Ketchikan Fire Department Mobile Integrated Healthcare

70 Bawden Street Ketchikan, Alaska 99901
Phone (907) 228 2461 – Fax (907) 225 9613
E-mail: KFDMIH@Ketchikan.gov

Providing care, with dignity and respect, to the vulnerable populations of Ketchikan.

Seven Months in Review

The Ketchikan Fire Department Mobile Integrated Healthcare Program (MIH) began providing services on June 10th, 2024. At its launch, MIH decided to concentrate on the following three areas: high utilizer reduction, education/outreach, and follow up care. MIH also had the opportunity to develop many community partners to help bridge gaps and connect our most vulnerable patients to the services they need. The following report will give a brief overview of the programs first seven months in operation and its results/findings. (Data reported between 6/10/24 – 1/23/25)

MIH Time Breakdown Estimation

- An estimated 35% of MIH time is spent on care coordination/case management and meeting with community partners.
- An estimated 25% of MIH time is spent in person with patients
- An estimated 15% of MIH time is spent on patient charting/reports
- An estimated 10% of MIH time is spent on training and outreach
- An estimated 10% of MIH time is spent on miscellaneous (cleaning/maintaining equipment, stocking/ordering supplies, etc....)
- An estimated 5% of MIH time is spent on transportation

Statistics and Demographics

- Patient contacts: 288 (ranging from 0 - 17 a day)
- Types of patient contacts: 31% initial contacts, 69% follow up appointments.
- Average appointment length: 65 minutes (ranging from 3 – 314 minutes)
- Average patient age: 52 years old (ranging from 24 years old – 93 years old)
- Patient sex: 68% Male, 32% Female.
- Patient ethnicity: 45% White, 43% Alaska Native, 5% Black, 4% Hispanic, 3% Asian.
- Housing status: 65% housed, 35% unhoused.
- Insurance coverage: 27% Medicare, 24% KIC Benefits, 23% Medicaid, 17% No Coverage, 8% Private, 1% VA Benefits.

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Services Rendered: (x % of patients received the following services.)

- 68% Case management
- 46% Risk reduction
- 37% Education
- 35% Chronic disease
- 33% Behavioral Health
- 27% Medication compliance
- 21% Wound care
- 17% Home Labs/EKG etc….
- 15% Facilitating transportation
- 10% Telehealth
- 6% Durable medical equipment
- 2% Vaccinations

Incoming Referral Source:

- 31% Family/friend
- 21% Self-referral
- 17% KFD EMS
- 12% KIC (health clinic, senior services, victim services, behavioral health)
- 11% Peace Health KMC (outpatient/clinic providers, behavioral health, social services, diabetes/endocrine)
- 6% Ketchikan Police Department
- < 1% Corrections
- <1% Public Health
- < 1% WISH
- < 1% SAIL

MIH Outgoing Referrals:

- 26% Peace Health KMC (same day clinic, providers, social work, home health)
- 19% KIC (health clinic, senior services, victim services)
- 16% required resources were locally unavailable
- 11% Other
- 9% Public Health
- 6% SEARHC
- 5% 988/Ketchikan Cares
- 4% SAIL
- 2% PATH
- 1% Rendezvous Senior Center
- <1% WISH
- <1% Community Connections

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High Utilizer Reduction

A high utilizer is an individual who utilizes emergency medical services (EMS) at a high rate (more than once per month). This usually warrants a referral to MIH from the Ketchikan Fire Department line crew. This small patient population represents a disproportionately large amount of call volume and use of resources. Our traditional healthcare systems inability to meet these patients' needs are part of what forces them to rely on EMS.

MIH collected referrals from KFD, KPD, KMC and other community partners for Ketchikan's highest utilizers. Once a release of information was attained, MIH looked at these individuals' 911 use over the six months period prior to MIH involvement and developed individual care plans, designed to better meet the needs of these vulnerable patients.

- 25 patients in Ketchikan were deemed "high utilizers."
- 17/25 patients were willing and able to participate in the program, and are now graduated, no longer needing MIH or EMS assistance.
- 4/25 patients are still receiving assistance to reduce EMS use.
- 4/25 patients were unwilling or unable to participate.

The 17 patients who were willing and able to participate in the program saw a reduction of 80.4% in their own 911/EMS use. This was achieved through months of education and case management, allowing us to take corrective action and connect patients to primary/specialty care, home health/hospice, SUD treatment, durable medical equipment, risk reduction services, assisted living, shelter, relocation services, etc. These patients are no longer considered "High Utilizers." The overall KFD call volume for 2024 was reduced by 10% when compared to 2023.

In the first month of 2025, 16% of KFD's EMS transports are from several individual "high utilizer" patients. This does not include all responses and resources, as only the calls warranting transport to the ER are easily identifiable/trackable. For example, MIH compiled data for one individual, our 3rd highest utilizer. In the last 9 months there have been 31 instances of transport to the ER from KFD EMS. We found 70 responses from emergency services overall. Using this patient as an average, we can create a multiplier of (2.26) emergency responses per EMS transport., We can then extrapolate the total impact of High Utilizers on emergency resources in the table below.

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The table below will estimate potential emergency resources that would have been utilized for 5 previous high utilizer patients. These 5 patients were enrolled in the MIH program and with help from MIH intervention, they are no longer high utilizers. The final two columns show the potential use of resources if MIH had not helped to meet patient needs.

Patient	Documented EMS transports.	Time frame in which transports took place before correction.	Estimated # of transports for one year without MIH.	Estimated # of emergency responses for one year without MIH.
Patient 1	14	8 months	21	47
Patient 2	7	2 months	42	95
Patient 3	14	3 months	56	127
Patient 4	2	2 weeks	52	118
Patient 5	15	9 months	20	45
Total	**52**		**191**	**432**

Source: KFD Fireworks/ImageTrend Data Reporting

Community Partners

MIH works closely with many local agencies and organizations by receiving and sending referrals and coordinating resources for patients enrolled in the program. Below are some examples of how we work with community partners.

Salvation Army

- As part of MIH's initiative to provide care to underserved and vulnerable populations, MIH has partnered with Salvation Army once a week to perform a weekly clinic called the "Mobile Health Hub." This clinic focuses on providing easier access to healthcare. Since its launch in September, MIH has established 61 new patients. Most of these patients are young men struggling with homelessness, mental health, or substance use. It is because of this clinic's success that we have seen a shift in our program's overall demographics from our previous quarter.

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Public Health

- MIH is now included in Public Health plans for future pandemic preparedness, increasing vaccine access for patients who are homebound or immunocompromised. Public Health participates monthly with MIH's Mobile Health Hub clinic, bringing STI testing and Flu shot administration to underserved patients.

Ketchikan Wellness Coalition (KWC)

- In addition to translation services for patients who speak Tagalog, MIH and KWC work closely together to help bring Naloxone kits and training to the public. Together, we have taught two training classes with several scheduled for 2025. We distributed over 200 rescue kits and have been told by KFD EMS our kits are found on scene after administration by a bystander. KWC provides MIH with risk reduction supplies for our Mobile Health Hub clinic.

Peace Health Ketchikan Medical Center (KMC)

- MIH now participates in KMC's Readmissions Review Team Meetings to reduce complications and prevent readmissions to the hospital. The team of social workers at KMC has been instrumental in some of MIH's biggest successes with complex patients. MIH has started to utilize telehealth with KMC providers and is continuing the process of expanding its scope of practice to bring homebound patients access to treatment/follow-up care at home, reducing non emergent KFD transports to the hospital.

Two new community partners (SEARHC and True North Recovery) recently began providing addiction services to patients in Ketchikan as of January 2025. MIH looks forward to continuing to connect patients to these vital resources.

Outreach and Education

- First aid/CPR class for staff and volunteers at Rendezvous Senior Center. Special thanks to the Ketchikan Volunteer Fire Department who raised funds to provide Rendezvous Senior Center with a new AED and First Aid Kit following training.
- KFD and MIH work together to provide instruction to students from Revilla High School who show interest in pursuing a career in the medical/emergency services fields. Classes take place at KFD Station 1 where students learn hands on skills.
- Our Mobile Health Hub clinic stations itself outside the Salvation Army every Thursday during lunch time. During this clinic, we provide care coordination, first

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aid/wound care, education, evaluation (treatment if needed), risk reduction supplies, food, warm clothes, hygiene products. (Special thanks to the Elks Lodge and Judy Zenge for providing MIH with supplies for the homeless.)

- MIH participated in Public Health's "Don't Fall for the Flu" drive, focusing on providing free flu shots to youth in the community.
- MIH participates in KWC community events.
- MIH has given presentations at the Library, AARP, Pioneer Hall, KMC, KIC, Community Connections, Public Health, SEANET, and more.

Concerns

Assisted Living Facilities (ALF)

- Ketchikan has a severe shortage of ALFs when compared to the rest of the country. Current wait times for ALFs are years long, leaving elderly residents to choose between a decline in health and lifestyle, or leaving Ketchikan.

Transportation

- Ketchikan residents with mobility issues must currently depend on Ketchikan Fire Department for non-emergent transport and lift assistance to and from their homes. This can lead to potential delays in response to actual emergencies or increases in overtime costs because of the need for additional off duty personnel to fill the vacancy. It would be of benefit to the community to not have to rely on an emergency service, for its non-emergent needs.

Conclusion

1. 80.4% reduction in call volume with 17 High Utilizer patients.
2. 10% overall reduction in Ketchikan Fire Department call volume.
3. Increased outreach efforts to patients who are struggling with substance use.
4. Increased outreach efforts to patients who are unhoused.
5. Continued expansion of program capabilities, increasing community paramedic scope of practice to include higher acuity skills and treatment options.
6. Improved communication between community partners, bridging gaps, advocating and connecting patients to appropriate resources.