CALIFORNIA PAN-ETHNIC HEALTH NETWORK

MAY 2023

TRANSFORMING EMERGENCY RESPONSE TO ADVANCE HEALTH EQUITY

INTRODUCTION

Every year, millions of Californians face an emergency or urgent medical situation resulting in an Emergency Medical Services (EMS) response. The California Emergency Medical Services Authority estimates that over 6 million calls every year are received (1). In 2019 alone, California's emergency departments handled 14.9 million visits (2). Unfortunately, limited data and research documenting the experience of communities of color with the EMS system prevent targeted interventions and system transformations in service of equity.

People Power for Public Health (PPPH), a project of the California Pan-Ethnic Health Network, and generously supported by the CARESTAR Foundation and the California Health Care Foundation, seeks to fill this gap by documenting and uplifting the experiences of communities of color. Through a large survey, listening sessions and key informant interviews that comprise PPPH, this brief is guided by the voices of community members to inform recommendations for system transformation to advance health equity.

RECOMMENDATIONS IN BRIEF

1. Strengthen access to primary, preventive, and behavioral health care
2. Protect patients and reduce consumer costs and coverage confusion
3. Diversify the emergency services workforce
4. Develop a statewide behavioral health crisis continuum of care

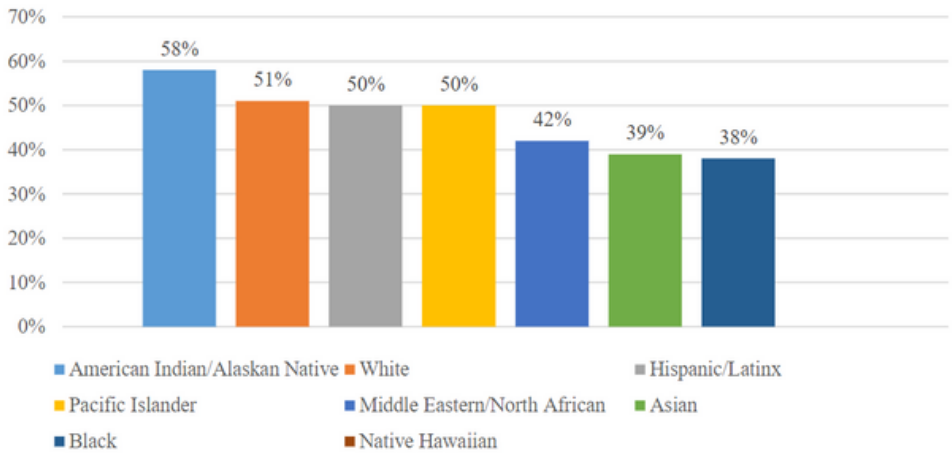
CONTINUE READING TO FIND OUT HOW DIVERSE VOICES LED US TO THESE RECOMMENDATIONS AND MORE.

(1) CA EMSA. 2019. "Emergency Services Data Report." Retrieved from https://emsa.ca.gov/wp-content/uploads/sites/71/2021/04/SYS_100-03_Annual_EMS_Report_CY2019.pdf
(2) California Health Care Foundation. December 2021. "California Emergency Departments: A Critical Source of Care." Retrieved from https://www.chcf.org/wp-content/uploads/2021/12/EmergencyDepartmentsAlmanac2021.pdf

COMMUNITIES OF COLOR RELY ON EMERGENCY MEDICAL SERVICES

The People Power for Public Health survey revealed **45% of respondents report using emergency medical services at least once during the previous three years.** This includes those who received prehospital emergency response services, such as ambulance or paramedic response, and those who were seen in an emergency department either after being transported by emergency medical services or upon self-referring to an emergency department. Variation by race/ethnicity is shown in Figure 1. Unlikely a reflection of health status, it's notable that Middle Eastern/North African, Asian and Black communities used emergency medical services less than other groups.

Figure 1: Use of Emergency Medical Services in the Last Three Years



Disparities by insurance type are more pronounced with low use by the uninsured (34%), moderate use by persons with employer-sponsored insurance (44%) and relatively high use at 65% of Medi-Cal survey respondents. This data is consistent with the California Health Interview Survey (CHIS), which provides data on visits to the emergency department in the past 12 months by insurance type. For 2020, CHIS data shows Medi-Cal members were most likely to have accessed emergency department services and uninsured Californians least likely (3).

This data documents disparities that reflect both the need for and barriers to accessing emergency care. Moreover, emergency services reflect not only urgency, but care of last resort highlighting the value of reducing the need for emergency medical services and improving the quality of necessary emergency services to advance health equity.

(3) https://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results

INSUFFICIENT ACCESS TO PRIMARY AND BEHAVIORAL HEALTH CARE

The biggest contributor to avoidable emergency medical service utilization is lack of access to primary care, including behavioral health care. In some instances, individuals lack access to care entirely due to being uninsured, but more commonly people have coverage, but additional barriers persist. In conversation with listening session participants, the need to increase access to high quality primary, preventive, and behavioral health care was a consistent theme. Common barriers to care include:

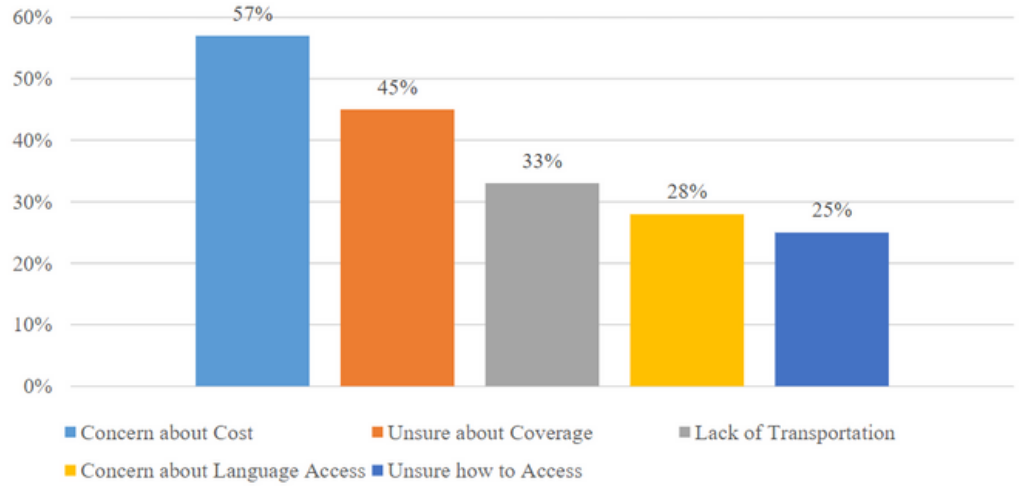
- **Coverage gaps,** particularly for those currently ineligible for Medi-Cal due to immigration status and those who transition between types of coverage frequently due to Medi-Cal income eligibility criteria.
- **Cost concerns,** including inflated and surprise bills, high deductibles and copays and misinformation about coverage that leads people to believe there will be high costs for care.
- **Nonexistent behavioral health services** and poor experiences with available behavioral health services.

> "WE ARE HAVING A VERY HARD TIME, ESPECIALLY AROUND MENTAL HEALTH. WE JUST DON'T HAVE THE SERVICES. THEY'RE JUST LEAVING PEOPLE TO TRY TO FIGURE THIS OUT."
>
> *-- Sacramento County Resident*

COMMUNITIES OF COLOR FORGO VITAL EMERGENCY HEALTH CARE FOR SEVERAL REASONS

While some emergency services utilization can be prevented, this safety net must be accessible to all when necessary. Survey and listening session participants both reported avoiding emergency medical services for several reasons. **Survey respondents report cost of emergency services as the most significant concern,** followed by concerns about insurance coverage, lack of transportation, language access, and uncertainty about who to call or how to access the system (Figure 3).

Figure 3: Top Concerns Related to Emergency Medical Services



While cost and insurance coverage were the top-rated barriers to accessing emergency services, **another consistent concern is fear of law enforcement involvement, with more than 1 in 5 respondents in every racial/ethnic group reporting it.** Listening session conversations revealed worry over police involvement, risk of an involuntary psychiatric hold, and being unable to choose what kind of facility would provide treatment (or being unsure where one would be taken by emergency responders or law enforcement).

"I often feel that law enforcement is put in a position to do a job that they are not trained to do. Law enforcement is often put into situations of social service versus doing the law enforcement element of it."--Sacramento County Resident

Listening sessions further uncovered details as to why communities of color may avoid emergency services:

- **Lack of information and education about when, how, and where to access emergency services.** Respondents had many questions about emergency medical services including who to call, who would respond, where one might be taken for care, and whether services were available to all. Many respondents who lacked good information about an appropriate place to seek care ended up in the emergency department, even when more appropriate alternatives existed.

"MANY PEOPLE DON'T EVEN KNOW WHAT RESOURCES ARE EVEN AVAILABLE AND WHERE TO FIND THEM, HOW TO ACCESS THEM... I HAVE HAD STORIES OF FOLKS THAT I KNOW WHO HAVE HAD TO CALL IN 5150S AND THINGS LIKE THIS, BUT THEY DON'T REALLY UNDERSTAND HOW TO HELP THEIR LOVED ONES."

-- Fresno County Resident

- **Cost concerns and coverage uncertainty cause people to avoid emergency services.** As shown above, cost is a top concern for communities of color in accessing emergency services. Many uninsured survey participants avoided emergency services entirely because of the potential bill. Even those with insurance coverage noted concerns about their costs for an ambulance ride, paramedic response, or even a surprise bill as an out-of-network charge. Participants also worried about the cost of hospital treatment because they were unsure where an ambulance would take them, which diagnostic or treatment procedures would be needed, and what would be paid by insurance.
- **Communities may not trust emergency services due to culturally incongruent providers.** Respondents also described the importance of having trust in first responders and health care providers and their desire to turn to people who are connected to their community for support, particularly for behavioral health support. People of color often believe they will not find that in most paramedics or other first responders, who are predominantly white and male. In addition, some respondents described the confusion, fear, and alienation they felt not receiving language assistance services during these potentially stressful times.
- **There is often frustration with emergency department experiences.** Many participants described frustrating experiences with seeking care at hospital emergency departments. For many health conditions, an emergency department is a last resort and inappropriate for the care being sought. Once there, respondents described long wait times, discrimination, including stigma related to perceived medication seeking, and a lack of culturally and linguistically responsive care as major challenges.

"AND YOU PREFER NOT TO GO. YOU KNOW, TO SPEND, I DON'T KNOW, FIVE, TEN HOURS, FIVE OR FOUR HOURS IN AN EMERGENCY ROOM FOR THEM TO TELL YOU EVERYTHING IS OKAY, MA'AM GO HOME. YOU AVOID GOING AND YOU NO LONGER WANT TO GO BECAUSE YOU ARE NOT RECEIVING PROPER CARE."

-- Kern County Resident

- **Information about alternatives to emergency departments is limited.** Many insured respondents described using urgent care clinics both as an alternative to calling 911 or visiting an emergency department, and as an alternative to primary care when they needed care outside of traditional hours or were unable to secure a timely appointment. Other respondents had challenges in understanding which urgent care clinics were covered within their network or experienced long wait times. Additionally, some respondents worried whether their health issue warranted going to urgent care or avoided going to urgent care due to potential high costs.

> "THE LIST OF URGENT CARES WAS NOT CURRENT, AND WE LEARNED THAT NOT ALL URGENT CARES HAVE THE SAME EQUIPMENT. IN THIS CASE, THE URGENT CARE ROOM WHERE WE WAITED FOR AN HOUR DID NOT HAVE AN ULTRASOUND MACHINE SO WE WERE REFERRED TO THE ER DOWN THE STREET THAT WAS NOT IN-NETWORK. THE POTENTIAL COST OF THE ER FOR AN ULTRASOUND SCARED US SO WE LEFT WITHOUT EVEN SIGNING IN."
>
> *-- People Power Survey Participant*

DESPITE THESE CHALLENGES, POSITIVE EXPERIENCES WITH EMERGENCY MEDICAL SERVICES WERE SHARED

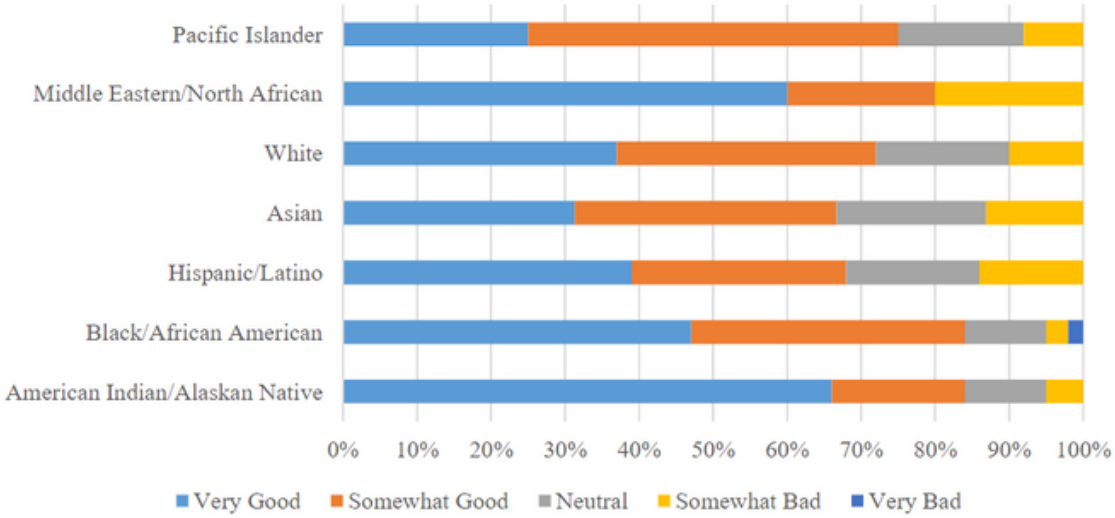
For those who seek emergency services, overall satisfaction is reasonable with 75% of survey respondents ranking their experience as very or somewhat good. However, variation by race/ethnicity exists with Asian and Hispanic/Latino communities having somewhat or very good experiences less than 70% of the time and African Americans having the highest percentage of very bad experiences (Figure 5).

Specific aspects of positive experiences included:

"[The] provider listened carefully and referred me to a quality facility. The check-in process was reasonable, and the wait time was reasonable. The physician and clinical care were excellent, all questions were answered, and the discharge was handled with care."

"The therapist understood the immediate needs of the mental health crisis, made themselves available, and helped find resources that did not activate the client's trauma (e.g., 5150 hold, etc.)"

Figure 5: Experience of Emergency Services by Race/Ethnicity



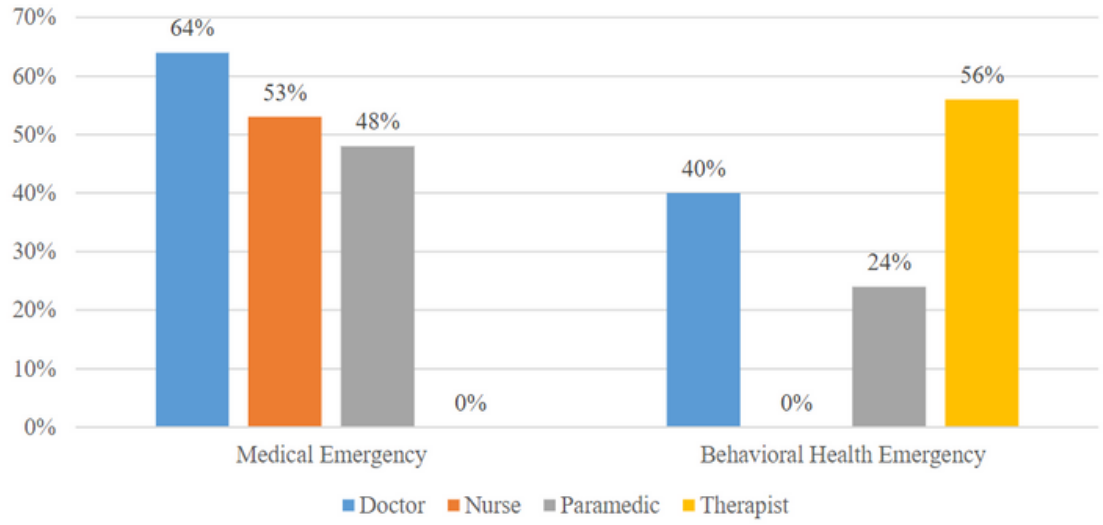
"I called 911 when I first injured my back. The paramedics who showed up were able to identify the problem that I had and told me what to do. They were upfront in letting me know that there is no emergency treatment for herniated discs or sciatic nerve injuries. They also said that if they took me to the hospital, I would be sent a big bill. Their advice was sound because the doctors I saw soon after told me the same thing."

"My mom had a mini stroke and speed of care helped prevent it from causing permanent problems. She was attended to promptly, and comprehensive diagnostics run even though she was uninsured. The diagnosis was received, and her treatment was initiated quickly."

THERE IS LITTLE SATISFACTION WITH OR DESIRE FOR TRADITIONAL EMERGENCY MEDICAL SERVICES FOR BEHAVIORAL HEALTH CONCERNS

Throughout our PPPH research, behavioral health crises stand out as the most challenging area to address. Listening session participants felt that traditional emergency medical services and emergency service providers are ill-prepared to care for individuals experiencing a mental health or substance use emergency. Survey particpants validated this result with a majority preferring a therapist responding instead of the more common doctor, nurse or paramedic (Figure 6). Specific subgroups prefer a peer support provider, including Pacific Islander (42%), Hispanic/Latino (26%), Asian (38%), Transgender (50%), and Gender Non-Conforming (42%).

Figure 6: Preferred Provider: Medical v. Behavioral Health Emergency



A lack of community-based behavioral health services often results in deteriorating conditions and ultimately crises. For those who do receive emergency services for their behavioral health crisis, the experience tends to be poor.

Specific findings related to behavioral health include:

- **Availability of services has not kept up with an increased willingness to seek behavioral health care.** Participants living with mental health conditions and/or substance use disorders reported barriers to both diagnosis and treatment, leading to an escalation of symptoms. Participants reported not knowing where to go for care, being turned away from care due to their level of need, poor experiences with care, and inadequate follow-up. Prevention and early intervention support for behavioral health care was lacking in communities of color. Sadly, some participants shared stories of how traumatic conditions or experiences when seeking care triggered or worsened their behavioral health conditions.

"[I HAD] DIFFICULTY RECEIVING ATTENTIVE CARE TO HELP FIGHT MY ADDICTION. I ALSO HAD DIFFICULTY WITH FINDING SOCIAL ALTERNATIVES FOR DRINKING/USING, SINCE I AM A MEMBER OF THE LGBTQIA+ COMMUNITY AND SUBSTANCE USE IS VERY NORMALIZED."

- **Most first responders are ill-equipped to respond to behavioral health crises.** Behavioral health related situations often involve police, in lieu of or in addition to paramedics, due to the continued stigmatization of people with behavioral health conditions as dangerous. Survey respondents and listening session participants agree that law enforcement is the wrong response to behavioral health crises. In fact, even the possibility of law enforcement response prevents the utilization of needed emergency services. In addition, paramedics often do not display the same competency in responding to behavioral health crises as they do for physical health emergencies, including how the process of transfer to a hospital can be traumatic for a person experiencing a behavioral health crisis.

> "WHEN A FAMILY MEMBER WAS GOING THROUGH A MENTAL CRISIS, WE HAD CALLED MANY AGENCIES TO GET IN-PERSON MENTAL HEALTH CRISIS MOBILE SUPPORT BUT ALL THEY COULD DO WAS CALL THE POLICE. POLICE [CAME] BUT WERE OF NO HELP."

- **Alternative destinations for behavioral health crises are desired but scarce.** Listening session participants shared concerns about whether the destination treatment facility would meet their needs. For those who have experienced historical and present-day injustices, including those who have been involved with the criminal justice system or lack stable housing, an emergency department may be ineffective due to a lack of appropriate support services. For example, respondents noted the lack of alternative destinations for behavioral health crises, including low-barrier drug treatment facilities.

> "MY LOVED ONE WAS TRANSFERRED FROM THE EMERGENCY ROOM TO A PSYCHIATRIC HOSPITAL OVERNIGHT. IT WAS VERY INCONVENIENT BECAUSE HE WAS TRANSFERRED TO A HOSPITAL OVER AN HOUR AWAY AND IT WAS DONE IN THE MIDDLE OF THE NIGHT; HE COULD NOT GET ANY SLEEP. I WAS ALSO UNABLE TO REACH HIM FOR A CERTAIN AMOUNT OF TIME. I WAS UNABLE TO VISIT HIM OFTEN DUE TO THE DISTANCE AND COULD NOT BRING HIM HIS CLOTHES AND AMENITIES OFTEN. ADDITIONALLY, HOSPITAL COSTS WERE VERY HIGH."

CALIFORNIA HAS AN OPPORTUNITY TO TRANSFORM EMERGENCY RESPONSE AND ADVANCE HEALTH EQUITY

The experiences of the community members represented in the People Power for Public Health project point to four clear areas of opportunity in order to transform emergency response and advance health equity:

1. **Strengthen access to primary, preventive, and behavioral health care.** It is clear that accessible, culturally and linguistically appropriate, high quality primary care, including low-acuity behavioral health care, can prevent the need for emergency services and improve health outcomes, particularly for communities of color. Steps to achieve this goal include the state: requiring minimum primary care spending thresholds by health plans so that investments are commensurate with need, and greater oversight of the availability of adequate behavioral health services for non-specialty conditions to address shortcomings.
2. **Protect patients and reduce consumer costs and coverage confusion.** Californians, especially low-income families and communities of color, should not be afraid to call 911 for fear of a bill. Patient protections should be passed to protect both the insured and uninsured from high, surprise, and inflated ambulance bills, and from unfair billing and collections practices. California can prevent those with coverage from facing surprise "out-of-network" bills bigger than their in-network cost-sharing, and those without coverage from having to pay more than what public programs do. Health insurance coverage requirements also need to keep up with the evolving emergency services system and patients' needs. As other care models are proven successful, such as alternative destinations for substance use disorders and mental health mobile crisis response, California should take appropriate action to ensure that consumers are protected from unreasonable costs as a result of using these services, and to communicate clearly with the public about these changes.

3. **Diversify the emergency services workforce.** There are numerous opportunities to create an emergency medical services workforce that better represents the diversity of Californians. California should broaden the types of providers that are part of emergency service delivery by including community health workers and peer providers to start. In addition, existing best practices related to training and licensing pathways and state grant programs for continuing education and training should be targeted to increase racial and linguistic diversity in the workforce.
4. **Develop a statewide behavioral health crisis continuum of care.** California must replace our current fractured and inadequate behavioral health crisis response system with a true continuum of care that reflects that needs of its diverse population. Successful local innovations in this area, such as non-law enforcement mental health crisis response teams, serve as building blocks for California to develop a statewide, equitable, efficient continuum that results in the right care, at the right place, at the right time for those who experience behavioral health crises.

RESEARCH METHODOLOGY

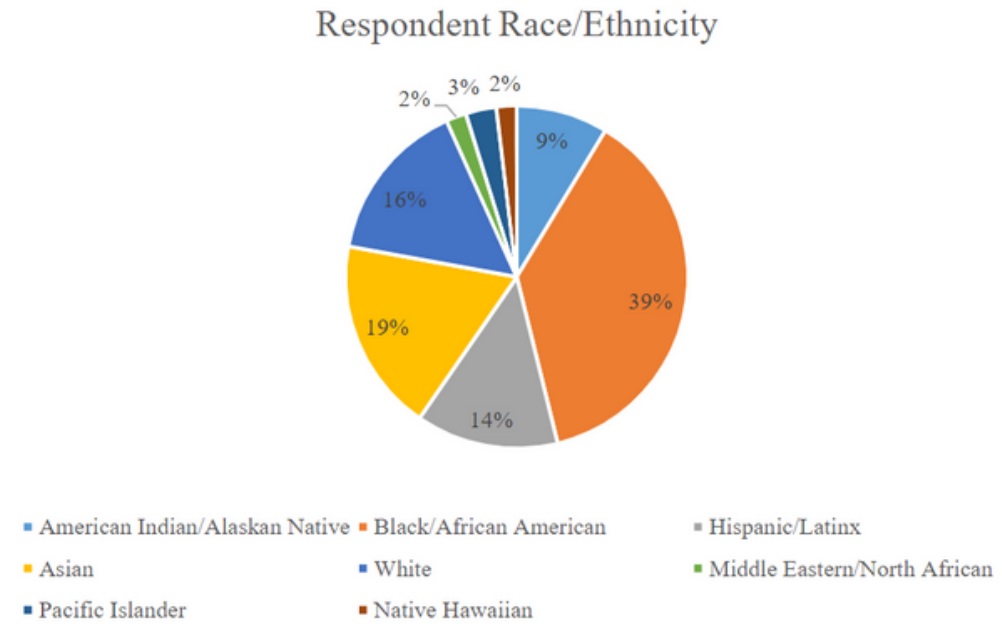
The People Power for Public Health project conducted research in three phases:
I: An online survey of 912 Californians, conducted between September 2021 and January 2022. The survey was administered in English, Spanish, Traditional Chinese, Korean, Tagalog, and Vietnamese using a convenience sample.

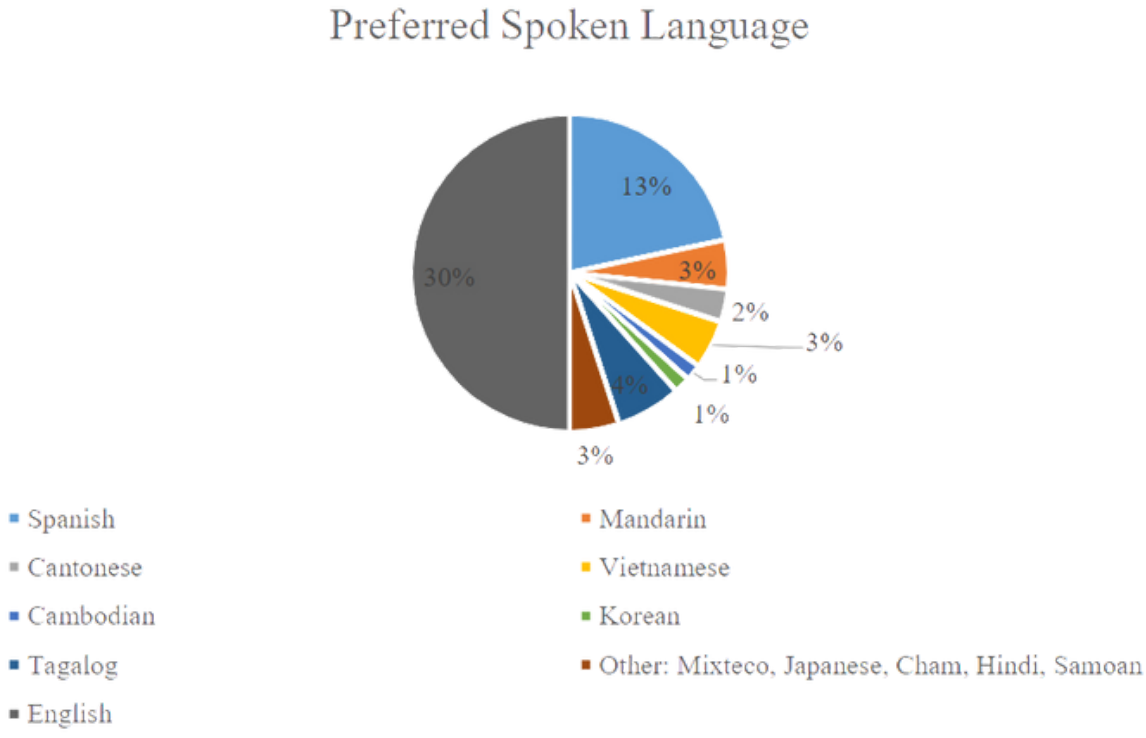
II: A series of 5 listening sessions with over 400 community residents in the counties of Sacramento, Fresno, Kern, Orange, and San Diego. In Sacramento County, this included interviews with currently incarcerated people.

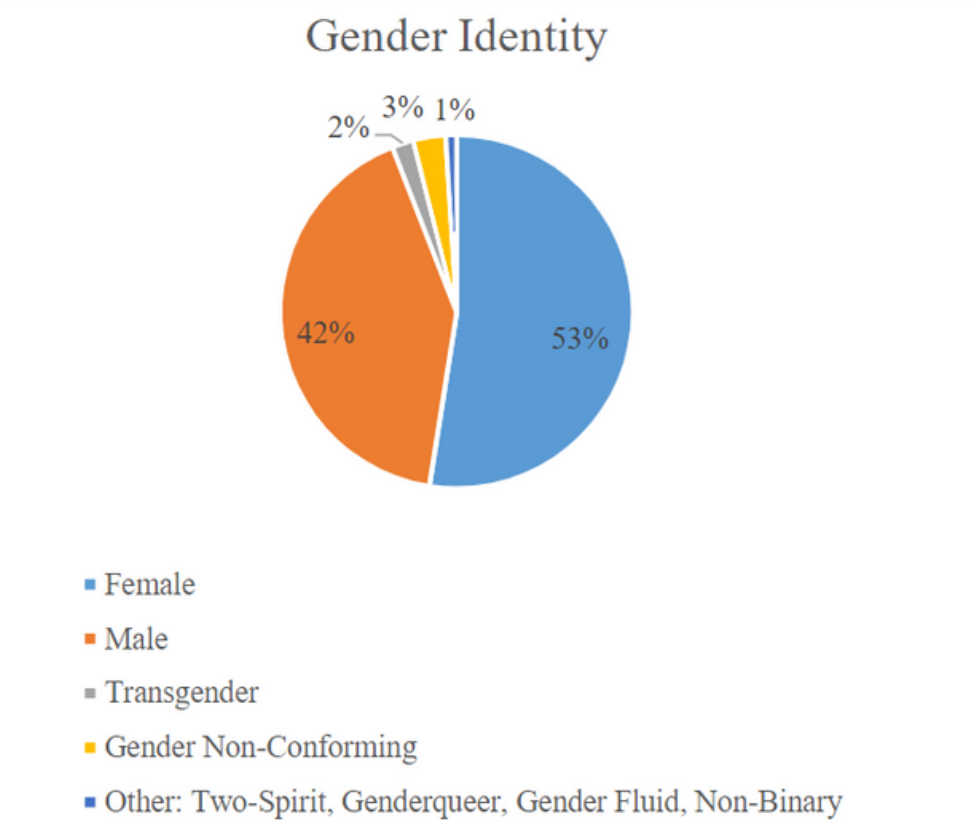
III: Key informant interviews with 12 community leaders and experts.

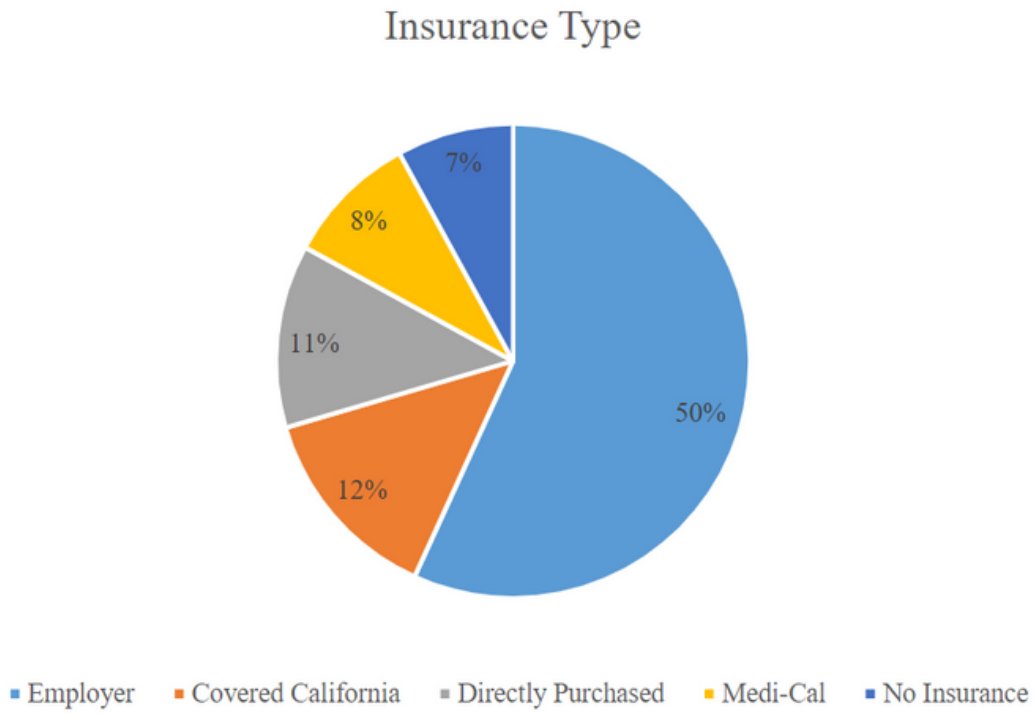
APPENDIX: RESEARCH RESPONDENT DEMOGRAPHICS

Online Survey Respondent Demographics






Gender Identity
2%
3%
1%
42%
53%
Female
Male
Transgender
Gender Non-Conforming
Other: Two-Spirit, Genderqueer, Gender Fluid, Non-Binary


Insurance Type
7%
8%
11%
50%
12%
Employer
Covered California
Directly Purchased
Medi-Cal
No Insurance

Listening Sessions

County	Partner Organization	Number of Participants	Communities Represented
Sacramento	Decarcerate Sacramento/Care First Coalition	130	Individuals experiencing homelessness and/or incarceration Community leaders working with unhoused communities: residents affected by incarceration: Latinx communities; and local advocates, organizers, and community members
Fresno	Central Valley Urban Institute	21	Black/African American Communities
Kern	Vision y Compromiso	9	Latinx communities, Community Health Workers
Orange	Multi Ethnic Collaborative of Community Agencies	229	Asian and Asian Immigrant Communities, Native Hawaiian & Pacific Islander, Multiracial Communities, White, Black/African American, Latinx Communities
San Diego	Vision y Compromiso	27	Latinx communities, Community Health Workers

Key Informants

Asantewaa Boykin, Anti-Police Terror Project (Oakland & Sacramento)
Roxanne Carrillo Garza, Contra Costa Cares (Contra Costa)
Megan Castillo, Reimagine LA County Coalition (Los Angeles)
Dan Geiger, Contra Costa Budget Justice Coalition (Contra Costa)
Taun Hall, Miles Hall Foundation (Contra Costa)
Elizabeth Kroboth, Transitions Clinic Network (San Francisco, Statewide)
Noe Paramo and Eduardo Ramirez Castro, Central Rural Legal Assistance Fund (Fresno)
Mari Perez-Ruiz, Central Valley Empowerment Alliance (Tulare, Greater Central Valley)
Bella Quinto, Justice for Angelo Quinto (Contra Costa)

Jane Smith, CARESTAR Foundation (San Francisco, Greater Bay Area)
Vanessa Terán and Genevieve Flores-Haro, Mixteco/Indigena Community Organizing Project (MICOP) (Ventura)
Kim Williams, Sacramento Building Healthy Communities HUB (Sacramento)

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