

THE RESOURCE ACCESS PROGRAM

A SUCCESSFUL PROGRAM DISBANDED

SUMMARY

The 2017/2018 San Diego County Grand Jury (Grand Jury) investigated the Resource Access Program (RAP) which was active in the City of San Diego from 2010 to late 2016. The investigation included examination of the funding sources for the program, the organization, the training of personnel, its operations, and the benefits to the public and to those who were directly served by RAP. The Grand Jury recommends that the mayor and city council of San Diego explore ways to replicate the success and benefits of the now-defunct Resource Access Program, with the goal of reducing over-use of emergency medical services thus improving the efficiency of the 9-1-1 system.

INTRODUCTION

RAP was a paramedic-based surveillance and case-management system that identified and provided services to a relatively small number of people who created a financial and logistical burden on Emergency Medical Services (EMS) by repeatedly calling 9-1-1 for situations that were not life-threatening or medical emergencies. RAP, a pilot program funded by grants, ended in December 2016 when its four paramedics, who were employees of and on loan from American Medical Response (AMR), were called back to AMR. When it was operating, RAP relieved the City of responding to 9-1-1 callers who did not require the full spectrum of emergency medical services. Instead, RAP reduced costs by providing the non-emergency care required in these calls. The Grand Jury investigated the social and economic value of RAP and how the termination of this program affected clients, city services, and available resources.

PROCEDURE

The Grand Jury interviewed:

- Personnel in the San Diego Fire-Rescue Department (SDFD)
- Former RAP staff
- Management of the Psychiatric Emergency Response Team (PERT)
- Deputy Fire Chiefs, San Diego Fire-Rescue Department

The Grand Jury reviewed the following:

- San Diego Fire-Rescue Department (SDFD) website (www.sandiego.gov/fire)
- San Diego Police Department (SDPD) website (www.sandiego.gov/police)
- Psychiatric Emergency Response Team (PERT) website (www.comresearch.org/pert.php)
- City of San Diego website (www.sandiego.gov)
- Newspaper and professional journal articles and reports on RAP and other paramedicine projects

Grand Jury members toured the San Diego Fire-Rescue Metro Command Data Center (MCDC).

DISCUSSION

The Origins of RAP

San Diego EMS serves a population of 1.39 million people living in a 362-square-mile area. Twenty-two years ago the City of San Diego initiated a program to identify the health-care needs of some of its most vulnerable citizens and connect them to appropriate medical resources. This program identified and monitored 18 chronic alcoholics who were frequent users of police and medical services. The SDPD Homeless Outreach Team (HOT) found that providing emergency care for this small group cost EMS providers, hospital emergency rooms, and police over \$1.5 million annually. Following this, the Serial Inebriate Program (SIP) was established in 2000 to address the issues of a second set of chronic alcoholics who were burdening the 9-1-1 system with repeated calls due to public intoxication that did not involve life-threatening or medical emergencies.

The program provided intensive case management and connection to services needed to achieve stability and long-term recovery. SIP is still in operation providing a cost-effective alternative to the unsuccessful revolving door practices that had been employed with this population and offering them treatment in lieu of incarceration.

Issues Addressed by RAP

Based on the success of SIP, San Diego leaders created RAP, a more general program to address overuse of the 9-1-1 system for issues other than true medical emergencies. EMS vehicles and ambulances were responding to emergency calls from the same individuals multiple times per month. These frequent users of the 9-1-1 system often suffered from mental illness or substance abuse which impair their judgment and ability to care for themselves. Over 70% were homeless. Their calls were often related to hunger, loneliness, and the harsh circumstances of living on the streets. These issues require long-term social and behavioral health services rather than the short-term medically oriented treatments available in emergency rooms.

State law requires dispatch of EMS responders to each call. The actual services required by a 9-1-1 call generally cannot be determined from the call. The use of emergency services for non-emergency cases creates unnecessary expense, puts additional strain on personnel and resources, and makes it possible that responses to actual medical emergencies could be unnecessarily and dangerously delayed. The RAP program was granted an exemption from the emergency-room transport requirement, which allowed the teams to treat clients in the field or transport them to alternative treatments more appropriate to their particular situation.

Formation of RAP & Street Sense

The RAP pilot project was funded by a \$15 million Beacon Community grant from the Office of the National Coordinator for Health Information Technology in 2010, an additional \$1 million from the Alliance Healthcare Foundation in 2011, and a \$2.5 million California Community Paramedicine Pilot Project grant in 2014. These funds supported RAP operations and allowed the development of a computer software tool called Street Sense, an innovative health information exchange. That program could link emergency-service personnel with key social service partners to reduce chronic misuse of the 9-1-1 system and make it more efficient and cost-effective. This

patient-centered program included the development of a history for each individual caller. Data included a number of measures from multiple incidents, including a number of 9-1-1 calls and ambulance transports, time interval between 9-1-1 calls, nature of incident and treatment actually required, and charges per patient and incident. This data could be employed both to match services to the needs of the individual patient and to provide outcome measures to evaluate the program. This electronic health-record system was critical to success of the program. It provided real-time data to EMS providers, case managers, and physicians about the patients being treated and gave them background records to help make decisions in real time about how to deal with an individual most effectively.

Who Were RAP's Clients?

The project focused on frequent 9-1-1 callers who had a substantial impact on a wide range of community resources, including law enforcement, the health care system, and EMS services. Individuals were classified by the number of ambulance transports, focusing first on 25 to 30 “mega users,” people who had 52 or more transports in the prior year. As the program grew more clients were added, including “super users,” who had 26 or more transports per year, and “frequent users,” who had eight or more.

RAP paramedics contacted these identified over-users to let them know about additional help that could be available to them and to offer them the opportunity to become part of the new program. Upon entry into the program their particular needs were evaluated and they were assigned a case manager who connected to social and mental health resources, housing and shelters, and other services that might have been unfamiliar or difficult for certain clients to connect with on their own.

Street Sense provided information to RAP to assist in understanding subsequent 9-1-1 calls by their clients. RAP personnel would respond to the call, meeting the client at the site of the incident or in the emergency room. After talking with the client a determination could be made to provide onsite treatment, transport to an emergency room, or transport to an alternative service facility. The RAP coordinator could also contact the primary-care provider and any mental health clinicians who had treated the client to notify them that their patient was calling 9-1-1 repeatedly. This allowed them to take steps to reduce future calls (e.g., by increasing medications, treating a physical problem, or counseling them on when it is appropriate to call 9-1-1). In addition, social workers or case managers assigned to that client could be informed of the call and updated on treatment decisions.

RAP Responses

When a 9-1-1 call came in from a source identified as a RAP client the RAP coordinator was notified. The coordinator could then access the data available on Street Sense for that client and identify the most appropriate resources to address that client's health and social needs by drawing on a network of community-based services that do not normally work together, including EMS, hospitals, primary-care providers, law enforcement, court officials, homeless- outreach teams, social workers, case managers, and housing providers. The Street Sense database was also used by the RAP teams to visit clients at home or at their street locations on a regular basis, provide follow-up care, and check on their welfare. These visits also improved RAP operations, as the callers became familiar with and trusted the teams to

help improve their lives. Access to alternative sources of assistance also meant that these individuals no longer saw the 9-1-1 system as their only avenue to help.

Benefits of RAP

RAP had a wide range of positive effects. For its clients, the frequent 9-1-1 callers, it provided individualized care that reduced their reliance on emergency room visits and provided more effective treatment for chronic everyday problems.

The program also provided the opportunity for agencies that serve the homeless and individuals living with substance abuse and behavioral health problems to coordinate their activities, resulting in a more efficient use of resources. The feedback these agencies could receive from RAP allowed them to prioritize the needs of new clients and to more effectively monitor old clients to see how they were progressing.

Changes in behaviors of the RAP clients also benefited EMS by reducing demands on the system. There was a substantial reduction in 9-1-1 calls by RAP clients over the time that RAP was in operation. One internal evaluation found that 9-1-1 calls dropped by over 70% among those previously identified as mega-users. Another evaluation found that only five of 28 mega-users were still in that category (i.e., making 52 to 300 calls per year) one year after entering RAP.

There were also substantial savings in cost of care for the targeted individuals as RAP developed and its client base continued to evolve. Although the exact numbers changed over time, every report on effectiveness showed marked improvements in health and reductions in misuse of the 9-1-1 system by the RAP clientele and savings in the operation of EMS services. As one example, post-pilot data showed a savings of over \$700,000 per year after accounting for program costs and a 40% reduction in the amount of time spent by EMS dealing with the RAP clients.

An evaluation of 13 community paramedicine programs, including RAP, was published in 2017. The analysis of the RAP program in San Diego compared 9-1-1 usage and treatments for the 12 months prior to enrollment in RAP with usage and treatments in the 12 months after enrollment on a case by case basis. Based on these data, the report estimated that RAP had resulted in 325 fewer emergency room transports, with a resultant savings of over \$500,000 per year. A summary of this analysis is presented in Table 1, which details the costs and savings from these reductions in unnecessary services.

Table 1. Costs and Savings from Emergency Transports, Fiscal Year 2016/2017

Number of Transports and ER Visits Avoided	325
Average Cost of Ambulance Transport	\$923
Average Cost of ER Visit	\$749
Savings from Ambulance Transports Avoided	\$299,975
Savings from ER Visits Avoided	\$243,425
Total Savings	\$543,400

RAP Disbanded

At the end of the pilot project period in December 2016, a decision had to be made concerning the continuation of RAP. AMR requested that it be disbanded and the paramedics reassigned to AMRs conventional response crews. The City Council considered including the program in the 2017/2018 budget, but was not able to find funds.

AMR stated that the paramedics who had been assigned to RAP were needed because staffing shortages led to a failure to meet performance standards. In October 2016 AMR had been fined \$291,000 for failure to meet performance standards in response time for 9-1-1 calls, followed by an additional \$75,000 fine for the period from January through June 2017. It was argued that the two additional ambulance units were needed to reduce response times to meet those standards. More recently, AMR has requested an increase in rates charged for ambulance transport because of its increased costs. One of its complaints in this request concerned the “over-triaging” of patients, or providing ambulance transport for individuals who did not actually require that service. This, of course, is precisely the problem that RAP was developed to resolve.

Negotiations between the City and AMR concerning these rate changes have included authorizing the City to seek a new EMS contractor in 2019 rather than 2020, the original termination date for the current contract. This, it would seem, provides an excellent opportunity for the RAP program, an effective, efficient, economical, and empathetic service to be reinstated. This program should be considered an essential service, and funding and administrative responsibilities should be within the SDFD Fire-Rescue unit, rather than determined by the decisions of an outside contractor.

FACTS AND FINDINGS

Fact: All 9-1-1 emergency calls must be answered and require a response.

Fact: A small number of individuals frequently overuse the 9-1-1 emergency response system for situations that are not life-threatening or medical emergencies.

Finding 01: This small group of frequent 9-1-1 callers creates a serious logistical and financial strain on emergency medical services.

Finding 02: RAP, a program designed to identify over users and reduce their 9-1-1 calls and ER visits, resulted in substantial financial savings and reduced strain on other emergency responders during the time it was in operation.

Fact: State law requires that, if further treatment is required, paramedic response teams can transport patients to an emergency room only.

Fact: Emergency medicine departments are not the proper treatment option for many 9-1-1 over users.

Finding 03: Paramedics in a program such as RAP require an exemption from current law, allowing them flexibility in deciding appropriate treatment options for clients in the program.

RECOMMENDATIONS

The 2017/2018 San Diego County Grand Jury recommends that the San Diego Mayor and City Council consider:

- 18-41: Exploring ways to replicate the success and benefits of the now-defunct Resource Access Program, with the goal of reducing over-use of emergency Medical services and thus improving the efficiency of the 9-1-1 system.**

REQUIREMENTS AND INSTRUCTIONS

The California Penal Code §933(c) requires any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the agency. Such comment shall be made *no later than 90 days* after the Grand Jury publishes its report (filed with the Clerk of the Court); except that in the case of a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such comment shall be made *within 60 days* to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code §933.05(a), (b), (c), details, as follows, the manner in which such comment(s) are to be made:

- (a) As to each grand jury finding, the responding person or entity shall indicate one of the following:
 - (1) The respondent agrees with the finding
 - (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.
- (b) As to each grand jury recommendation, the responding person or entity shall report one of the following actions:
 - (1) The recommendation has been implemented, with a summary regarding the implemented action.
 - (2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
 - (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.
 - (4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.
- (c) If a finding or recommendation of the grand jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if

requested by the grand jury, but the response of the Board of Supervisors shall address only those budgetary or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with the Penal Code §933.05 are required from the:

<u>Responding Agency</u>	<u>Recommendations</u>	<u>Date</u>
Mayor, City of San Diego	18-41	9/4/18
San Diego City Council	18-41	9/4/18