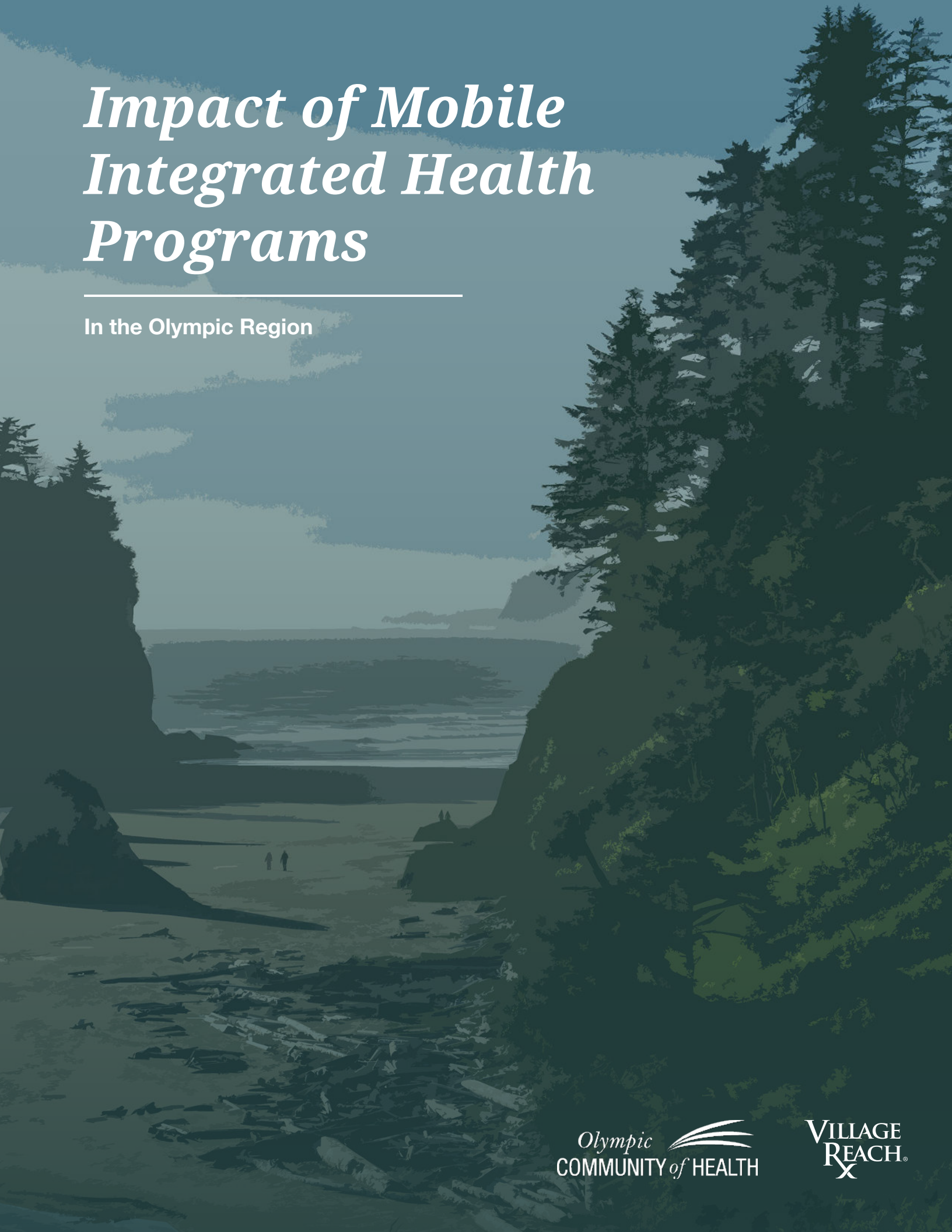
Impact of Mobile Integrated Health Programs

In the Olympic Region



Olympic COMMUNITY of HEALTH

VILLAGE REACH Rx

Introduction

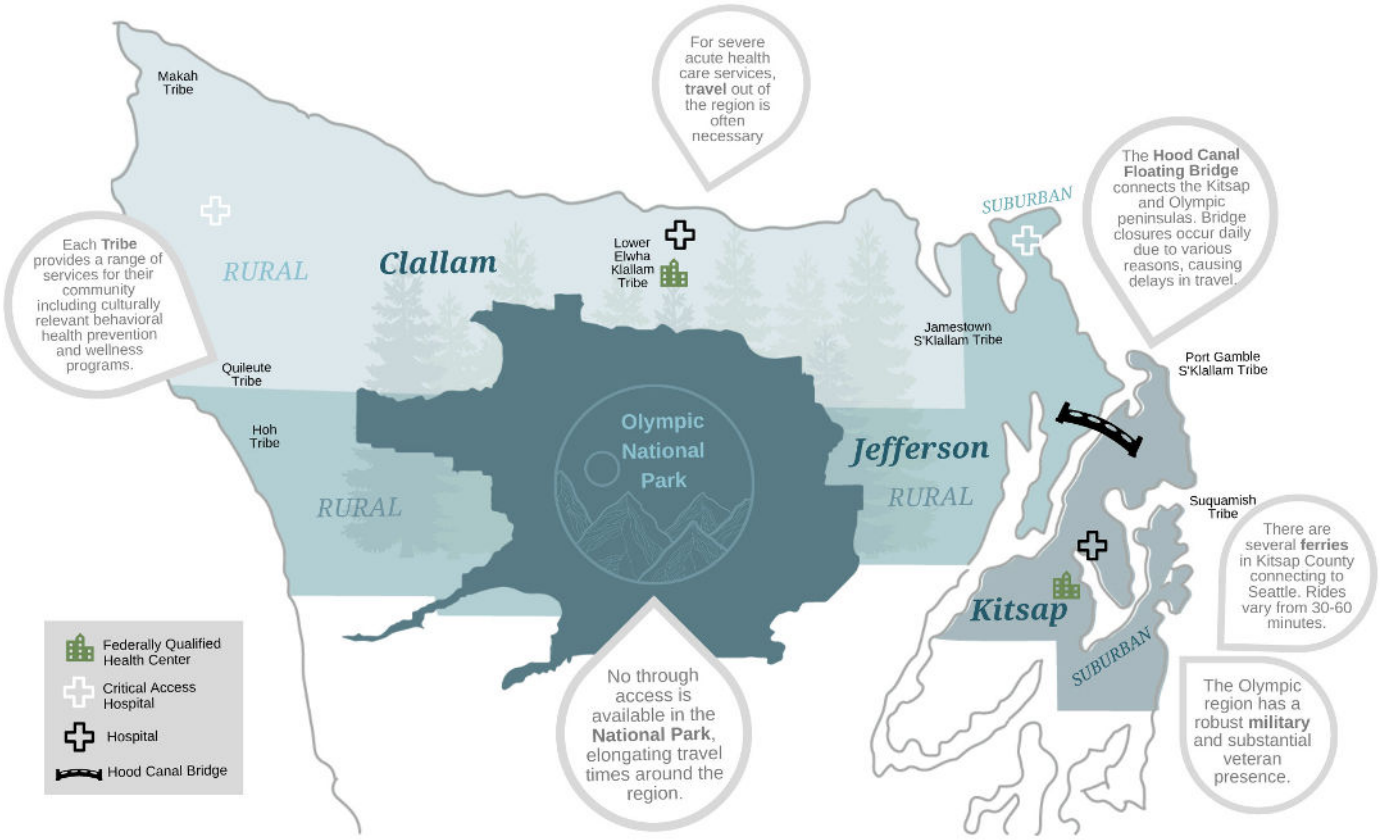
Across the Olympic Region, Mobile Integrated Health (MIH) programs help people access care and reduce preventable use of emergency services. These programs play a critical role in meeting community needs and ensuring emergency resources remain available for life-threatening situations. Olympic Community of Health (OCH) commissioned this evaluation to understand the impact of MIH programs and identify opportunities to support programs in strengthening their effectiveness.

Olympic Community of Health & the Olympic region

OCH is a regional non-profit that brings together partners from different backgrounds, sectors, communities, and Tribes to tackle health issues no single sector or Tribe can tackle alone. OCH works with partners across the region to support healthy people and thriving communities. OCH serves the Olympic region which spans Clallam, Jefferson, and Kitsap Counties, and includes the sovereign nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes.

The region's unique geography, including waterways, bridges, peninsulas, and a national park, impacts the services available and the way individuals and families seek and receive care.

It takes about ***4 hours*** to drive from **Neah Bay** (upper Northwest corner of Clallam) to **Port Orchard** (South Kitsap)



Mobile Integrated Health programs

MIH programs are community-based care initiatives that provide non-emergency health and social support. These programs aim to better address the needs of people using emergency services by connecting them with appropriate services, such as behavioral health care, primary care, case management, housing support, fall-prevention visits, and more. MIH teams often include paramedics, Emergency Medical Technicians (EMTs), nurses, Substance Use Disorder Professionals (SUD-Ps), Mental Health/Behavioral Health Specialists, and Social Workers who proactively work with individuals who frequently call 911 and those with complex health and social needs. **MIH programs are shaped by the communities they serve, so they often look different from one place to another as they respond to local needs and gaps.**

Port Angeles Fire Department Community Paramedicine Program providing care to a client

In 2013, the Washington State Legislature passed a law that specifically authorizes fire departments to develop Community Assistance Referral and Education Services (CARES) programs to provide community outreach and assistance to residents of its jurisdiction. The law specifies that these programs should address, identify, and provide resources to individuals who utilize 911 or the emergency department for non-emergent needs. All six programs included in this evaluation are fire department led and five of them are CARES programs.

Members of the East Jefferson Fire Rescue CARES team

Programs included in this evaluation

Clallam County

- Port Angeles Fire Department Community Paramedicine Program

Jefferson County

- East Jefferson Fire Rescue Community Assistance Referral & Education Services (CARES)
- Quilcene Fire Rescue CARES

Kitsap County

- Kitsap Fire CARES Program which includes Central Kitsap Fire & Rescue CARES, Poulsbo Fire CARES, and South Kitsap Fire CARES

Evaluation approach

OCH partnered with VillageReach, a public health nonprofit, to assess whether MIH programs are making a positive impact in the Olympic region. The following "chain of results" shows how MIH programs are intended to work:

1 Problem

An increasing number of people lack access to essential health and social services. As unmet need grows, emergency services see more calls for chronic challenges and basic needs instead of acute emergencies. This strains emergency services, increases costs, and still leaves community needs unmet.

2 Connection to Services

People who need support are connected to an MIH program.

3 Delivery of Services

Individuals receive the services they need — either directly through the MIH program or through referrals and partnerships with community organizations.

4 Impact

Services effectively meet needs, stabilize individuals, and reduce reliance on emergency care and crisis response systems.

5 Health Systems Outcome

Emergency services are less strained, resulting in:

- Faster response to acute emergencies
- Improved staff morale and reduced burnout

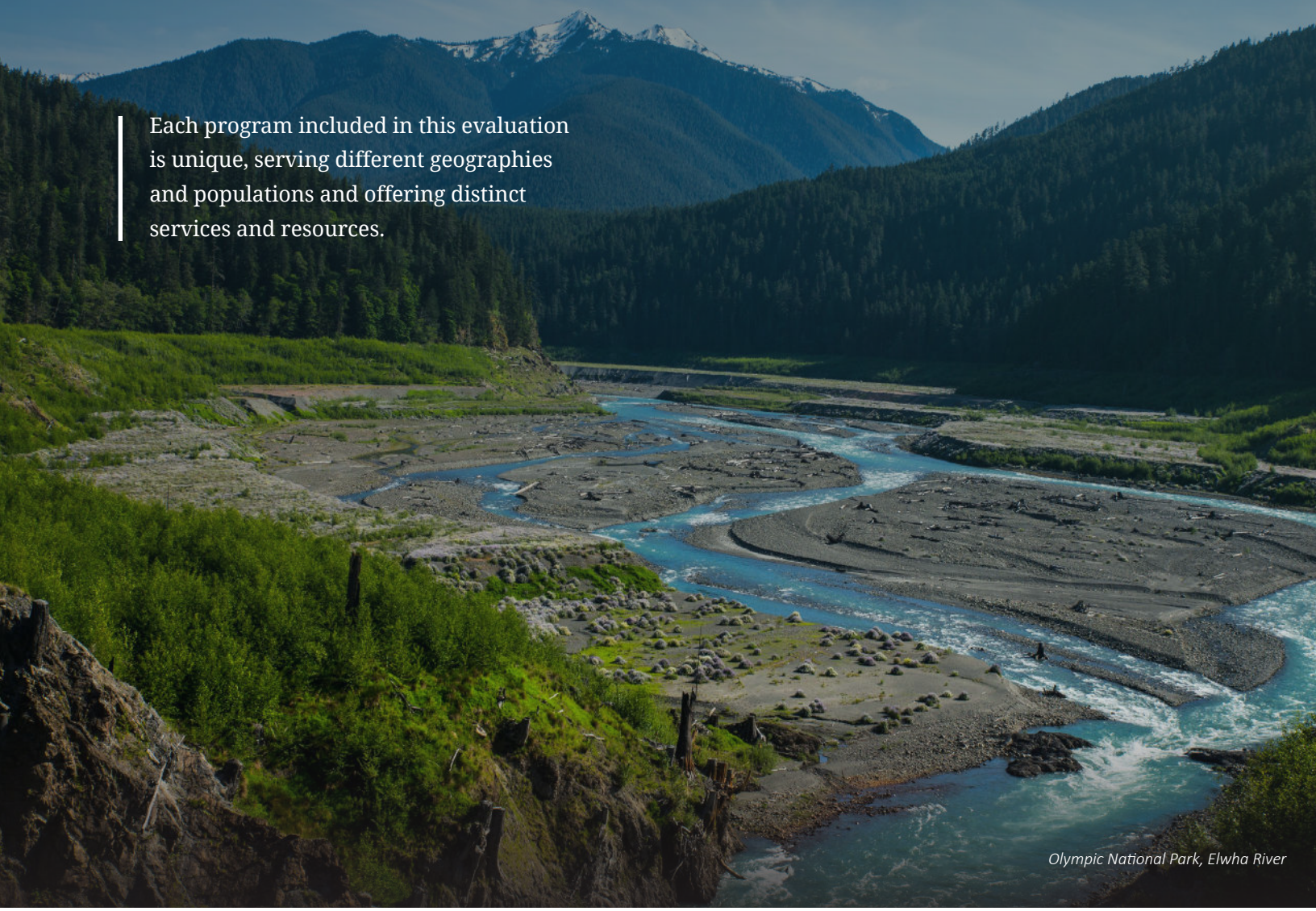
To determine whether MIH programs are effectively achieving each of these steps, this evaluation explored the following questions:

CONNECTION
Are MIH programs reaching the people who need them?

DELIVERY
Do MIH clients get the services and support they need?

IMPACT
Are MIH programs reducing the need for emergency care?

SUSTAINABILITY
What are the key factors that influence the success of MIH programs?



> Each program included in this evaluation is unique, serving different geographies and populations and offering distinct services and resources.

Olympic National Park, Elwha River

Methods

The evaluation was funded by OCH and conducted by a third-party evaluator, VillageReach. The goal of the evaluation is to provide regional insights into who MIH programs serve, the services provided, the benefits, and ways to ensure sustainability. This evaluation is not intended to compare programs or determine which MIH models are most effective. Each program included in this evaluation is unique, serving different geographies and populations and offering distinct services and resources. The programs are at different stages of development, with some operating for over five years and others only a few years old. Instead, this evaluation focuses on sharing regional insights into who these programs serve and the impacts of their services. Differences in results across programs may reflect variations in community context and population needs rather than program effectiveness.

VillageReach met with each program to explain the purpose of the evaluation and offered two participation options:

Option 1

Provide anonymized raw data for VillageReach to analyze

Option 2

Provide results from the program's existing analysis to be included in the evaluation

The Port Angeles Fire Department Community Paramedicine Program provided summarized analysis results. VillageReach did not perform or validate any of the analysis.

The three Kitsap Fire CARES programs provided raw anonymized data from Julota, a client management system, which VillageReach used to calculate indicators such as average age, insurance status, percent of clients reached and average time to reach them in Power BI. Julota links CARES client data with other systems to calculate reduction in 911 calls and emergency department visits so their automated analysis was used for those indicators.

East Jefferson Fire Rescue and Quilcene Fire Rescue each provided data on CARES clients from Connect2 Coordinator, a client management system, along with emergency response data from the Emergency Services Operations (ESO) Solutions system. Data from the two systems were matched by name and then assigned a unique patient ID prior to being shared, ensuring that no identifying information was included. Raw data were then analyzed using Power BI.

In addition, VillageReach interviewed four fire chiefs (one from Port Angeles Fire Department, Quilcene Fire Rescue, East Jefferson Fire Rescue, and Central Kitsap Fire & Rescue) along with 1-2 program staff from each program to ask questions on the background of the programs (when and why they started), perceived impact on clients, impact on fire agency personnel and operations, along with key factors of success and major challenges and barriers.

East Jefferson County

Data included

We used all data provided by partners' current records systems. For most programs, the earliest available date in the current system occurs after program launch due to agencies transitioning to new data systems. Earlier records from previous systems were not included in the analysis. "Data used" spans from that earliest available date to the date the partner provided the data. As shown in the table below, some programs have less than one year of data and small client bases.

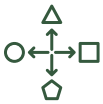
Program	Start Date	Data Used	Months of Data	# of People*
Clallam – Port Angeles Fire Department	Mar 2019	Mar 22, 2021 - Oct 15, 2025**	55	1,918
Jefferson – East Jefferson Fire Rescue	Jan 2021	Jan 15, 2025 - Aug 20, 2025	7	143
Jefferson – Quilcene Fire Rescue	Jul 2023	Dec 06, 2024 - Aug 20, 2025	8	42
Kitsap – Central Kitsap Fire & Rescue	Jan 2023	Jan 16, 2023 - Sept 25, 2025	32	1,223
Kitsap – Poulsbo Fire Department	Jan 2021	Oct 21, 2022 - Sept 25, 2025	35	993
Kitsap – South Kitsap Fire & Rescue	Jan 2024	Feb 16, 2024 - Sept 25, 2025	19	607

** This includes all individuals in the database, including those who were referred but may have opted out of services. For most indicators, only enrolled clients were included in the analysis; however, the full dataset was used to calculate indicators such as percent reached and percent enrolled.*

*** Several indicators were introduced after 2021, so the timeframe for those specific measures is more limited.*

Limitations

There are several limitations to this evaluation.



Variations in data sources and methods

Because Port Angeles Fire Department Community Paramedicine provided its own analyzed results, VillageReach cannot verify those findings or confirm that the methods used are identical to those applied in other program analyses. Similarly, for 911 calls and emergency department reduction analyses in the Kitsap programs, VillageReach used automated analysis from Julota. Based on verbal descriptions from Julota on how these indicators are calculated, we attempted to apply similar methods to the East Jefferson Fire Rescue CARES and Quilcene Fire CARES analyses.

Lack of comparison group and client perspective

We did not compare people who received MIH services to those with similar needs who did not receive MIH services. Because of this, we cannot know for sure how clients would have done without the program. Some clients may have improved even without MIH services, while others may have experienced worse outcomes without additional support. Also, we did not talk directly to clients or local partners to hear their perspectives and perceptions of the program.

Not designed for program comparison

This evaluation is not intended to compare programs or determine which MIH models are most effective. MIH programs are tailored to meet the unique needs of the communities they serve and are shaped by available resources, which influence how, when and where services are delivered. A program with a higher reduction in 911 calls and emergency department visits does not necessarily indicate that it is more effective at reducing the need for emergency services. Those differences may be due to other factors such as population served, the reasons individuals are utilizing emergency services, and the resources available within the community.

Key Findings

CONNECTION

Are MIH programs reaching the people who need them?

MIH programs are rapidly and effectively connecting with vulnerable community members. Most people are contacted within one to three days of referral, and the majority choose to engage in services. Over 3,500 people, most of whom are seniors and/or low-income individuals, have been reached reached by the MIH programs included in this evaluation.

Demographics of clients

Most MIH program clients are over the age of 65. This is a particularly vulnerable population that often has limited support and complex needs.

Percentage of clients over the age of 65

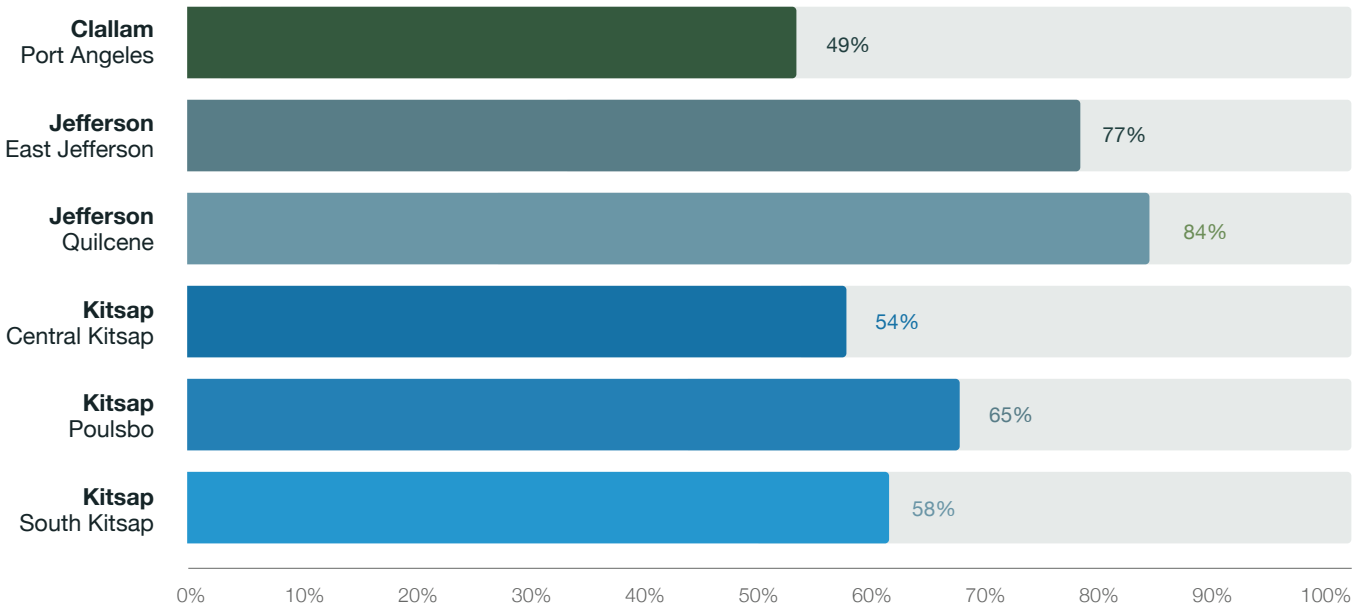


Figure 1

Insurance Status

Among clients with known insurance status, most are covered by Medicare and/or Medicaid, while very few have private insurance. These programs provide services at no direct cost to patients. As a result, insurance information is not required for care delivery and is not consistently collected.

Addressing this data gap represents an opportunity for improvement because clearly demonstrating the extent to which MIH programs serve Medicare and Medicaid populations could strengthen the case for increased government investment and future funding.

Insurance status of clients

	Dual Eligible Medicaid/Medicare	Medicare Only	Medicaid Only	Other	Not Recorded
Clallam Port Angeles	8%	20%	14%	5%	52%
Jefferson East Jefferson	34%	26%	16%	5%	19%
Jefferson Quilcene	14%	14%	3%	6%	63%
Kitsap Central Kitsap	11%	39%	25%	18%	7%
Kitsap Poulsbo	5%	25%	10%	7%	53%
Kitsap South Kitsap	12%	39%	25%	10%	14%

Table 1

Calawah River Bridge, Clallam County

Timeliness

Most clients are referred to MIH programs after a 911 call, when emergency responders identify underlying needs that could be better addressed by an MIH program. The programs then follow up with those referred (by phone or in-person) to see if they are interested in receiving services. People are usually contacted very quickly after referral, with most programs achieving a median of 3 days or less for contact and all agencies achieving a median of no more than 5 days between referral and initial contact. The program with the longest follow-up time noted that delayed data entry, such as recording follow-ups one to two days after they occur, partially contributed to this finding.

Hood Canal, Kitsap County

Ability to reach people

Programs successfully reach most referred people (71-98%, depending on the program). When people cannot be reached, common reasons include the inability to find someone who is homeless or moves frequently, lack of phone access, unanswered calls, relocation (sometimes outside the service area), or the person passing away. Again, it is important to acknowledge and consider variations in community context and population in differences in results across programs.

Percent of people referred to MIH programs who were reached

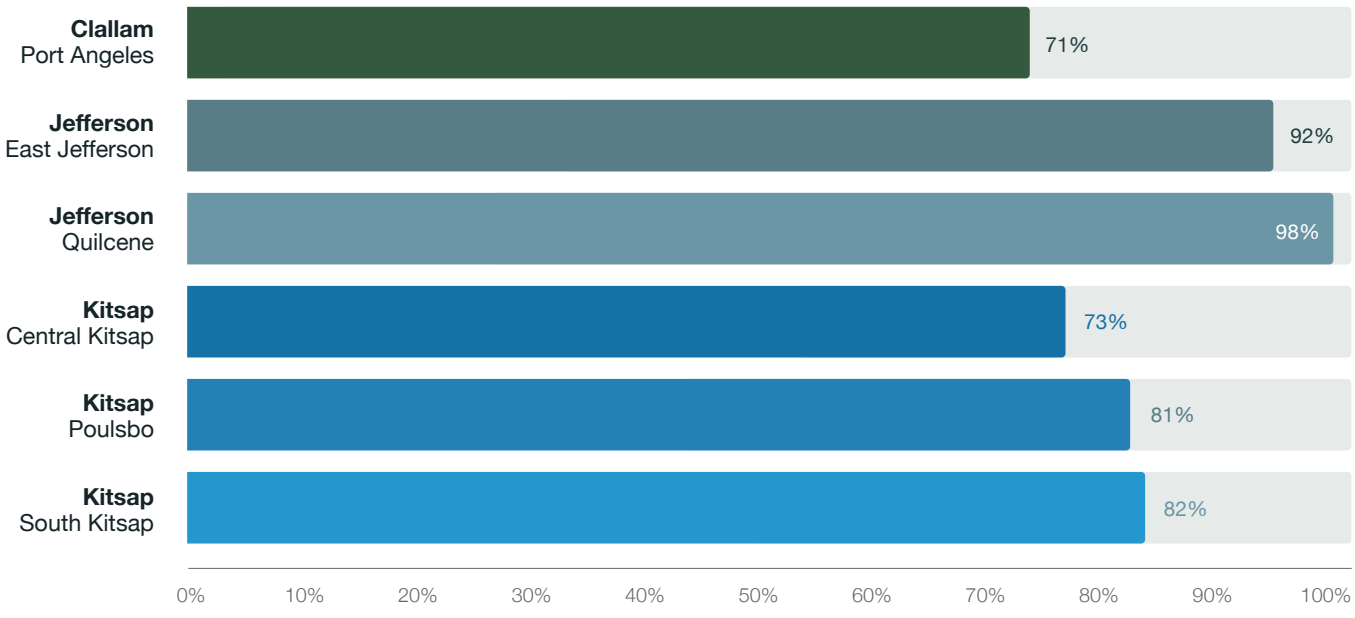


Figure 2

Bremerton Waterfront View from Warren Avenue.

Ability to enroll clients

Once people are reached, the majority agree to enroll in the MIH program, with acceptance rates 97% or higher, for four of the six programs. One example of the importance of considering community context and population when interpreting results is East Jefferson Fire Rescue CARES program's acceptance rate. Program staff note that building trust is critical, as many clients are older and focused on aging independently at home, making them reluctant to accept additional resources or support. As a result, for some people it takes multiple visits, or unfortunately, multiple adverse events, before a person is willing to enroll in the program.

Percentage of individuals reached that enroll in service

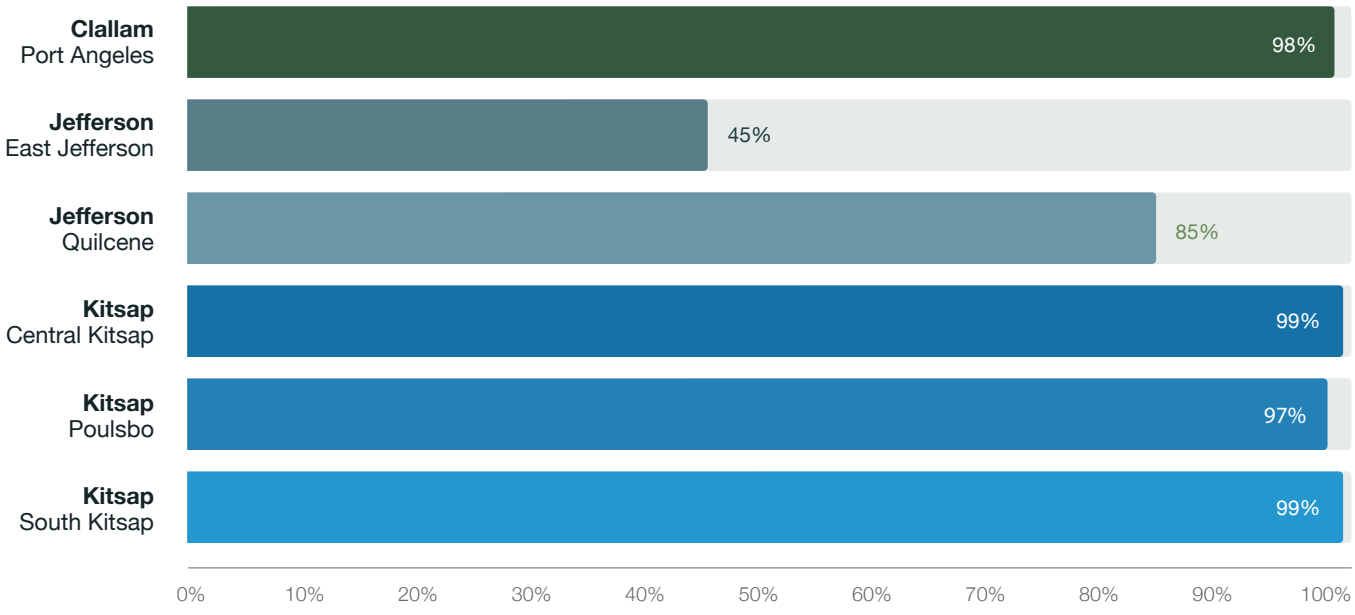


Figure 3

DELIVERY

Are MIH clients getting the services and support they need?

Success looks different for each client, depending on their goals.While quantitative data related to this question is limited, qualitative insights show that many clients receive the support they need through MIH programs.

MIH programs tailor services and support to what their clients need. After a person is enrolled in an MIH program, the team works with them to set goals. Common goals include reducing falls, accessing treatment for substance use, connecting with mental health services, addressing physical health needs, and/or addressing social needs such as stable housing. Much of the work is case management: building a relationship, finding out what a client wants and needs, and then ensuring effective connections to resources and services. Some programs also address needs directly. For example, East Jefferson Fire Rescue CARES can help declutter homes and install safety equipment for clients who have experienced repeated falls.

Kitsap Fire CARES staff visiting a client

Success Stories

Fire chiefs and program staff shared numerous stories that illustrate the impact of the services provided, underscoring that success can take many forms depending on the individual. For some, it means reconnecting with family before the end of life; for others, success looks like making peace with the decision to leave home to receive the care they need in a long-term facility.

Below are two case studies highlighting different ways MIH programs have improved quality of life and health outcomes for clients:

1 A safe transition to assisted living

The MIH program received a referral from the local Area Agency on Aging (AAA) for an older adult living alone in a rural area with very concerning conditions in his home. When the MIH program first connected with the client, he was experiencing severe cognitive decline, had little food in his house, was wearing dirty clothes, did not know how to work his cellphone, and his home was in disarray.

The MIH program immediately contacted his son, who was unaware of the severity of the situation, and arranged a FaceTime call to show him what his father was experiencing. The program guided the family through next steps, including medical appointments to confirm cognitive decline and exploring assisted living options. MIH staff supported the client with grocery shopping, medication management, and regular check-ins throughout the process.

Because the client's cognitive decline left him unable to reliably meet his essential needs alone, the MIH team, the client, and the family collectively decided to transition the client to assisted living with 24/7 support, a significantly safer environment for the client. The client's son was able to come in person to help with the move to an assisted living facility. When the MIH team came to say goodbye, the client was cleanly dressed and positive about the transition, a notable change from their visit and a clear sign he was receiving more of the support he needed.

> MIH intervention was essential in alerting the family to the seriousness of the situation and walking them through the process of getting the client safely moved into an assisted living facility that could meet the client's needs.

2 Supporting long term recovery

A middle-aged woman was referred to the MIH program because she was experiencing active substance use, untreated mental illness, and housing instability. She was referred to the MIH program by multiple agencies, including the fire department, emergency department, and a local behavioral health provider. In the year before she received MIH support, this woman made more than 60 calls to 911 and had nearly 50 emergency department visits.

The MIH team started coordinating across agencies to schedule medical and behavioral health appointments, improve communication between her, her primary care provider and psychiatrist, arrange in-home caregiving and support services, and adjust medications to reduce side effects and encourage adherence. Despite these efforts, the client frequently canceled appointments and services, often at the last minute. It took a year of support, a long-term relationship, and ongoing care coordination to improve the situation. Long-term efforts included a direct line to the MIH team that she could call for non-life-threatening emergencies, arrangement with a pharmacy for daily medication dispensing, and quarterly multidisciplinary meetings between the MIH team, primary care, psychiatry, case management and substance use disorder specialists.

With support from MIH, she has been able to maintain extended periods of sobriety, secure stable housing, and consistently take prescribed medication. Her mental health has improved significantly, and instead of using emergency services, she now proactively contacts MIH staff for support.

> This shift reflects her trust in the MIH program, as well as her increased confidence, independence, and effective coping strategies. In the year after MIH intervention, her use of 911 and the emergency department declined by more than 75%.

Bainbridge Island, Kitsap County

IMPACT

Are MIH programs reducing the need for emergency care?

Data show that MIH programs reduce their clients' 911 calls and emergency room visits, signaling that clients are getting the support they need to avoid unnecessary use of emergency services. This reduction also reduces strain on emergency response systems and saves money for insurers and clients.

Reduction in 911 calls

There were drastic reductions in the number of 911 calls clients made in the three months after being discharged from an MIH program compared to the three months prior to enrolling. Across the region, there was a 20-86% reduction in 911 calls among MIH clients, depending on the program.

For the Kitsap Fire CARES programs, East Jefferson Fire Rescue CARES, and Quilcene Fire CARES, analysis was to clients who had some interaction with emergency services before, during, or after their time in CARES. This approach allowed us to focus specifically on changes among individuals who actually use emergency services. Additionally, if a client does not appear in emergency service records, it is difficult to determine whether they never used services or simply could not be matched across systems (e.g., due to variations in name spelling).

Finally, because Quilcene Fire Rescue serves a small population and is a relatively new program, only a small number of clients were available for inclusion in this analysis. Only eight clients met the criteria have having been out of CARES for at least three months and having at least one interaction with emergency services that we could match to them. With small sample sizes, results can be heavily influenced by a single individual. For example, one of the eight clients contacted emergency services five times in the three months after ending their CARES service.This single case of high 911 utilization had a significant impact on the average. These, as well as local context, are important reasons results should not be utilized to draw comparisons between programs.

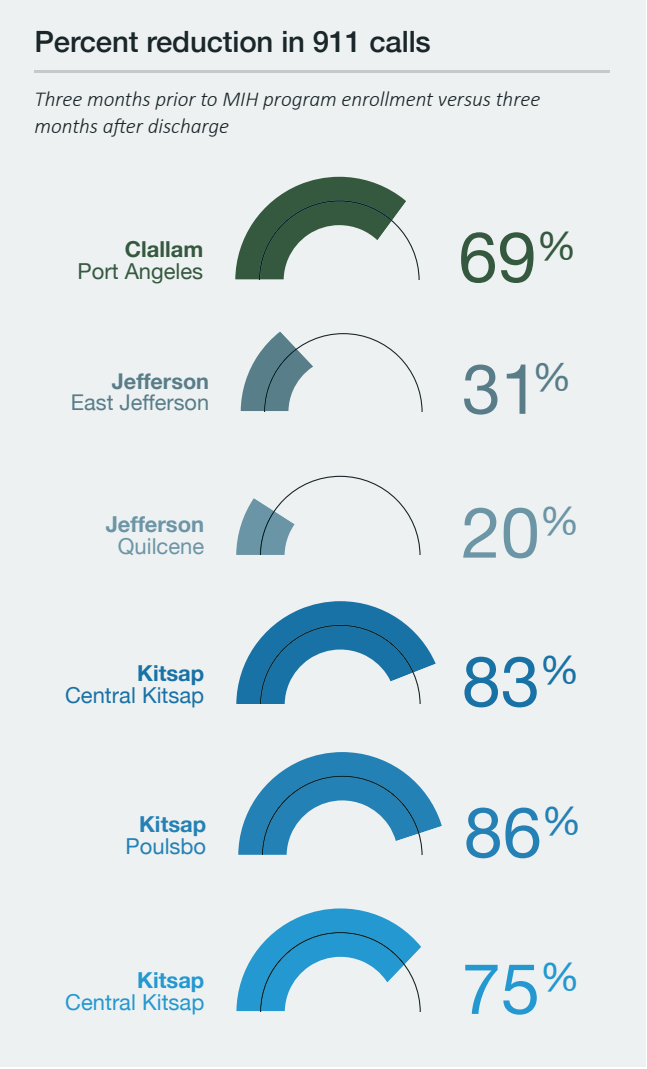


Figure 4

This finding is supported by the experiences of fire personnel. Every one of the four fire chiefs interviewed emphasized that MIH programs have a significant impact on emergency operations. As one chief put it, "We saw a difference on day one," noting a sharp decline in repeat callers with non-emergent issues. One chief explained that this matters because emergency response crews aim to leave the station within 60 seconds of a call and arrive on scene within 8.5 minutes. **Every extra minute spent with someone whose needs are not life-threatening could delay their response to the next critical emergency.**

Bremerton Manette Bridge

Reduction in emergency room visits

Kitsap County Fire CARES programs provided emergency room visit data. For those three programs, emergency room visits dropped substantially after clients enrolled in an MIH program. Comparing the three months before enrollment to the three months after discharge from an MIH Program, visits decreased by 66-83%, depending on the program. This signifies a two-fold benefit. First, clients are having their needs met before reaching a level that requires emergency intervention. This is a critical benefit, as emergency service systems must respond to and effectively meet the needs of their communities. Two, this reduces strain on emergency services ensuring they can focus on urgent and life-threatening situations.

We recommend that all programs begin tracking their clients' emergency department utilization, as these data are essential for accurately estimating cost savings and understanding the program's impact on reducing strain on emergency services. This may require integrating or linking data systems to ensure clients can be accurately tracked across multiple points of care.

Percent Reduction in Emergency Room visits by Kitsap County MIH clients

Three months prior to service compared to three months after service

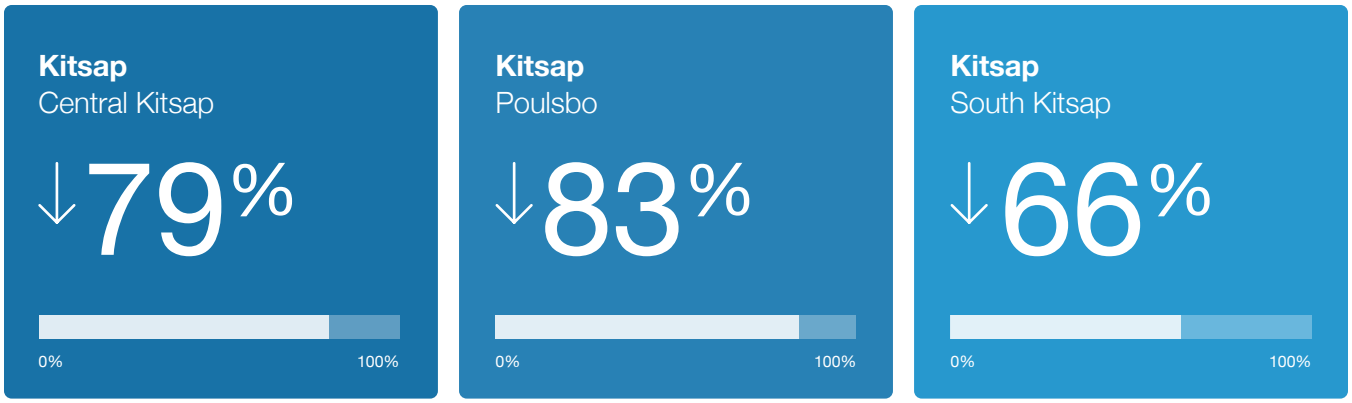


Figure 5

Cost savings

MIH programs likely generate cost savings across multiple parts of the emergency response and healthcare system through reduction in 911 calls, fire agency responses, emergency room visits and hospital admissions. However, based on the data available for this evaluation, we were only able to calculate savings associated with reductions in emergency room visits for the Kitsap County Fire CARES programs. As these savings represent just one component of MIH's overall impact, the financial estimate presented here should be considered a conservative and likely understated reflection of the program's true system-wide value. **We recommend that future evaluations incorporate additional data sources so that cost savings across other points in the system, such as 911 call volume and fire agency response activity, can also be quantified.**

Port Angeles Fire Department Community Paramedicine Program providing care to a client

Emergency room visits represent one of the most expensive levels of care in the United States' health system, driving up costs for insurers, patients, and even hospitals when full reimbursement is not possible. According to Washington HealthCareCompare, the average emergency room visit at St. Michael's Medical Center, Kitsap County's primary hospital, costs $1,282. This still likely underestimates the true cost of many ER visits, as it includes expenses related to ER physicians and staff, but does not account for additional hospital services such as specialists, anesthesia, imaging, or the use of specialized equipment.

Over the Evaluation Period

1,384
estimated ER visits prevented

$1,774,429
estimated cost savings

In addition to cost savings, reducing ER visits has many potential benefits to both the clients who prevented a visit and to the staff treating them. When clients prevent ER visits by receiving care from a primary care doctor or other provider they can see regularly, they get better coordination of care and consistent management of chronic conditions. For hospitals, preventing ER visits can lead to lower patient volume which allows staff to focus on the most emergent cases, reduces waiting times for everyone, and also prevents burnout and overwork for staff.

Improvement to emergency personnel morale

In addition to cost savings, Fire chiefs and program staff emphasized how these programs boost morale among emergency responders. This is particularly important given nationwide shortages of emergency medical service (EMS) providers. Fire chiefs and firefighters we interviewed spoke about the toll of repeatedly visiting the same addresses, knowing they cannot solve the underlying problem. They noted it is difficult to leave someone who needs more help than they can provide. At the same time, when they are with clients who are not experiencing life threatening emergencies, they feel immense pressure to move on quickly and be ready for the next emergency. **Being able to refer clients to MIH programs and then later follow-up to hear how they are doing has a powerful positive impact on personnel.**

Members of the Kitsap Fire CARES Team

> "The reason [that CARES has an] impact on the 911 responders is there is a sense of hopelessness of the mental health of the firefighters and paramedics. It can be overwhelming…it's hard to quantify but I'm certain that there is less of a sense of hopelessness in the headspace of the firefighters [now]."
>
> – Fire Chief

Hood Canal Washington with Olympic Mountains

SUSTAINABILITY

What are the key factors that influence the success of MIH programs?

Funding is the biggest challenge for MIH programs. When fire chiefs and MIH staff were asked to identify key factors for continued program success, all cited funding as the primary pre-requisite, with most expressing uncertainty about long-term sustainability if the necessary funds were not available.

An estimated 35% to 100% (depending on the program) of these MIH programs' budgets are funded by grants, with all programs relying on grants to some extent.

Grants

Grants are time-limited, come with administrative requirements that can be burdensome and many grant makers limit repeat funding, making long-term sustainability difficult. As a result, several programs reported having no guaranteed funding source beyond their current grant cycle, placing them at risk of reduction or closure once grants expire.

While programs are exploring strategies to diversify funding, such as sharing staff with hospitals or substance use treatment providers to reduce costs, these approaches have not fully offset reliance on grant funding. Fire agencies also described challenges incorporating MIH costs into their operational budgets, citing limited revenue and competing priorities as a huge challenge.

This challenge is consistent with findings from a 2025 performance audit by the Office of the Washington State Auditor which found that nearly three-quarters of MIH programs included in the audit were at risk of having insufficient funding in the next five years.

View Performance Audit

> "If [our current grant] went away, I don't know that we'd be able to sustain [our program]. Because it would be supplanted by money for the 911 budget and I'd have to choose… the choice I'd have to make is "Is it [the MIH program]? Or is it a fire engine? Or a fire station?"
>
> – Fire Chief

Conclusion

MIH programs in the Olympic region are making a measurable and meaningful difference for the communities they serve. Across six programs, key findings include:

MIH programs reach people who need them

The evaluation found that MIH teams are successfully identifying and engaging some of the region's most vulnerable residents, particularly older adults and people with limited financial resources. Programs consistently reach and enroll the majority of people referred to them, often within only a few days, demonstrating strong program responsiveness and an ability to build trust with people who may not otherwise be connected to services.

MIH programs meet the needs of their clients

Once enrolled, clients receive tailored support that helps them navigate medical, behavioral health, and social needs that range from securing safety equipment and managing chronic conditions, to stabilizing housing and accessing treatment. Evidence from case studies and reductions in client use of 911 and emergency room services demonstrate that clients' needs are being effectively met before they escalate into emergencies.

MIH programs create operational efficiencies

These programs also reduce strain on emergency services, reducing 911 calls and emergency room visits. Fire chiefs noted immediate operational benefits, reporting that MIH programs free up crews for life-threatening emergencies and reduce the emotional burden responders face when they encounter needs they cannot address in the field.

Taken together, the findings show that MIH programs effectively connect people to needed services, deliver individualized support, reduce avoidable emergency service utilization, and strengthen the broader emergency response system.

However, these benefits can only be maintained if programs have reliable, long-term funding. Financial instability remains the primary barrier to sustaining existing programs and expanding services to communities where needs remain unmet.

Continued support and investment from state, regional, and local partners will be essential to ensuring that MIH programs can continue delivering critical, life-stabilizing services across the Olympic region.

Recommendations

Support sustainable funding models

MIH programs deliver clear benefits to both the communities they serve and the fire agencies that provide them, yet sustainable funding remains a persistent challenge. This is not unique to the Olympic region; it is a statewide and national issue. Based on the evaluation results, the specific recommendations are:

Amend Washington state law to require private insurance to reimburse MIH services

The evaluation findings support the State Auditor's recommendation to the Washington State Legislature to "Amend state law to require private insurance companies to develop ways to reimburse services provided by [MIH] programs."

Combine multiple funding streams for a "braided" funding model

To reduce reliance on any single source, MIH programs should strive for a "braided" funding model (a combination of multiple funding sources). This approach was recommended by key informants, and the Auditor's report found that half of audited programs already use more than one source of funding. Each type of funding comes with a unique set of pros and cons and each agency will have to assess what is most appropriate for their situation. Furthermore, some agencies included in this evaluation are Fire Departments (funded by the city they serve) while others are Fire Districts (funded by property taxes in the area they serve) so they have different limitations in terms of the types of revenue they can raise and how they can use that funding. **A braided approach can include a combination of any of the following:**

1. **GRANTS:** Often the starting point for new programs or expansion within existing programs. These funds can be time-limited and competitive, which may create sustainability challenges once the grant period ends.

2. **INSURANCE REIMBURSEMENT:** While currently limited, MIH programs can expand reimbursable services by partnering with or becoming mental or physical health providers accepting insurance. Reimbursement processes can be administratively complex, and requirements such as insurance coverage or co pays may create barriers for MIH clients.

3. **HOSPITAL OR HEALTHCARE PARTNERSHIPS:** Collaborations where hospitals provide staffing, financial support or other resources to sustain MIH programs. Other types of healthcare partnerships such as Hospice and home healthcare can be mutually beneficial. These partnerships depend on aligned goals, a shared understanding of success and how it will be measured, and strong relationships, which can vary significantly across communities.

4. **FIRE AGENCY OPERATIONAL BUDGETS:** Allocate funds from agency operational budgets to cover the full or partial cost of MIH programs. There are legal considerations in terms of what services fire agencies are mandated to provide and limitations on what activities can be funded through operational budgets so this may not be feasible for every agency.

5. **LOCAL TAX LEVIES:** Dedicated funding approved by voters. In the state of Washington, fire districts are funded by property taxes and there are legal limits to how much these taxes can be raised and what activities they can fund which means this is not an option for all agencies.

A diversified funding model creates stability, increasing the likelihood that MIH programs can continue delivering critical services without interruption.

Close gaps in data collection

1 Strengthen the collection of patient impact data

Interviews with MIH staff and fire chiefs revealed compelling stories of how MIH programs have transformed lives. In addition, existing data on reduced 911 calls and emergency department visits suggest clients are better supported and have access to more resources, reducing the need for emergency services. However, consistent quantitative data (i.e., what services clients receive, referral outcomes, the impact on health and quality of life) are not systematically collected. Similarly, most programs have some qualitative data such as success stories and case studies of how clients have benefited from their services, but this isn't systematically collected, consistently documented, or consistently shared. Expanding processes to capture these metrics would provide a clearer picture of program effectiveness and client outcomes and provide evidence to support additional funding.

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2 Standardize data collection and reporting

Currently, programs collect different variables in different ways. For example, some track whether goals were met or referrals completed, while others do not. Insurance type may be recorded using fixed options in one program and open-text fields in another. Additionally, methods for calculating indicators like "911 calls averted" vary across programs. Decisions such as whether to include all clients in 911 reduction analysis or only high utilizers, how to include repeat clients, etc. can have significant impacts on the result. **Establishing standardized data collection methods and calculation protocols across the region, and ideally statewide, would enable programs to more effectively demonstrate collective impact**. In addition, it would help new programs develop data analysis protocols more easily by adopting standard approaches and best practices.

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3 Prioritize data required by Washington State law

Washington State law requires that CARES programs measure 1) any reduction of repeated use of the 911 emergency system attributable to the program, 2) any reduction in avoidable emergency room trips attributable to the program, and 3) estimated amounts of Medicaid dollars that would have been spent on emergency room visits had the program not been in existence. However, programs were unaware of these requirements and do not currently track all three. This aligns with the State Auditor's findings that only about half of CARES programs measure these metrics and that no standardized methodology or reporting mechanism exists. **As these indicators are important to the legislature, they represent the highest-priority metrics to standardize, collect, and report across programs.**

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Cape Flattery, Clallam County