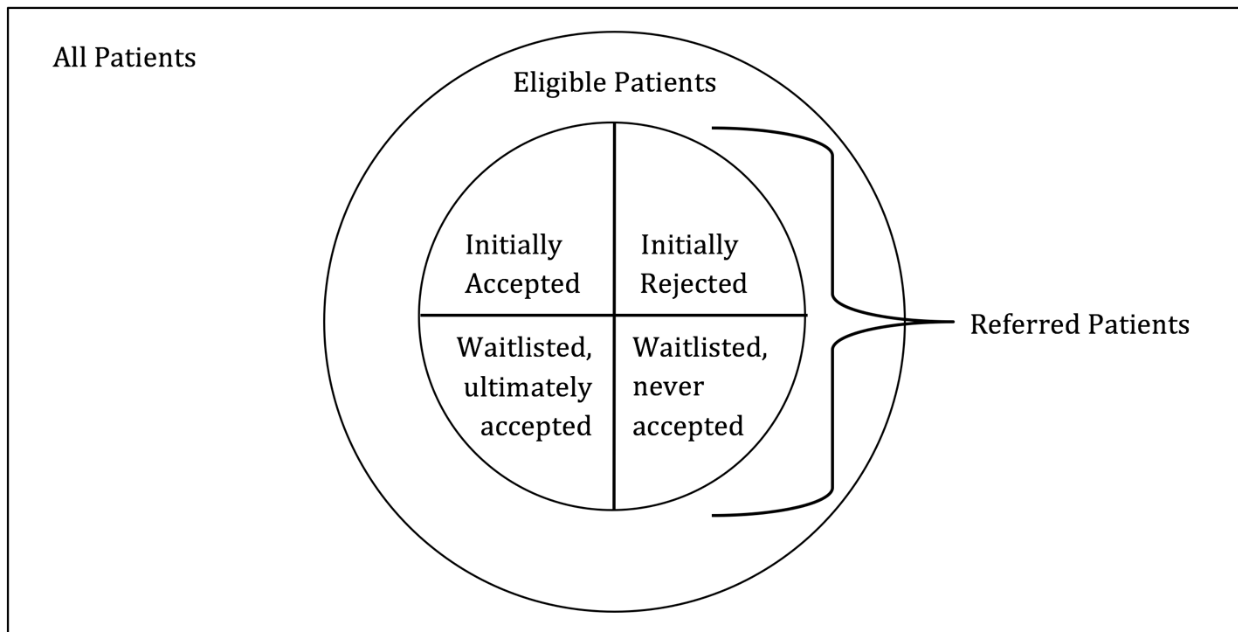


Figure 2. Patient populations to be analyzed.

Overview of Data Sources

Referral Form Data
The REACH/EMS pilot referral form (see Appendix 1) will be used as the primary source of information on the pool patients referred into the program. The referral form will provide information about patient age, gender, race, housing status, referral reason, known health and behavioral health conditions, and existing services the patient reports receiving. As described in the Program Procedures, the referral form will also be used to document whether the referral was initially accepted, rejected, waitlisted, or more information was needed and how the REACH CM made initial contact with accepted patients. Analysis of the referral forms, which include reasons why referrals were rejected or more information was requested, can also yield information useful for improving the referral process.

REACH Data

Agency, REACH's data system, will be used to track all information about patients with accepted referrals. It will provide information on the monthly number of active, outreach, alumni, and discharged patients on the REACH CM's caseload. For each patient designated "active" at some point during pilot period, the following data will be pulled and analyzed:

- Intake information (e.g. history of incarceration, health/behavioral health conditions, services patient already has in place)
- Monthly number of CM encounters that were by phone, face-to-face, or indirect (communicating about the patient with another provider), and whether EMS staff were present during the encounter
- Monthly number of hours of CM services
- Monthly number and type of issues addressed, referral attempts, and successful referrals to services (outcomes)
- Length of time from outreach to active status and from active status to alumni/discharged status (if applicable)

EMS Data

The software used by EMS providers in King County, ESO, will be used to compare age, gender, and 12-month 9-1-1 utilization between referred patients, enrolled patients, and the general population of patients served by Puget Sound and Renton Regional Fire Authorities. For each patient with an active status designation in REACH's database at any time during the pilot period, the ESO will be used to gather monthly 9-1-1 utilization data while they are active REACH patients, during the prior 12-month pilot period, and after they stop engaging with REACH.

Patient Surveys

During the final month of the pilot period, patient feedback will be solicited in the form of a survey that can be administered in a written or oral format depending on patient preference. The REACH case manager will coordinate a meeting with patients and a third party to administer surveys. See Appendix 3 for a sample survey.

Key Informant Interviews

After the completion of the pilot period, key informant interviews will be conducted with stakeholders such as those listed below. See Appendix 4 for sample questions.

- FD CARES staff and Renton Fire first responders
- REACH CM(s)
- Renton Fire, PSF, REACH, and EMS leadership

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Appendices

Appendix 1: Referral Form

☐ Eligibility Confirmed *Inclusion Criteria: homeless or unstably housed* *Exclusion Criteria: PSH, AFH, SNF** *PSH = permanent supportive housing, AFH = adult family home, SNF = skilled nursing facility	☐Verbal consent to share referral form (referrer initial:_____)

If patient declines referral, reason: ____

REACH/EMS Pilot Referral Form

Date:__________ Time:________ Referrer: ______________________________ [Renton/Puget Sound]

Patient Information

Name:__________________________ DOB: _________ Gender: ______ Race: _______________

Patient #: ____________ Physical Description: ______________________________________

Phone #: _______________ [call/text] Address: ____________________________ [living/mailing]

Alt Phone #: _________________ [call/text] Email: ___________________________________

What is the best way to get in touch with you? _______________________________________

Where do you go during the day?____

Where do you sleep?____

If housed, are you worried that in the next 12 months you may not have stable housing? Yes No Unk

Care team: ____ Last contact:_______________

Assessment
Reason for referral:____

____

Living condition: __________________________________ Any Hazards: ______________________

Medical conditions: ____

Behavioral health: ____

911 calls in last 12 months:_________ Risk score:______

Safety Assessment
History of Violence? Yes No If yes:____

Weapons in the home, belongings, or on person? Yes No If yes:___________________________

Animals in the home or with client? Yes No If yes:____

For REACH staff only
Referral status (circle one): Accepted Not Accepted Waitlist Need More Info

If not accepted or need more info, reason: ____

Initial contact (if accepted): No Contact EMS Present EMS Not Present

Appendix 2: REACH Clients Designations

Provided by REACH

Active Clients

- CM has regular contact with client (monthly, bi-weekly, weekly)
- Service Plan in place—client engaging to their capacity
- Includes clients with long-term jail/institution stays that are returning

Outreach Clients

- Regular contact or infrequent contact
- Assigned to you to try to engage
- CM is focused on engaging the client
- Not actively engaging in Service Plan

Alumni Status

- Client is stable
- Connected to services
- Minimal Client Contact Hours (ex. Quarterly or semi-annual encounters, only comes in to go to groups/events, brief check-in's w/ CM etc.)
- Alumni status is based on a clinical decision made by case manager & direct supervisor. These clients will not be counted on your active case load.

Discharged

- No Contact six months or more
- Placed/Sentenced in an institution for a year or more
- Moved away or out of state
- All discharges will be re-screened upon return
- Based on behavior or better served by another agency

Discharging is based on a clinical decision made by case manager & direct supervisor. On case-by-case basis discharge may be determined by REACH Direct Supervisor.

Appendix 3: Sample Patient Survey

We want to hear about your experience with the program where fire departments introduce patients like you to [name of case manager], who works for REACH. We won't collect your name, but we will combine information from all the surveys to share with the public.

1. How do you feel about the fire department introducing you to your REACH case manager?

1	2	3	4	5
Strongly dislike	Dislike	Don't like or dislike	Like	Strongly like

2. Did working with the REACH case manager help you?

1	2	3	4	5
Made things a lot worse	Made things a little worse	Did not affect me	Helped me a little	Helped me a lot

3. What did you like about working with your REACH case manager?

____

____

4. What didn't you like about working with your REACH case manager?

____

____

5. Do you have any suggestions for how the program could be better?

____

____

6. Is there anything else you want us to know?

____

____

Appendix 4: Sample Questions for Key Stakeholder Interviews

Questions for all stakeholders:

- What went well?
- What are areas for improvement?
- Do you feel that this program is a good use of resources?
- Do you think this program was implemented in an equitable manner?

Questions for FD CARES team:

- Do you feel like you were trained adequately on the referral pathway?
- Did you feel the referral pathway operated smoothly?
- Do you feel that the program reduced burden on you and your team?

Questions for REACH CM(s):

- Do you feel like you were trained adequately on the referral pathway?
- Did you feel the referrals you received from fire departments were appropriate?
- Did you feel the referral pathway operated smoothly?
- How did demand compare with your capacity?
- Were you able to connect patients to the resources that they needed? What barriers existed?