REACH/EMS Pilot: Program Evaluation

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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Introduction

Fire Department Community Assistance, Referrals and Education Services program (FDCARES) nurses are staffed within Puget Sound Fire Authority (PFA) and Renton Fire Authority (RFA) for the purpose of assisting community members with wellness and non-life threatening medical issues, before an issue becomes an emergency.[1] First responders and FDCARES nurses frequently respond to 9-1-1 calls for patients experiencing unstable housing situations. Many of these individuals experiencing unstable housing are dealing with homelessness in addition to behavioral health problems, addiction related illnesses, and physical/disease related medical conditions. PFA, RFA, the REACH organization, and Public Health Seattle & King County's Emergency Medical Services Division implemented a collaborative pilot project to develop a linkage through existing organizational resources. The goal of this pilot project was to divert this unique patient population to alternative case management services in order to improve the experience of care, reduce reliance on 9-1-1- for non-medical needs, and address the needs of the target population. Patients who called 9-1-1 and met the criteria of being homeless, were referred by FDCARES nurses and supervisory staff members to REACH case managers (CM). After a referral was made, CM worked with clients to connect them to needed resources and/or social services.

This evaluation of the REACH/EMS Pilot assesses whether the program achieved its goals, through using a mixed methods approach.

Background

The National Public Health Problem

Homelessness is an ongoing public health concern in the United States. The U.S. Department of Housing and Urban Development (HUD) has a national requirement that necessitates all Continuums of Care to conduct a Point-in-Time Count (PTC) in order to record major trends in homelessness over time and continually track progress towards ending homelessness.[2] Within the United States, in 2018, the total number of homeless individuals tallied during the PTC was approximately 553,000 people nationwide.[2] This number has been continuously increasing with a 0.3 percent increase in homelessness from 2017 to 2018.[2] Various factors have directly correlated with this increase in homelessness, specifically substance-related illnesses.[3]

National studies suggest that homelessness correlates directly with substance-related illnesses.[3] Individuals experiencing homelessness often use substances in attempts to attain acute relief from their problems.[3] In contrast, substance related illnesses only intensify their problems and reduce their chances for positive prospective opportunities.[3] Currently, the majority of addiction-related services encompass the treatment program ideology, which focuses on abstinence only.[3] This is less effective than harm reduction strategies which additionally address the possibility of relapse (an occurrence to which homeless individuals are susceptible).[3] Statistical evidence such as this provides a general understanding of how vulnerable minority populations have an increased susceptibility to substance related illnesses. Due to the increased susceptibility to substance-related illness, this population is in need of social services rather than emergency care.

Mental health-related illnesses are an additional factor affecting the homeless population within the United States. In 2019, a study conducted by the National Institute of Mental Health found that approximately 6% of Americans are severely mentally ill.[4] In comparison, it is estimated that of the entire homeless population in the United States, 20% to 25% suffer from some form of severe mental illness.[5] Many individuals who suffer from homelessness are hindered by serious mental illnesses which create barriers in self-care and social circumstances ultimately creating further barriers when attempting to recover and/or obtain stable housing.[6] With depression, anxiety, bipolar disorder, schizophrenia, and addiction related disease being amongst the leading mental illnesses within the U.S. homeless population, one can understand how homelessness exacerbates mental illnesses, through

exposing the population to higher levels of psychiatric stress, only to cause further problems, and limit positive prospects towards recovery.[7]

With mental health and physical/disease related health conditions being key factors among the unstably housed population, homelessness has evolved into a national public health crisis.[2] Many EMS agencies have attempted to combat this national public health issue through implementing Mobile Integrated Health (MIH) Units.[8] MIH programs are implemented for the purpose of adding a component encompassing a wellness based mobile healthcare provider.[8] MIH enables individuals to be treated, managed, and educated towards services they are eligible.[8] King County is currently encountering a significant homelessness problem as well and is implementing actions towards diverting this vulnerable population to existing resources through MIH.[9]

The Regional Public Health Problem

Among the numerous organizations within King County attempting to minimize the prevalence of homelessness, All Home, one of Seattle and King County's leading Continuums of Care, has been coordinating housing and service funding for homeless families and individuals in addition to continuously conducting the PTC for Seattle and King County.[10] During the PTC for January 2019, a recorded total of 11,199 individuals were discovered to be experiencing homelessness in Seattle/King County.[10] Twenty-two percent (1,149 individuals) of the unsheltered population were located in Southern King County.[10]

The PTC count showed that the majority of homeless individuals living in King County were male (56%), 40% female, 2% transgender and 3% reporting as gender non-conforming.[10] In terms of race and ethnicity demographics, the majority of individuals experiencing homelessness in King County identified as people of color (57%).[10] Forty-two percent of homeless individuals reported as White, while 32% identify as Black or African American, 15% Hispanic or Latino, and 10% American Indian/Alaskan Native.[10] Additionally among those who identify as Black or African American in King County, 6% comprise within the general population of King County, compared to 32% consisting in King County's homeless population, Hispanic or Latino (10% compared to 15%), and American Indian/Alaskan Native (<1% compared to 10%).[10] When comparing these homeless racial demographics with King County's general population, racial disparities can be observed, suggesting cultural inequities that still remain within King County.[10]

Barriers to accessing social services are also a primary factor correlated with homelessness. In 2018, eighteen percent of all homeless PTC survey respondents indicated they were not currently accessing any services or assistance.[10] The majority of respondents (76%) reported encountering obstacles when seeking help involving general social services (e.g. free meals, emergency shelter, bus passes, hygiene services, day shelter services, and health services).[10] Lack of transportation for accessing services was reported as the top barrier (28%), with an additional 28% of respondents not knowing where to go for help.[10] These data provide evidence of the specific needs individuals experiencing homelessness have.

Physical health related illnesses are also quite prevalent among the homeless in King County.[10] As of 2018, it is estimated that approximately 6.4% of the general population of King County are living with a disability.[10] In contrast, thirty seven percent of homeless individuals in King County have indicated living with at least one health condition that is disabling.[10] These health conditions may consist of behavioral conditions (e.g. psychiatric or emotional conditions (PTSD)) and/or physical/disease related health conditions (e.g. physical disabilities and/or infectious disease).[10] These health conditions frequently prevent homeless individuals from maintaining employment, living in stable housing, or maintaining basic care for themselves.[10] Much of these health-related illnesses are worsened through the combination of addiction related disease and homelessness.[10] Addiction related diseases involving drugs or alcohol are among the top 3 reasons for individuals becoming homeless in King County.[10] Sixteen percent (n=127) of the 798 drug and alcohol-caused deaths in 2018 occurred among people presumed homeless.[11] Statistical evidence such as this reflects the immense barriers in which behavioral related illnesses place on the homeless population.

The King County Medical Examiner's Office (KCMEO) provides strong evidence of the localized public health issue caused by homelessness within King County. The KCMEO reported of investigating the deaths of 194 individuals alleged to be homeless in 2018.[12] Twenty one percent of the homeless deaths reported were within the Southern King County region (n=40).[12] The total number of homeless individuals deceased within King County in 2018 demonstrates an increase of 25 more deaths among homeless individuals when compared to 2017 (n=169). [13] Through examining this evidence, one can understand the disastrous result which follows when unstably housed individuals are unable to obtain services needed. To avoid this outcome, various King County organizations are attempting to divert homeless individuals to alternative existing resources through a collaborative linkage which aids in helping participants find the correct services they need.

The REACH/EMS Pilot

Goal of the Pilot: Southern King County fire departments specifically, have been overburdened by 9-1-1 calls from the homeless population due to a deficiency in services to vulnerable populations experiencing homelessness, mental illnesses and/or chemical dependencies.[14] Puget Sound Fire Authority reported 1.18% of the population served by the department in 2016 accounted for 40% of 9-1-1 calls.[9] This population is defined as "low acuity", involving a complex patient population which typically consists of a wide-range of medical, behavioral, and social needs, yet does not necessarily need emergent medical attention.[9] To respond to the issues faced within the region, the Division of Emergency Medical Services, Public Health-Seattle & King County (PHSKC), REACH, Renton Fire Authority (RFA), and Puget Sound Fire Authority (PSF), collaborated in developing and funding a pilot project which was initiated with the goal of connecting high-need (yet low acute medical need) patients who are experiencing homelessness or at risk of homelessness to medical and social services. An organizational collaboration was conducted towards developing a referral pathway linking low acuity homeless patients who receive EMS care to REACH in order to link these patients to appropriate services. REACH, a non-profit organization, has a historical presence of working to improve the quality of life for unstably housed adults (many of whom suffer from substance-related illnesses) in the greater Seattle and King County area.

Pilot Procedures: The pilot currently operates under the mobile integrated health model. The process begins with the FDCARES division of both PSF and Renton Fire. When a 9-1-1 call is received by either fire department, first responders from emergency vehicles determine whether the patient classifies as a low acuity patient. If the patient is categorized as a low acuity patient, an FDCARES unit consisting of an emergency medical technician (EMT) and nurse will respond to address any underlying medical issues causing the patient to call 9-1-1. In attempts to minimize the challenges FDCARES staff often face by patients who are homeless, specifically those who are experiencing addiction related disease and/or mental health disorders, patients are then referred to REACH CM's. Through this new partnership with REACH, the MIH vision will be enacted to further harm reduction and develop a linkage between two existing entities (Fire departments and REACH).

During the beginning of the pilot period the following objectives were set:

> *1. Develop an understanding for the characteristics of people experiencing homelessness and housing instability in Southwest King County through analyzing patient demographics.*

2. Determine whether patients enrolled in the pilot increased their engagement with REACH through analyzing encounters.

3. Identify services provided to patients enrolled in the pilot and outcomes produced.

4. *Examine effective program facilitators reported by project partners.*

5. Identify gaps in the program and areas for improvement reported by project partners.

The purpose of this paper is to describe the methods and outcomes of the program evaluation. Results from this program evaluation will potentially aid future pilots through expressing the strategies within the pilot that were deemed successful in addition to the barriers that can be avoided in future projects.

Methods

The mixed methods evaluation of the REACH/EMS pilot included both quantitative and qualitative data collection and analysis. With input from advisors and program stakeholders, the evaluation plan was created. PSF and RFA completed REACH/EMS referral forms with patients over a 12-month period and administered completed referral forms to the assigned REACH CM's for the program. Quantitative information was extracted from the referral forms containing patient data involving, age, gender, race, housing status, referral reason, known health and behavioral health conditions, and existing services the patients reported receiving at the time of enrollment. Additionally, the referral form was also used to document the current referred status of the patient as documented by the REACH CM. This included the referral being initially accepted, rejected, waitlisted, or more information was needed. After the referral form was completed, referral status information was inputted into the REACH database. REACH's database was also utilized to gain access to quantitative information on services provided to individual participants that were accepted into the REACH/EMS pilot. Patients who were initially accepted by REACH CM's were matched to the PSF and RFA's ESO database to determine if 9-1-1 calls were reduced for clients who accepted services during the pilot period. All data was de-identified and aggregated in order to determine the frequency of 9-1-1 usage among the study population.

Qualitative data was collected through 8 site visits, 8 interviews, and 4 completed surveys with a total of 12 key project partners involved in planning and executing the REACH/EMS pilot project. Project partners included supervisory staff and CM's from REACH, as well as officers, supervisory staff and FDCARES nurses from PSF and RFA. Site visits and ride-a-longs were conducted with direct service providers from all involved organizations in attempts to understand the firsthand experiences that CM's, key stakeholders, and first responders were encountering during the pilot period. This observational

data collected during the site visits informed the interviews administered to key stakeholders (e.g. supervisors, and chiefs) and REACH CM's. Observational data from site visits also informed the surveys, which were administered via REACH to participants of the pilot program and separate surveys via online dispersal to FDCARES nurses affiliated with PSF and RFA. The qualitative data was aggregated, de-identified and evaluated for themes and commonalities in perceived gaps, strengths and recommendations for future cross-system collaborations.

Evaluation Findings

Pilot User Demographics

During the 12-month pilot, 79 clients were referred to the REACH/EMS pilot program. Of these 79 clients, FD staff referred a total of 68 clients through the formal referral form process. The other ten clients were referred through an alternative method (e.g. verbal, warm hand-off). Of these 68 referrals, REACH labeled a total of 37 participants as "accepted" on the referral forms (as shown in Table 1.0). Of these 37 participants, ages ranged from 26 to 71 years old. Additionally, the majority participants were female. One hundred percent of the 37 accepted individuals reported of being homeless. As demonstrated in Table 1.0, participants were racially diverse, with the majority participants being White. Of the 37 accepted participants, the number of 9-1-1 calls per participant within the last 12 months prior to referral date ranged from one to twenty-four, with a mean of four 9-1-1 calls per participant.

Table 1.0: EMS/REACH Client Demographics (N=37)

Characteristic	**N (%)**
Accepted Referrals	37
Sex	**N=37**
Female	22 (59)
Male	15 (41)
Age, yrs.	**N=37**
Mean	42
Race/Ethnicity	**N=37**
White	18 (49)
Native Hawaiian/Other Pacific Islander	2 (5)
Hispanic/Latino	1 (3)

Black/African American	6 (16)
Two or More Races/Ethnicities	4 (11)
Unknown/Not Reported	6 (16)
Homeless	**N=37**
	37 (100)
Number of 9-1-1 Calls Prior to Referral Date (12-Month Period)	**N=37**
Mean	4

The majority participants (29) reported using at least one or more substances (see figure 1). Of those, the majority reported using methamphetamines. Table 2 shows the breakdown of substance use for the 29 patients who reported substance use. Of the total number of participants using substances, 11 (30%) reported using 1 substance, 5 (14%) reported using 2 substances, 8 (22%) reported of using 3 substances, 4 (11%) reported using 4 substances, 1 (3%) reported using 5 substances, and 8 (22%) participants reported using 0 substances.

Figure 1: Percentage of Participants Reporting Substances Used (N=29)

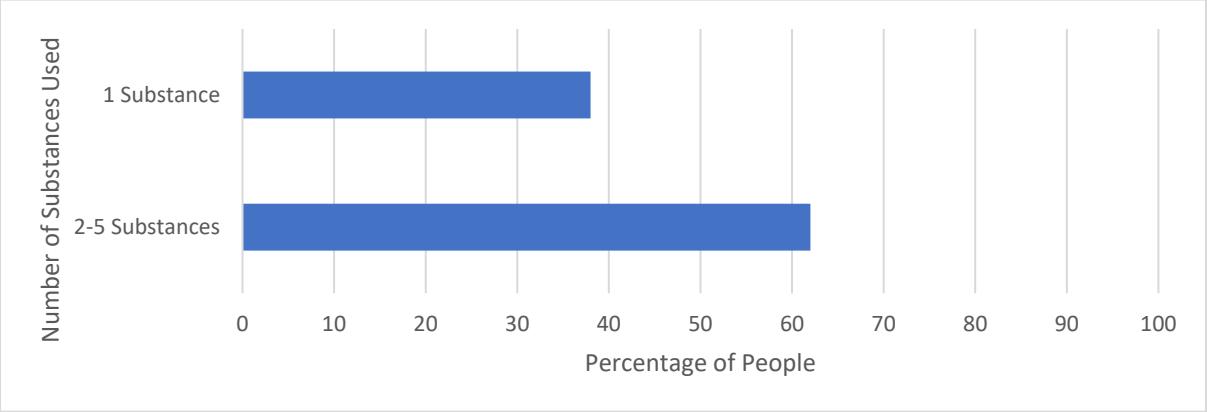


Table 2.0: EMS/REACH Client Characteristics (N=37)	
Characteristic	**N (%)**
Substance Use	**N=37**
Methamphetamines	17 (26)
Alcohol	14 (22)

Tobacco	9 (14)
Heroin	7 (11)
Marijuana	5 (8)
Other Substances Reported[1]	13 (20)

[1]Hypnotics, sedatives, tranquilizers, Barbiturates, Hallucinogens, Opiates, and Cocaine

The majority participants (23) reported being diagnosed with at least one physical/disease-related health condition (see figure 2). As seen in Table 2.1, the leading health condition consisted of cardiovascular conditions, which included a leading diagnosis of hypertension (8). Health conditions categorized as "other health diagnosis" were rather diverse spanning from pregnancy (2) to insomnia (1). Of the total number of participants reporting physical/disease-related health conditions, 9 (24%) reported having 1 health condition, 3 (8%) reported 2 health conditions, 2 (5%) reported 3 health conditions, 4 (11%) reported 4 health conditions, 0 (0%) reported 5 health conditions, 2 (5%) reported 6 health conditions, 2 (5%) reported 7 health conditions, 1 (3%)reported 8 health conditions, and 14 (38%) reported 0 health conditions.

Figure 2: Percentage of Participants Reporting Physical/Disease-Related Health Conditions (N=23)

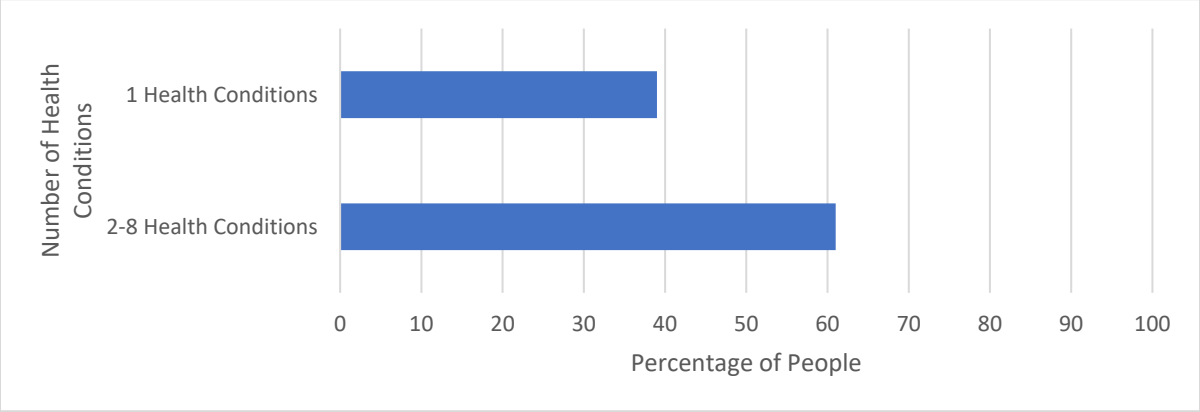


Table 2.1: EMS/REACH Client Characteristics (N=37)	
Characteristic	**N (%)**
Physical/Disease Related Health Conditions	**N=37**
Cardiovascular Conditions	14 (21)
Organ Dysfunction	12 (18)
Physical/Mobility Impairments	11 (16)
Respiratory Conditions	6 (9)
Epilepsy & Recurrent Seizures	4 (6)
Cancer	3 (4)
Infectious Disease	3 (4)
Other Health Diagnosis	14 (21)

The majority participants (27) reported having at least one or more behavioral health conditions (see figure 3). As seen in table 2.2, the leading behavioral health condition reported was depressive disorder. Of the total number of participants reporting behavioral health conditions 13 (35%) reported having 1 behavioral health conditions, 4 (11%) reported 2 behavioral health conditions, 8 (22%) reported 3 behavioral health conditions, 1 (3%) reported 4 behavioral health conditions, 1 (3%) reported 5 behavioral health conditions, and 10 (27%) reported 0 behavioral health conditions.

Figure 3: Percentage of Participants Reporting Behavioral Health-Related Conditions (N=27)

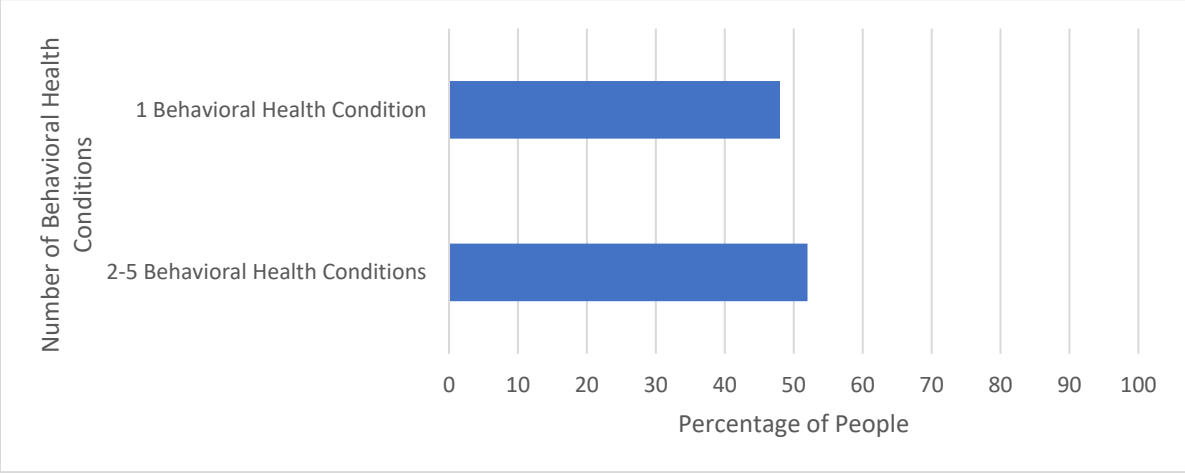


Table 2.2: EMS/REACH Client Characteristics (N=37)	
Characteristic	**N (%)**
Behavioral Health Related Conditions	**N=37**
Depressive Disorder	11 (20)
PTSD	9 (16)
Bipolar Disorder	9 (16)
Psychotic Disorder	9 (16)
Anxiety Disorder	4 (7)
ADD/ADHD	3 (5)
Developmental Disability	2 (4)
Other Mental Health Diagnosis	8 (16)

Enrolled Patients Increased Engagement with REACH

Table 3 provides the breakdown of patient referral status. The main reason for not getting accepted into REACH referral status was related to clients not being homeless. If a client was not eligible for the REACH/EMS pilot program services, the client was diverted to other applicable REACH services. REACH CM's reported reasons for clients being waitlisted due to, clients not being homeless, transferring service providers or living in a shelter, the inability of locating the client, as well as clients having low call volumes and/or no chronic health conditions. Additionally, two client referral forms were classified as "need more information" due to CM's needing consent information from EMS. Due to PSF and RFA merging fire authorities, RFA had fewer referrals than PSF due to RFA being unable to hire FDCARES nurses until July 2019. This delay in hiring FDCARES nurses ultimately minimized the number of referral forms completed.

Of the 37 accepted referral forms, the leading referrals made were for substance-related issues, mental health-related issues, and physical/disease-related health issues (see Table 3). When the referral form for a participant was created by FDCARES nurses or other fire department staff, more referral forms were completed when the initial responding EMS unit was present on scene, compared to referral forms created when EMS were no longer present. The majority referrals were created during the business hours of 0900 to 1700.

Table 3: Pilot Usage, and Referrals (N=37)	
Characteristic	**N (%)**
Referral Form Status	**N=68**
Accepted	37 (54)
Waitlisted	4 (6)
Needs More Information	5 (7)
Not Accepted	4 (6)
No Status Provided	18 (26)
Referral Location	**N=37**
Renton Fire Authority	5 (14)
Puget Sound Fire Authority	32 (86)
Referral Reason	**N=37**
Substance-Related Issues	16 (43)
Mental Health-Related Issues	9 (24)
Physical/Disease-Related Health Issues	4 (11)
Lack of Accessible Resources	3 (8)
Multiple Reasons	5 (14)
EMS Present During Referral	**N=37**
Present	11 (30)
Not Present	7 (19)
Not Recorded	19 (51)
Time Referral was Created	**N=37**
Between Business Hours (0900-1700)	16 (43)
Outside of Business Hours	14 (38)
Not Reported	7 (19)

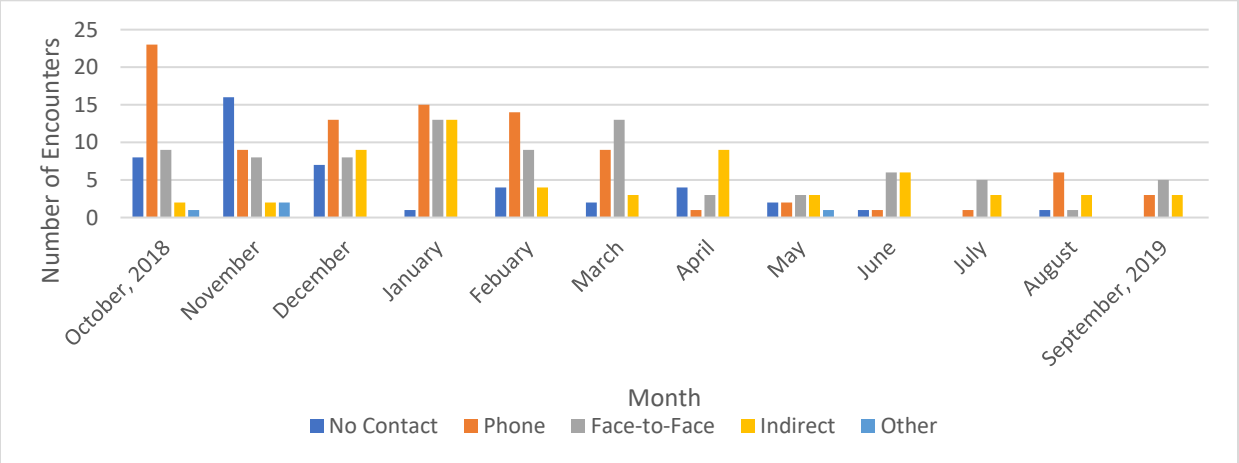
Of the 37 accepted clients, the majority of encounters REACH CM's had with clients were through the phone (see Table 4). As seen in Figure 4, October had the leading number of phone encounters for the 12-month pilot period, while January and March tied for the leading number of face-to-face encounters. As for the total number of encounter hours, the majority of hours REACH CM's spent with clients were face-to-face (see Table 5). As seen in Figure 5, January held the leading number of face-to-face hours,

and February had the leading number of encounter hours spent on the phone. As for indirect encounters, January held the majority.

Table 4: Total Number of Encounters (N=37)	
Characteristic	**N (%)**
Total	**290**
Face-to-Face	97 (33)
Phone	83 (29)
Indirect	60 (21)
No Contact	46 (16)
Other[1]	4 (1)

[1]Used when the encounter does not fit into the other categories listed (e.g. planning)

Figure 4: Monthly Number of Case Manager Encounters (N=37)

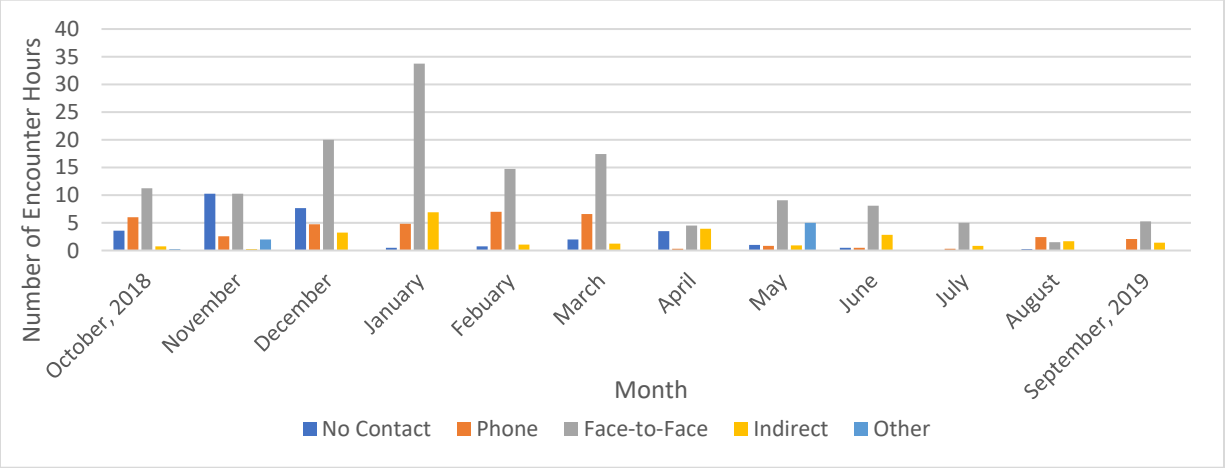


REACH mentioned the reasoning for the majority of encounters occurring during the fall and winter months was due to the change in weather patterns becoming colder, making living conditions more challenging for the homeless population. Furthermore, the surge in phone encounters during October 2018 (Figure 4) was due to REACH CM's attempting to serve the increased demand of clients attempting to obtain shelter and referrals to services. REACH additionally mentioned how the demand from clients increases during the fall due to cold weather shelters usually not opening until December or January.

Table 5: Total Number of Encounter Hours (N=37)	
Characteristic	**N (%)**
Total	**236**
Face-to-Face	141 (60)
Phone	38 (16)
Indirect	25 (11)
No Contact	30 (13)
Other[1]	2 (1)

[1]Used when the encounter does not fit into the other categories listed (e.g. planning)

Figure 5: Monthly Number of Case Manager Encounter Hours (N=37)



Services Provided and Outcomes

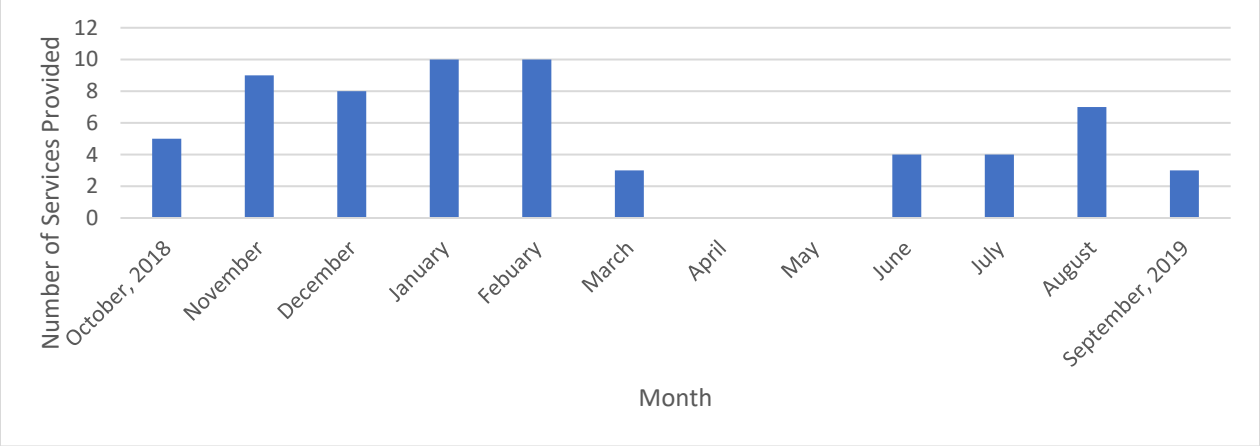
During the 12-month pilot, of the 37 accepted clients, there were a total of 63 services provided from REACH CM's. "Services Provided" involved referral services provided by REACH CM which were tangibly provided with an impact. As seen in Table 6, the leading referral service provided involved CM's providing some form of economic assistance. Economic services provided by REACH CM's varied from assistance in transportation to assistance towards employment. The months of January and February tied in the majority of services provided during the 12-month pilot (see figure 6). During the months of April and May 2019 no services were provided to clients. This is because during the month of April and May a work stoppage was initiated. The work stoppage was initiated due to REACH CM's providing harm reduction services to patients that failed to align with PSF and RFA organizational policies. The work

stoppage was lifted in June on the terms that REACH CM's treatment methodologies aligned with the organizational policies of PSF and RFA.

Table 6: Services Provided (N=37)	
Characteristic	**N (%)**
Services Provided[1]	**N=37**
Economic Stability	27 (43)
Health and Healthcare	19 (30)
Education	11 (17)
Social and Community Context	5 (8)
Neighborhood and Built Environment	1 (2)

[1]Services Provided were categorized based upon the 5 Social Determinants of Health[14]

Figure 6: Monthly Number of Services Provided (N=37)



*During the months of April and May a work stoppage was conducted halting all operations (excluding office encounters).

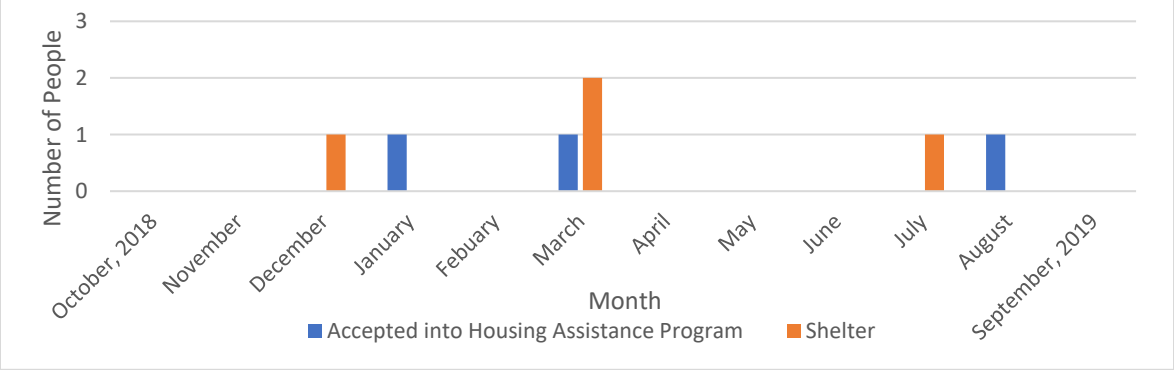
As a result of the encounters and services provided, there were a total of 7 occurrences involving people being stabilized during the 12-month pilot period (see Table 7). These outcomes consisted of REACH CM's removing clients from homelessness and referring patients to either a shelter and/or being accepted into the REACH housing assistance program. Of the total stabilization occurrences, there were more occurrences of participants obtaining shelter as compared to participants gaining acceptance into a housing assistance program. The majority of these outcomes occurred during the month of March (see

Figure 7). These outcomes reflect the immense amount of logistical needs this vulnerable population requires in order to obtain an outcome encompassing safe housing.

Among the 37 accepted participants, more 9-1-1 calls were made to Renton and Puget Sound Fire Authority during the 12-month pilot period as compared to the year prior (October 1st, 2017 to September 30th, 2018) with an average of five 9-1-1 calls per participant during the pilot period. Despite there being more total placed calls during the pilot period, out of the 37 accepted participants, some participants did reduce their 9-1-1 call utilization during the pilot period compared to the year prior by a reduction average of three 9-1-1 calls per person.

Table 7: Outcomes and 9-1-1 Utilization (N=37)	
Characteristic	**N (%)**
Outcomes	**N=37**
Accepted into Housing Assistance Program	3
Shelter	4
ESO 9-1-1 Utilization	**N=37**
Prior to 12-Month Pilot (Mean)	125 (3)
During 12-Month Pilot (Mean)	188 (5)
Difference	63
Number of Participants who Reduced 9-1-1 Utilization	11 (30)
Mean Reduction Among 9-1-1 Calls	3

Figure 7: Monthly Number of Outcomes (N=37)



*During the months of April and May a work stoppage was conducted halting all operations (excluding office encounters).

Qualitative Data: Findings from Interviews, Data Surveys, and Site Visits

The Major Facilitators Identified by Project Partners Included:

A shared common goal of providing a service to a vulnerable population

All respondents reported similarities in organizational goals in terms of serving the homeless population. Specifically, various similarities between PSF/RFA and REACH were mentioned due to both organizations working with vulnerable populations and having a shared goal of connecting vulnerable populations to resources. All respondents mentioned themes of how impressed they were with the multi-organizational compassion which was displayed towards patients in addition to the willingness to work together as a collective to serve a vulnerable population.

A linkage created between existing resources

The project was a step towards further unification of existing resources, working towards a shared goal of creating further options for clients. Respondents discussed the importance of continuing this unification of resources in attempts to better serve vulnerable populations. Respondents additionally remarked on the linkage of two existing resources introducing cross-system collaboration, thus enabling a broadened perspective for providers in terms of treatment methodologies on patients.

Increased education towards alternative methods

Some respondents reported how organizations gained an increased understanding/education towards the different patient care interventions either organization utilizes on a daily basis. Specifically, respondents reported how staff members and first responders from PSF/RFA gained a better understanding of the harm reduction approaches that REACH utilizes towards treating homelessness and addiction-related illness.

Benefit to the community

Respondents reported they did not think harm was done to the homeless population or the larger community, because of the improved trust that was established between the homeless population and PSF/RFA responders. During the interviews and site visits, stakeholders additionally addressed, that in order to prevent future harm to the homeless community, the program must maintain sustainability in order to provide consistency for the vulnerable population.

Monthly planning meetings

When interviewees were asked about monthly planning meetings, responses were mixed. Some respondents felt meetings were too frequent, while other respondents recognized that monthly meetings were necessary in order to maintain productivity. Some who viewed the meetings as advantageous mentioned the usefulness of being able to sit with all the stakeholders at the same table. Meetings enabled stakeholders to correct issues and provide feedback in discussions. Meetings also provided a sense of quality and quantity of work that was being conducted which ultimately aligned all stakeholders to be on the same page for success.

The Major Gaps Identified by Project Partners Included:

Differences in work culture

Responses from interviews, surveys and site visits all included themes of work culture gaps. The majority of interview respondents reported differences among treatment methodologies/operations between REACH and PSF/RFA at least once during the pilot program. This was because REACH utilizes a chronic patient care approach which is relationship-based, while the fire departments usually provide a more acute service, focused towards emergent care. PSF/RFA reported of challenges encompassing separating oneself from the mindset of the crisis care model, and instead coming on scene with more of a long-term care model. This is an attempt to serve the patient and not the incident. Some respondents additionally mentioned that due to emergency staff wearing uniforms and emergency vehicles having emergency lights mounted, some patients are intimidated, due to existing warrants or triggered PTSD related symptoms from past law enforcement incidents. Respondents added how these emergency cultures limit the chances of homeless individuals calling 9-1-1.

Homeless individuals who didn't call 9-1-1 were initially being missed in this pilot study due to the eligibility criteria. Respondents explained how this eligibility criterion of only reaching out to individuals who called 9-1-1, conflicted with REACH's CM work culture. This was because REACH work culture consisted of rarely turning down care/assistance to homeless patients regardless of their involvement with the EMS system. Due to this work culture conflict, REACH CM's changed their eligibility model, and began searching for clients in February who were not calling 9-1-1 and were located within PSF/RFA jurisdictions. This conflicted with the original pilot eligibility criteria and complicated the referral process.

Lack of initial clarity in organizational policies/standards

Respondents mentioned how there was an initial lack in transparency among the organizational policies of REACH and PSF/RFA. Both organizations reported that at the beginning of the pilot period there was a lack of communication about either organization's policies involving the harm reduction model. This is because REACH was initially conducting harm reduction strategies that were not accepted within the regional jurisdictions of PSF/RFA. This resulted in an approximate 2-month hold on pilot operations during the month of April and May 2019. There was a general theme among respondents that while some progressive harm reduction strategies, such as syringe exchange and naloxone administration, were normalized policy standards among REACH, such policies did not match PSF/RFA harm reduction policies. As such, REACH staff was limited in conducting harm reduction strategies because they operated under the umbrella of PSF/RFA. The majority of respondents additionally mentioned the need for increased transparency and a thorough understanding of both organizational policies prior to future pilot initiation. Numerous respondents specifically reported how the public needs to have more involvement/transparency as well when initiating pilot projects which involve harm reduction. This is so community members such as residents, city officials, and law enforcement, can take part and agree upon localized interventions affiliated in serving the target population.

Challenges in the referral process

The majority of respondents reported challenges related to the referral process, such as a lack of communication after a referral was made or created. This was due to the lack of an official method for receiving referral updates or obtaining further information after patients were referred. Respondents reported a major reason for this lack of communication was due to REACH CM's and FDCARES nurse schedule differences.

Reports indicated that inadequate descriptions of clients on referral forms caused challenges when searching for clients in addition to determining whether clients were homeless or not. Respondents additionally reported how "face-to-face" or "warm hand-offs" between FDCARES nurses and REACH CM's significantly improved the chances of finding the clients due to clients being present during the transfer of care. Various respondents additionally mentioned how referral forms were forgotten sometimes due to a "warm hand-off" occurring on scene of the 9-1-1 call. Referral forms were forgotten due to the transfers being immediate and as such there was less attention to filling out the referral forms.

Remarks were also made on the referral process being rather slow. Respondents reported of feeling the continuous need to play catchup due to the referral process lacking efficiency. The majority respondents mentioned how a more streamlined IT referral process would be a more efficient approach in future pilot projects.

Other key project design limitations

An additional gap that was noted by the majority of direct patient care providers (CM's and FDCARES nurses) was the difference in operational time frame between the two organizations. Respondents mentioned a generous number of eligible clients were missed for warm hand-offs during the nighttime and on weekends due to REACH CM's operating during daytime hours only, while PSF/RFA staff operated 24 hours a day. Many eligible patients had crisis at night, yet patients were harder to find when a warm hand off wasn't conducted. A few respondents reported this potential gap could be mitigated by having both organizations available 24/7.

A few respondents additionally mentioned how PSF and RFA merged fire authorities during the pilot which created some initial staffing difficulties. PSF was already fully staffed with FDCARES nurses so they were able to quickly receive the pilot training and begin conducting referrals, yet RFA was not staffed with FDCARES nurses until July 2019 which reduced the number of referrals within the Renton region.

Other Populations missed

Some respondents reported IV Drug users are being missed from the program. Respondents reported this population was being missed due to the multi-organizational agreement to not conduct harm reduction services during the pilot, preventing the CM's from exchanging syringes and Naloxone to homeless individuals in the region.

Numerous individuals additionally reported how patients who were not homeless were missed during the pilot program. Some respondents further explained how low-income populations, such as senior citizens, were also missed during the pilot period due to eligibility criteria involving the homeless population only.

Discussion

The purpose of this pilot was to combine existing resources to provide better services to a vulnerable population. A linkage was developed between two existing resources, which historically have had

minimal collaboration due to their differing treatment methodologies. This pilot also uncovered clear evidence involving the amount of effort the homeless population needs in order to be better served.

290 encounters, 236 encounter hours and 63 services provided, resulted in 7 total occurrences of individuals being stabilized. Of these seven outcomes, four occurrences involved clients being referred to a shelter and three clients were accepted into a housing assistance program. This number of successful outcomes directly reflected the immense complexity of this target population involved and the efforts needed to properly serve this vulnerable community.

Demographics were complex among patients who were referred to REACH. Physical/disease related health conditions fluctuated in severity with most participants experiencing more than one health condition. The majority of patients additionally reported experiencing at least one behavioral health condition. Of the individuals with behavioral health conditions, the majority reported being diagnosed with more than one health condition. Furthermore, the pilot showed that the majority of homeless individuals who called 9-1-1 in South King during a 12-month pilot study, were using substances, with the majority using more than one substance. These complex characteristics of participants provided evidence towards how diverse and unique this vulnerable population's needs are, as well as how the collaborative usage of existing resources with diverse service capabilities are needed in order to continue serving this population.

Work culture gaps were discovered among collaborating organizations. Stakeholders from participating organizations mentioned how organizational policies in patient treatment interventions were not addressed with the full transparency/clarity needed prior to pilot initiation. This caused a work stoppage during the months of April and May for the pilot. Further work culture gaps were discovered when a population being missed was revealed by REACH CM. When REACH CM's were seeking individuals, who called 9-1-1, CM would frequently meet additional individuals (in camps) who were homeless yet failing to meet the eligibility criteria for the pilot due to not calling 9-1-1. This created a gap in work culture for the organizations due to REACH discovering a population which needed services, yet the population not meeting the pilot's eligibility criteria.

Project partners reported gaps in referral process. Respondents mentioned that due to the referral process being hard copy paper, the referral process lacked efficiency in terms of communication among service providers. Respondents additionally mentioned how the referral process lacked inclusiveness towards alternative populations such as homeless individuals who aren't calling 9-1-1.

Challenges were faced when obtaining patient perspectives of the pilot. REACH CM's reported of the inability to obtain participant survey responses because CM's were unable to find clients. Due to this target population being homeless, this population's location tends to be transient. This posed as a challenge for CM's when searching for clients with no designated address.

By examining these key points which occurred during the 12-month pilot, one can gain a clear understanding towards the main concepts and gaps which were involved when serving this target population. By using this highlighted information, planning and processing can be improved in future projects to better serve individuals experiencing homelessness.

Conclusion

The REACH/EMS pilot provided a needed service to low acuity 9-1-1 callers experiencing homelessness in the cities of Kent and Renton. This evaluation was developed to assess the extent to which the pilot achieved its goals set at the beginning of the 12-month period. Through both quantitative and qualitative evaluation methods several key points were highlighted in this evaluation which should be interpreted as recommendations for future projects of this kind within King County.

The results of this evaluation showed that a great deal of resources are needed to address the needs of a highly complex patient population, which justifies the ongoing collaboration between different service-delivery agencies. Due to the majority of clients experiencing multiple substance addictions, behavioral health conditions, and physical/disease-related health conditions, it is apparent that participating agencies with different missions and ways of delivering services need to continue collaboration in serving this target population.

Additionally, it would be advantageous for partners in future collaborative organizational projects to address organizational policies with full transparency/clarity prior to project initiation. Through improving planning measures by educating either organization on various policies prior to project initiation, staff members would benefit from an increased understanding in the reasoning for policies, in addition to mutual organizational goals.

Referral processes can also be improved in terms of efficiency. By implementing a more IT-based referral process, efficiency would not only increase but also improve communication among service providers. Additionally, by implementing more inclusiveness in the referral process by having an eligibility criterion which is inclusive to homeless individuals who aren't calling 9-1-1, referral numbers

may increase, as well as fill in gaps in work cultures. This is because, organizations would no longer have the work culture challenge in refusing referral services to ineligible clients.

Moving forward, future stakeholders should utilize this pilot evaluation in order to gain further evidence and understanding towards the shifts which need to be made in order to continue improvements towards serving this target population. Through the generous effort of 290 encounters, 236 encounter hours and 63 services provided during this pilot program, a vulnerable population was provided an improved service through incorporating case management services within emergency medical operations. This pilot project was an integral step towards introducing further unification of existing resources to strategically better serve homeless individuals, who would normally solely rely on emergency medical services for support. In order to continue properly serving this population though, further linkages between existing resources must continue to be developed through increasing community education and implementation of pilots such as the REACH/EMS pilot which breaks the mold of conventional service methods.

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Appendix A: 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:_____) Patient Declined 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 rejected or need more info, reason: _____

Initial contact (if accepted): N/A EMS Present EMS Not Present

Updated 9.23.2018

Appendix B: Key Staff Member Interview Questions (i.e. Chiefs, FDCARES supervisory staff, and REACH supervisors)

1. What do you feel went well in this pilot project?
2. Where in the pilot project do you see room for improvement?
    - What resources are needed to see these improvements take place?
3. How do you feel this program's resources were used?
    - How can this program be more efficient towards current or future usage of existing resources?
4. In your opinion how smoothly was REACH's integration into the fire department's existing work?
5. What work culture changes or shifts were noticed in staff, when analyzing the linkage of FDCARES and REACH?
    - How could these work culture differences be eased, and future collaboration improved?
6. Were the monthly meetings useful to you? If yes, in what way where they useful?
7. How did the demand of clients compare with your capacity?
8. How do you feel this program was administered in terms of equity?
9. What populations are being missed from the pilot program's services?
10. What was the community's reaction to this pilot?
11. What, if any, harm was placed upon the community by the initiation of this pilot?
12. How would expanding the pilot program minimize barriers faced during the pilot?
    - What resources are needed for this expansion?

Appendix C: Key Staff Member Qualitative Data Results N=6

Question 1: What went well in the pilot

Response (Count)
Identified a need (1)
Gained increased knowledge towards REACH resources (1)
A linkage between two existing resources (5) - Two educated backgrounds combined (1)
Both organizations willing to help designated population (3)

Question 2: Room for improvement

Response (Count)
Referral process (4)
Education in organizational policies encompassing harm reduction (3)
Incorporating other existing organizations/resources (1)
Incorporating REACH into FD (1)

Follow-up: Resources needed for improvements

Response (Count)
REACH needs closer response to calls enabling warm hand offs (1)
Transparency with community and other organizations (3)
Increase HR presence for REACH case managers (1)
More streamlined IT referral process (1)
Increasing education towards available existing resources (2)
Improving education in harm reduction (2)
Better assessment tools in the field (1)
Financial resources (1)
Not Sure (1)

Question 3: How the program's resources were used

Response (Count)

Resources were sufficient (4)
Employee resources were sufficient (1)
More REACH employees were needed initially (1)
Frugality was involved (1)
Resources for referral process caused delays (1)

Follow-up: Improving efficiency towards resources

Response (Count)
Improving referral process (1) - More IT approach (1)
Shared databases (1)
Improved transparency among organizational policies (1)
Improved public education (1)
Training in existing organizational resources (1)
Determining resources for financial sustainability (1)
Incorporating vehicles for REACH (1)
Not Sure (1)

Question 4: REACH integration into FD existing work

Response (Count)
Was smooth (1)
Was not smooth (3)
REACH displayed flexibility towards FD policies (1)
Different organizational ethics/policies in harm reduction (1)
Different organizational policy/standards in employees (1)
REACH supervision was limited (1)
Communication systems were a barrier (1)
Unable to answer (1)

Question 5: Work culture changes or shifts

Response (Count)
Adapting to FDCARES work hours (1)
Different harm reduction strategies among FD and REACH (5) - Increased FD education towards harm reduction strategies (2) - REACH used more conservative means of harm reduction (1) - REACH harm reduction strategies pushed FD boundaries of comfort (1) - REACH learning to communicate harm reduction strategies to community (1) - Different task lists between emergent care and harm reduction (1)
Staff acceptance of REACH Case Managers (1)
Difference in emergent services and longitudinal care service (1)

Follow-up: Differences eased, and collaboration improved

Response (Count)
Transparency in organization policies prior to start of pilot (5) - Clarifying REACH harm reduction approaches to FD (1) - Training first responders in harm reduction strategies prior to pilot (1) - Meet communities with services they are ready for (1)
Changes to referral process (2) - Determination of who is making referrals (1) - Different communication pathway in referral process (1) - Follow-up with FDCARES showing referral is being used (1)

Question 6: Usefulness in monthly meetings

Response (Count)
Yes, Useful (3) - Sitting with all stakeholders (1) - Enabling corrections and feedback discussions (1) - Aligning everyone on the same page for success (1) - Provided sense of quality and quantity of work (1)
Too many meetings (1)

- Did not need to be every month (1)
Meetings were repetitive (1)

Question 7: Demand of clients compare with capacity

Response (Count)
More capacity than demand at first (3) - Case managers were limited by 9-1-1 usage only (1) - Case managers began searching for clients (2)
More demand than capacity (1)
Capacity was handled sufficiently (2)
Clients were hard to find (1)
REACH case managers needed more time for client (1)
Lack in communication of REACH capacity (1)
Challenges of treatment hindered capacity/intake (1)

Question 8: Equity in program administration

Response (Count)
Program administered equitably (5) - Equitable in terms of specific population and eligibility criteria (1)
Many individuals in the region are white (1)
Always room for improvement (1)
Equity lacked (1)

Question 9: Populations missed

Response (Count)
People not calling 9-1-1 (2) - People of color (1) - High acuity medical need (1)
IV drug use population (2)
Patients already tied to shelters (1)

Individuals who are not homeless (2)
Not sure (2)

Question 10: Community reaction to pilot

Response (Count)
Invisible to public (3) - Majority of public unaware of program (3) - Unawareness level by community could have been improved (1) - Politicians and community members were initially unaware of REACH strategies (1)
Significant impact to homeless community (1) - People now have a number other than 9-1-1 for help (1) - Homeless realized FDCARES was there to serve them better (1)
Generally positive (1)
Negative at one point by community (3) - Questions of agreement in harm reduction (2) - Kent PD not happy with needle distribution (1)
First responders noticed improved patient opportunities (1)
Community was happy there was a resource (2)

Question 11: Harm upon community

Response (Count)
No harm to clients (1)
Only harm placed on clients was unsustainability of program (1)
No harm to community (6)
Harm reduction strategies created a political stir (1) - Officials in Kent worried about appearances (1) - PD disagreed with harm reduction strategies (1)

Follow-up: Resources needed for improvements

Response (Count)
REACH needs closer response to calls enabling warm hand offs (1)

Transparency with community and other organizations (3)
Increase HR presence for REACH case managers (1)
More streamlined IT referral process (1)
Increasing education towards available existing resources (2)
Improving education in harm reduction (1)
Financial resources (1)
Not Sure (1)

Question 12: How expanding program would minimize barriers

Response (Count)
Higher contact rate of client (2)
Reduction of high utilizer 9-1-1 calls (2)
Educate community members (1) - Particularly PD (1)
Acceptance by community (1)
Barriers that already occurred would be solved (2)

Follow-up: Resources needed for expanding program

Response (Count)
Referral process (1) - Integrating IT referral process (1)
Increased Spanish speaking staff (1)
Removing eligibility criteria involving frequency of 9-1-1 calls (1)
Reducing uniform usage among 9-1-1 population (1)
Having designated shelter in the community (1)
A unification of medical and communal services (1)
Allowing case managers full scope of practice (1)
Acceptance/Approval from community (2) - Resource needs to stay in community to educate community (1) - Approval of harm reduction practices (1) - Community understanding

Sustainable funding (2)
Correct infrastructure (1)
Improving education in harm reduction (1)
Financial resources (1)
Not Sure (1)

Appendix D: FDCARES Nursing Staff Member Survey

Attention survey respondent: This survey has been created in attempts to gain a further understanding of the FDCARES nursing staff's perspective of the pilot program affiliation with REACH. No personal information will be requested nor released to the public. Responses provided may be used for scholarly and public informational purposes, in attempts to gain an improved understanding towards the pilot program.

1. How was your experience in regard to training on the referral pathway?

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

2. What barriers did you face when using the referral pathway?
    - What solutions could be implemented to mitigating these barriers?
3. In your opinion how smoothly was REACH's integration into the fire department's existing work?
4. What cultural similarities were encountered when working with REACH? (i.e. organizational mission, ideologies, operations, etc.)
5. What cultural differences were encountered when working with REACH? (i.e. organizational mission, ideologies, operations, etc.)
    - How could these differences be eased?
6. In what ways do you feel that the program reduced burden on you and your team?
7. How do you feel this program was administered in terms of equity?
8. What populations are being missed from the pilot program's services?
9. Would expanding the pilot program minimize barriers faced during the pilot?

1	2	3	4
Yes	No	Not sure	Prefer not to answer

10. If answered "yes" for question 9, how would expanding the pilot program minimize barriers?

Appendix E: FDCARES Nurse Survey Data Results N=4

Question 1: Experience with training on referral pathway

Response (Count)
Strongly Dislike (0)
Dislike (1)
Don't like or Dislike (2)
Like (1)
Strongly Like (0)

Question 2: Barriers to referral pathway

Response (Count)
Issues getting in contact with case managers (2) - When patient was in crisis or afterhours (1) - For warm hand-offs due to meetings (1)
Issues receiving updates and responses towards patients that were referred (2)

Follow-up: Solutions to mitigating these barriers

Response (Count)
Two-way communication is needed regarding referral confirmations, and updates (1)

Question 3: REACH integration into FD existing work

Response (Count)
A work in progress (1)
Difficult at first due to no transportation (1)
Barriers involving limited hours and days available (1)
Better question for case managers (1)

Question 4: Cultural similarities with REACH

Response (Count)
Both organizations care for the community (1)

Both organizations care for vulnerable populations (1)
Similar goals in terms of care and connecting resources for vulnerable populations (2)

Question 5: Cultural differences when working with REACH

Response (Count)
Different operating hours (1)
Different operational methods (1)
Lack in two-way communication towards mutual patients (1)
Lack in communication with case managers (1) - REACH meetings (1) - In the field working with clients (1)

Follow-up: Differences eased, and collaboration improved

Response (Count)
Same operating hours (1)
Different referral pathway (1) - Implement IT referral form (1)
Improving communication methods towards mutual patients (1)

Question 6: Ways the program reduced burden

Response (Count)
Helpful when able to access patient (1)
Good work with high 9-1-1 utilizing homeless population (1)
No change in FDCARES workload (1) - Benefitted patient due to better patient management (1)
Unsure due to no ongoing communication with REACH team (1)

Question 7: Equity among program administration

Response (Count)
Equally (1)

Not sure (1)
Didn't understand question (2)

Question 8: Populations missed

Response (Count)
Population that isn't homeless (1)
Homeless individuals who need assistance when calling 9-1-1 (1)
Housed seniors with low-income (1)
None (1)

Question 9: Would expanding pilot program minimize barriers

Response (Count)
Yes (2)
Not Sure (2)
No (0)
Prefer not to answer (0)

Question 10: How expanding pilot program will minimize barriers

Response (Count)
Expanding REACH availability timeframe (2) - Being available on scene/responding to calls (2) - Operating 24/7 (2) - Pro-actives with CARES as needed (1)

Appendix F: REACH Case Manager Interview Questions

1. How well did the training you received prepare you for using the referral pathway?
2. How were the monthly meetings useful to you?
3. What barriers did you face when using the referral pathway?
    - What solutions could be implemented to mitigate these barriers?
4. In your opinion how smoothly was REACH's integration into the fire department's existing work?
5. What cultural similarities were encountered when working with FDCARES? (i.e. organizational mission, ideologies, operations, etc.)
6. What cultural differences were encountered when working with FDCARES? (i.e. organizational mission, ideologies, operations, etc.)
    - How could these cultural differences be eased?
7. How effective were you in connecting patients to the resources they needed?
8. How did the demand of clients compare with your capacity of resources?
9. How do you feel this program was administered in terms of equity?
10. What populations are being missed from the pilot program's services?
11. How would expanding the pilot program minimize barriers faced during the pilot?
    - What resources are needed for this expansion?

Appendix G: REACH Case Manager Qualitative Data Results N=2

Question 1: Preparation and training for referral pathway

Response (Count)
No training Provided (1) - Integrated late into the project
Adequate amount of training (1) - Ride-a-longs benefitted prior to Pilot start of pilot - Communication with FDCARES nurses prior to start of pilot - Adjustments made to referral form prior to pilot

Question 2: Usefulness of monthly meetings

Response (Count)
Not useful (2) - Different people every month (1) - Communication issue towards who would attend (1) - No need for every month (1)

Question 3: Barriers using referral pathway

Response (Count)
Lack of verbal communication between Nurses and Case Managers (1)
Inadequate client descriptions created challenge in finding client (1)
Paper referral forms forgotten to complete causing database issues (1)
Referral pathway unclear for some first responders (1)
First responders respond to eligible patients but only FDCARES provides referrals (1)

Follow-up: Solutions to Barriers

Response (Count)
Meeting with nurses face-to-face (1)
Obtain consent for photo on referrals (1)
REACH case managers work same shift as FDCARES nurses (1)
Enable first responder's eligibility to create referrals to case managers (1)

Question 4: REACH integration into FD existing work

Response (Count)
Smoothly at first (1)
Discovered REACH harm reduction policies differ with FD policies (1)
Started late, wasn't integrated normally (1)

Question 5: Cultural similarities with FDCARES

Response (Count)
Compassion towards clients and population (2)
Willing to work with other organizations (1)
Care coordination when working with clients (1)

Question 6: Cultural differences with FDCARES

Response (Count)
Organizational mission and operations (2) - FD is Para militaristic (1) - FDCARES wears uniforms which can intimidate certain populations (2) - Vehicle emergency lights trigger PTSD in populations (1)
FD has different ideologies in social justice (1)
REACH case managers represent the population they serve (1)
FDCARES provides acute service/REACH provides chronic harm reduction (2)
Lack of employee diversity in FD (2)
FDCARES wears uniforms which can intimidate certain populations (1)

Follow-up: Solutions to cultural differences

Response (Count)
More racial diversity among FD employees (2)
Emergency personnel willing to dress down from uniform (1)
FD increases employee education in social justice (1)

Question 7: Effectiveness in connecting patients to resources

Response (Count)
Effective (1) - Barriers faced if client was already assigned to shelter (1) - Inability to work with client if already assigned to case manager (1) - Challenging for substance users to maintain sobriety in shelter (1)
Not sure (1)

Question 8: Demand of clients compared to resources

Response (Count)
Sufficient resources for the demand (2)
Many clients were not eligible due to not calling 9-1-1 (1)
Case Management had no sure access to shelters (1)

Question 9: Program administered in terms of equity

Response (Count)
Lacked racial equity among clients (2) - People of color reluctant to call 9-1-1 (2)
People who didn't call 9-1-1 received less services (2)
Some clients did not call 9-1-1 enough to receive referral (1)

Question 10: Populations missed in pilot program

Response (Count)
People of color (2) - Many afraid of white individuals in uniform (2) - Specifically, African American males (1)
Individuals afraid to call 9-1-1 (2) - Individuals with criminal backgrounds (1)
Terminally ill populations (1)

Question 11: How expanding program would minimize barriers

Response (Count)
Continue referral opportunities for displaced individuals (2)

Follow-up: Resources needed for expansion

Response (Count)
Increased diversity among FD employees (1)
Increased language diversity among FD employees (1)
Case Manager available 24 hours (1)
FDCARES resource available 24 hours (1)