Ketchikan Fire Department
Mobile Integrated Healthcare
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E-mail: KFDMIH@Ketchikan.gov
Providing Care, with dignity and respect, to the Vulnerable populations of Ketchikan.

MIH First Quarter Report

June-August 2024

Executive Summary

- MIH has reduced targeted High Utilizers 911 use by 40% as compared to previous quarter by connecting patients to appropriate resources and providing routine care.
- Still working with PeaceHealth to determine reduction in readmission rates amongst high utilizers.
- Strong expansion of community partnerships since beginning which has allowed for more patient care.
- More services being provided to reduce community risk and increase overall wellbeing of Ketchikan
- Alaska Natives have become our highest ethnic demographic served amongst our clientele.
- Despite a reduction in MIH use by unhoused populations, there has been a significant increase in health and welfare disparities for the unhoused.
- In the future, MIH will create a position for a Mental Health Clinician.

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Services Report

MIH Contact Data

Our MIH team feels that maintaining a high-quality data collection system is an important key to ensuring consistency, efficacy, and legitimacy of our program. In this section, we will provide a short summary of our first quarter data points like number of contacts, services provided, lack of services in the community, etc.

Our first quarter has yielded 70 1-on-1 patient contacts and 13 public outreach events. Basic demographics breakdown as such:

- Age ranges of patients are from 25-98 y/o with an average of 63.
- Patient gender breakdown is 53% Female, 47% Male.
- Ethnic breakdown is 41% Native Alaska, 39% White, 10% Black, 7% Filipino, and 2% Hispanic.
- Housing status reveals 71% of our contacts were with housed patients and 29% were with the unhoused.
- We still only have 1 patient who self-identified as a veteran.
- General insurance policies across patients were:
    - 26% Alaska Native Benefits, 26% Medicare (A/B), 15% Private Benefits, 10% None, 10% Medicaid, 3% Veterans Insurance

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- Our most common diagnoses amongst patients were:
  - 60% Hypertension, 43% Substance Use Disorder, 23% Mental Health Disorders, 21% Diabetes, 16% Respiratory Disease, 10% Dementia, 10% Cancer, 10% Degenerative Conditions, 4% Stroke.
  - Notably no patients with a hx of Heart Attack.

An interesting note is that despite the changes in social services availability in the community for the unhoused, we have had a reduction in our utilization by the unhoused. MIH has noticed a significant increase in the health and welfare disparity from the homeless populations that we have served. MIH has had multiple patients report to them that the only way for them to have their basic needs met is to commit misdemeanors to spend time in correctional facilities. This is directly correlated to known information about recidivism. One study has shown that **for every 1% increase in food insecurity in a population, there is a direct 14% increase in violent crime**. There has been a significant strain on our unhoused population due to mass burglary, recidivism, and food insecurity. MIH is still trying to understand how much food insecurity has occurred in the short time we have been active. MIH looks forward to working more closely with KPD and KWC on how to mitigate Ketchikans social and welfare disparities to improve the health of our population.

The average age of a City of Ketchikan resident is 37 y/o, with only 22% of the population over the age of 60. Despite this,

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67% of our patient contacts are above the age of 60. Culturally we all understand that the elderly are generally more vulnerable to health and welfare disparities. Geriatric medicine goes beyond just "treating" health conditions. Vulnerable populations, like the elderly, require extensive social work to ensure their basic needs are being met in order to promote recovery or maintain control of their chronic disease processes. Isolation, abuse, or neglect are some of the more insidious factors that affect our elder population. MIH has been proud of its connection with Rendezvous Senior Services and KIC Elders program in helping ensure that some of our people continue to be cared for. MIH believes there should be an increase across all of Ketchikan (City, Borough, and Saxman) to increase senior services to meet the ongoing growth and current need of this population.

Brief Note on Data Collection

MIH is refining our data collection and intake process so that we may be able to identify more points such as patients living above/below poverty lines, need for assistance of daily living tasks, and other health/social disparities found in patients that need to be accounted for. Our team is working with similar community paramedic organizations across the country to continue providing the best understanding of how our work is affecting the community.

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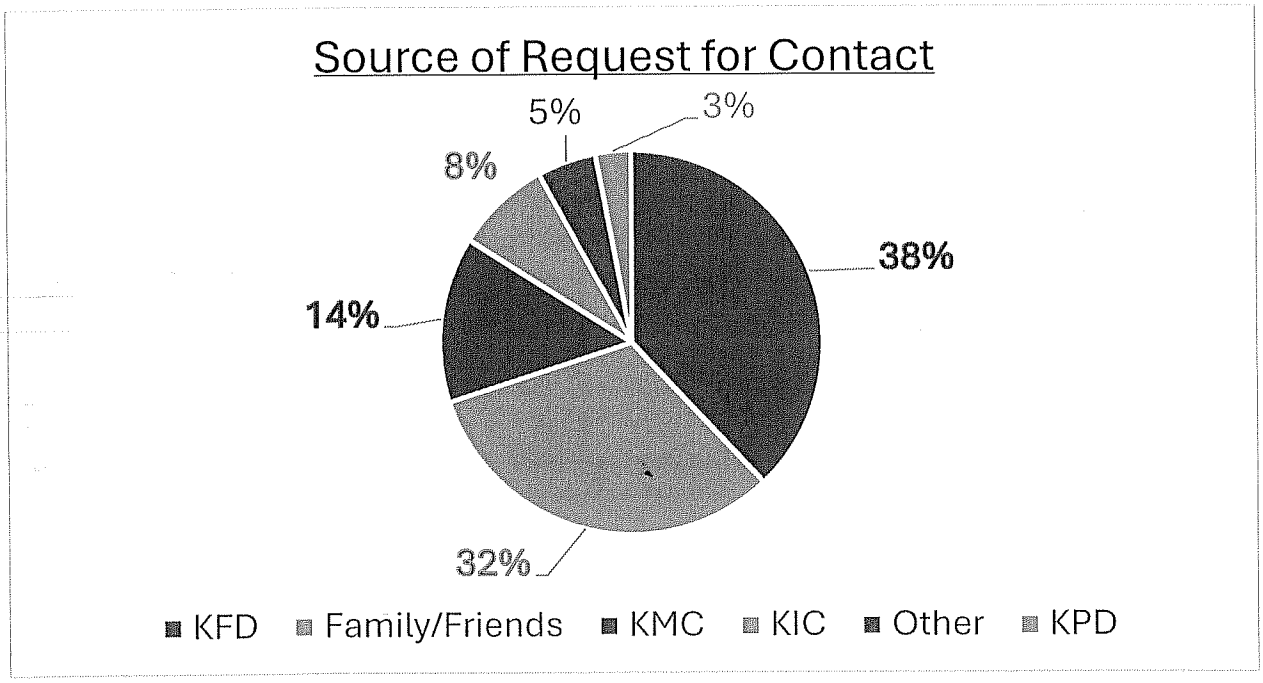

MIH has noticed a significant increase in the "family/friend" category as we have received numerous requests for contact from word of mouth. This is a unique aspect of Ketchikan where often times working at the interpersonal level is more effective than anything else. We view this as a testament to our care and are proud that the community sees a value to us.

On the same note, we continue to receive the majority of our requests for contact from the KFD and have shown great success in this aspect. On the contrary, we have seen a significant decrease in requests directly from PeaceHealth. MIH has been working diligently with MD Joe Livengood, CMO/KFD Medical Director, to create structured systems to allow for MIH to receive and execute care on PeaceHealth's Behalf.

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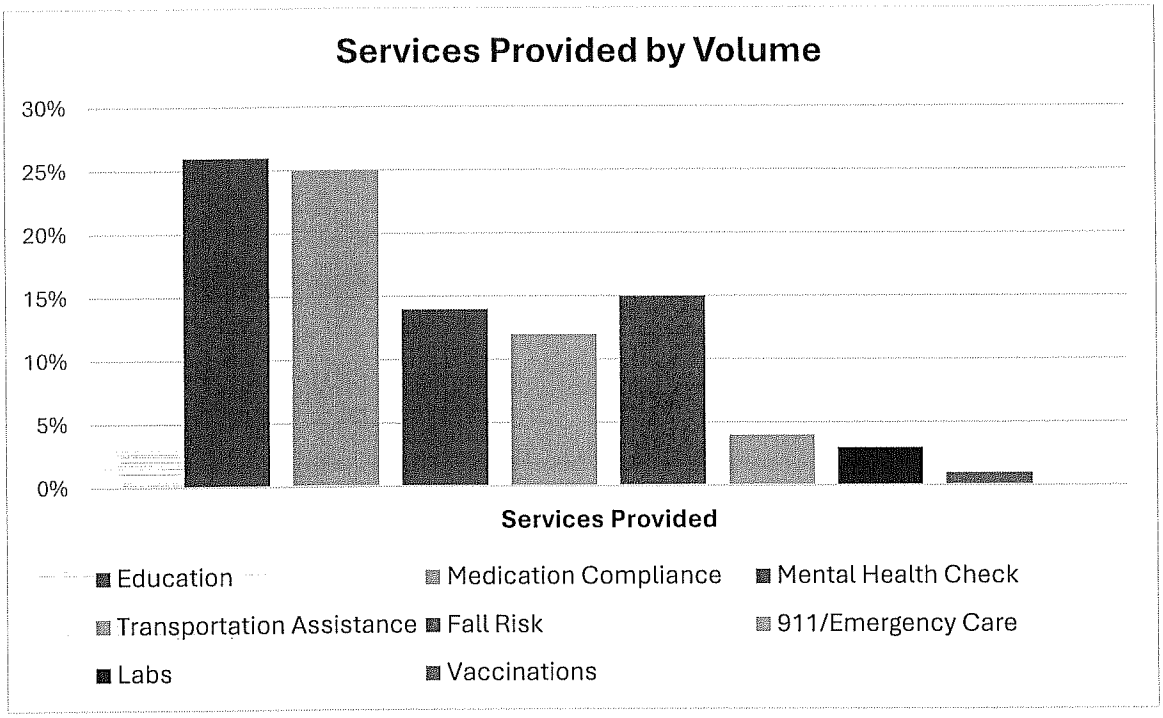

MIH has been increasing it's domain of care within it's first quarter. We have continued with a primary focus on Education, Fall Risk Assessments, Medication Checks, and Mental Health Checks. These continue to be some of the most effective methods of preventative care. MIH has refined our process by incorporating new clinically researched worksheets to validate our care. We also have expanded with other services including blood draws(labs) and vaccinations. 911/Emergency care is the few times where MIH had arrived to perform routine care and has had to perform emergency care/activate emergency services for transport. MIH will be introducing programs to increase utilizations of other services that will be described later in this document.

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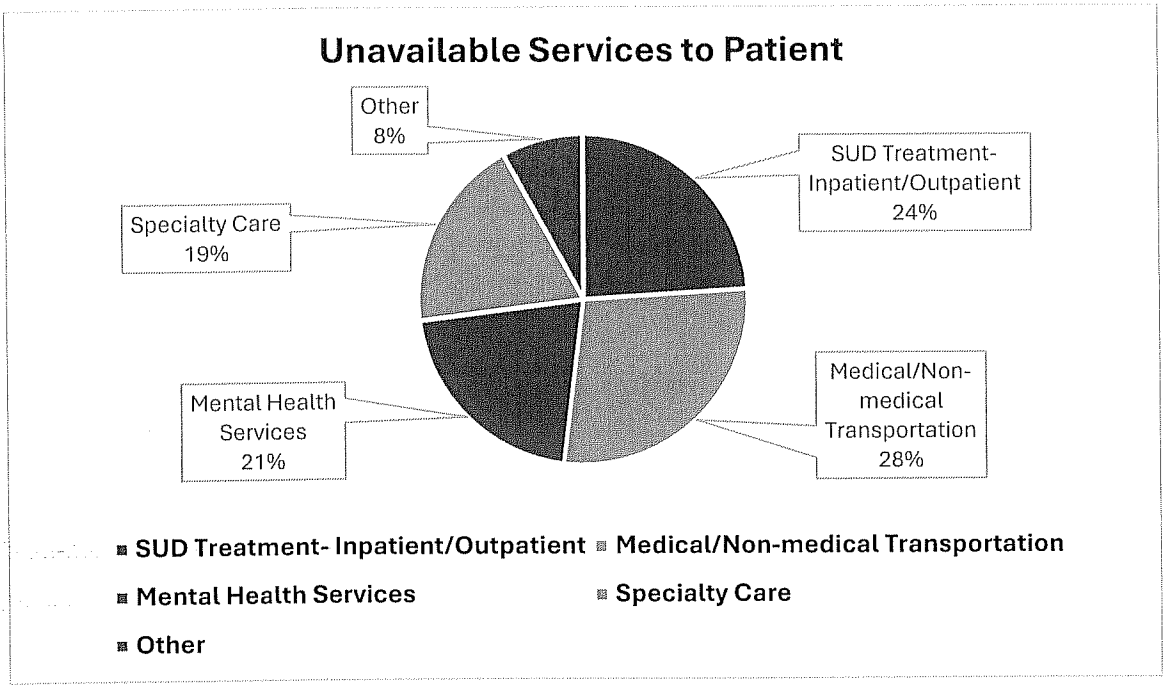

Connection of patients to structured services is a critical part of the MIH mission. Every time we are unable to correct one of these aspects for our patients, it leaves a significant amount of risk for them. These markers have continued the trend in terms of prevalence within our vulnerable populations. As MIH develops, we will develop more complex controls to evaluate degrees of efficacy in impacting these markers.

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To put it simply, we know how often we either connect people to services or can't. This is a brief summary of that data:

- 71% of our patient contacts have referrals to all resources that were determined to be needed at that time or required no referrals.
- Another 17% we were unable to connect that patient to any resources needed at all.
- The remaining 12% was for patient we were able to connect to some services, but unable to connect to all services that that patient needed.

Reasons for inability to connect patients to resources are mostly due to isolation of Ketchikan. We culturally know that living on an island in remote Alaska means we have less access overall, which includes medical and social services. Beyond that, losing our local inpatient and outpatient SUD treatment center has had a disastrous effect on our overall Behavioral Health in the community. MIH will continue to evaluate this data and develop how we record it to identify more specific causation and relationships.

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Mobile Health Hub

MIH is proud to announce that in addition to our routine weekly visits with the Salvation Army and outings with other community partners, we will be introducing a new program called the "Mobile Health Hub". This will be a monthly public clinic in tandem with the Ketchikan Wellness Coalition and Public Health alongside any other community partners who will provide services to the public. The list of services includes public medical education, rapid STI testing, free medical supplies, vaccinations, limited field care, and much more to the people of Ketchikan. This clinic will be mobile and monthly, but scheduling is still being coordinated with Public Health at this time.

Landslide Response

At the time of the landslide response, our MIH crew came into action alongside our Emergency Services but in a different function. One of our Medics became Logistics Chief for the EOC, helping coordinate shelter supplies and resources for the initial 24 hours while performing other duties associated with the role. Our other Medic helped coordinate logistics at the Kayhi Shelter while spending time acting as the medical standby. This is simply a brief note regarding MIH contributions during a time of true disaster where all members of the community had given an overwhelmingly positive response. We are humbled, and grateful for the opportunity to serve.

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Community Partnerships

A hallmark of Community Paramedicine is the integration with community partners to effectively coordinate and execute good patient care plans. At the start of our program, we unfortunately lost First City Homeless Shelter and any possible connections with KAR House or Gateway. In the wake of losing services, many people have come together to consolidate and care for our community.

Since our inception we have gained 9 new community partners, to a grand total of 15 agencies that we coordinate care with. We are very happy to announce this as it has been very much so to the benefit of our patients. This is a required aspect of our grant writing that we do track, and we have over-performed in.

High Utilizer Data Review

The MIH program is proud to present our first quarter successes in regard to High Utilizer specialty services. We have seen an overall 40% reduction in 911 transports in our highest utilizers. To be clear, these are patients that are medically complex and chronic high utilizers of 911/emergency services. They require a multi-disciplinary response from many agencies working on many aspects of their care. Effectively, MIH has taken the burden of these patients care and broken it down into smaller, more effective pieces amongst more appropriate healthcare/social work teams. Many High Utilizer patients will chronically require

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assistance from most, if not all resources they are connected with. Simply put, one of the goals of MIH is not to "get rid of" 911 responses, but to ensure that 911 is being used appropriately for emergencies by either providing care ourselves or tagging in community partners.

Generally, reduction in 911 volume is a poor metric to evaluate a Community Paramedicine Programs efficacy when used by itself. This is a general flaw in all preventative medicine as if you fix one problem a medically complex patient has, at some point more will rise. KFD MIH recognizes this and while pure reduction in 911 response is a weaker data point, it is still important. Reduction in 911 response has more systemic effects such as improvement in crew health/longevity, reduced public risk due to emergent apparatus response, and less overtime costs for callback coverage. It is important to also note that while KFD activations have been steadily rising over the last few years, 911 activations are generally correlated to things like population sizes and seasonal fluxes. Ketchikan obviously does less calls in the winter because there are simply less people. Not to mention call volume increases in the summer because 15,000 tourists are appearing most days of the week. This is why MIH focuses less on pure 911 reduction and more on improvement in quality of life with connection to services for our patients.

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Please note that some patients were removed from the previous list as MIH has never made contact or received a request from contact from them. These are all patients that MIH has either seen and cared for or received requests for contact for.

MIH High Utilizer Data

Housed?	EMS Use 3/01/24-6/11/24	# of EMS use that is IFT	EMS Use 6/11/24-7/11/24	EMS Use 7/11/24-8/11/24	EMS Use 8/11/24-9/11/24	Notation
Yes	11	5	0	1	1	With change in non-emergent transport policy, Patient has been appropriately going home from Hospital by Taxi.
No	9	0	3	4	0	Placed in definitive care in Anchorage Pioneer Home. Unknown amount of non-transports due to sheer volume.
No	7	0	2	0*	0*	*3 non-transport contacts since last transport. MIH has not been able to make contact.
Yes	5	2	0	0	0	Homehealth Corrected in-home Complications.
No	5	0	5	1	1	Patient was successfully placed in long term care and rehab/services, but has since relapsed and is homeless again.
Yes	2	1	1*	3*	1	**8 non-transport contacts. Patient has been successful in out-patient rehab and receives physical therapy services
Yes	5	0	0	2	3	Declined MIH services.
Yes	4	0	4	0	0	Brought Home through Reconnection program under PATH
Yes	4	0	0	1	1	MIH has assisted in medication compliance and remote monitoring with good improvement in Quality of Life.
60%	52	8	14	9	7	First Quarter total transports is 31. (40% decrease)

An "IFT" is an Inter-Facility Transport. This is a non-emergent, medically necessary transport between two places such as a Medevac or Take-Home from Hospital

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*A "non-contact" is a non-medical public assist that originated with a 911 call. These are not typically charted as "patients" which makes data extraction somewhat difficult.

MIH is expanding our data collection process so that we can track more in-depth markers such as specific Social Determinants of Health, Mental Health progression markers, etc. for more robust clinical care and funding opportunities.

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Clinician Hiring and Role

With the growth, scope, and operations of MIH coming into fruition our need for a Mental Health Clinician has changed. Initially the program was conceived with the intent of Crisis Intervention. While this is an essential program, MIH in conjunction with KWC has found that crisis intervention would still be best kept within the purview of Emergency Services. MIH has been supporting emergency services with additional Mental Health training and updating policies to reinforce positive care. Furthermore, by working directly with patients who were once in crisis, MIH has demonstrated a reduction in 911 activations by those patients through correcting some of those patients social determinants of health.

In the future, MIH will be looking to hire a Mental Health Clinician to coincide with MIH mission of bridging care from Crisis/Emergency care to long-term structured care. This may work best to start on a consultancy-type basis where after MIH Paramedics make an initial medical and social evaluation, a referral will be made to the Clinician on an as needed basis for care. This will allow MIH to complete a more integrated approach to bridging the continuity of care and connect patients to quality structured care after MIH.