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.

MIH Contact Data

Talk can only get an agency so far. From the beginning, the MIH team understood that to prove efficacy and worthiness of our program, we would need to have tangible evidence to show not only the care we provide to our community, but what obstructions we (and our patients) routinely face that prevent healing. We will provide anecdotal stories that speak to our agency's beliefs and provide context for different social issues our community faces.

During our first month, we documented 27 patient contacts and conducted 3 partnership events at the First City Homeless Shelter while it was still active, providing general outreach, care, and sharing of information. We have instituted routine "clinic days" where we provide outreach twice weekly. Once on Tuesday mornings at 0900-1000 in front of the PATH, and again on Thursday afternoon 1300-1400 in front of the Salvation Army.

Our first month in operation provided us with the following demographics data:

- Ages range from 36-90 years old with an average of 63.
- Patient gender breakdown is 52% Female, 48% Male.
- Ethnicities included 45% White, 37% Alaska Native, 11% Filipino and 7% Black.
- Housing status showed 55% housed and 45% unhoused.
- There were only 2 instances where patients had veteran status.

It is worth pointing out that none of our clients live within either the Pioneer Home or the Manor assisted living facilities. To date, we

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have one documented referral that MIH has not been able to assist with since it is outside of City limits, and 12 more that were unfortunately declined during professional conversation due to residency out of The City.

The most common diagnoses shared between patients are as follows:

- Hypertension 70%
- Alcohol Dependance 37%
- Diabetes 30%
- Behavioral Health Disorders 30%
- COPD 19%

These numbers reflect complications across all our patients, and it is worth noting that patients typically possess multiple diagnoses.

To properly provide exposition to the rest of our data, we will provide insight into how a typical visit occurs within MIH. MIH will receive a request for contact. This will always include a Release of Information signed by the patient, articulating a specific need for that person.

MIH will then gather relevant healthcare and social history about the patient prior to scheduling an appointment with them. To date, all referrals received by MIH have resulted in appointments scheduled for the same day, barring one instance where MIH received a request end of day Friday. That patient was seen the following Monday morning. The speed at which MIH can respond is something our patients commend us on, but if other support

systems dwindle and need increases, it may not be maintainable with our current model.

Upon arrival, MIH will perform an assessment. This usually involves asking about health history, recent changes to daily living, social determinants of health assessment, and whether the patients' basic needs are being met. MIH will remain with patients while also performing home safety checks, medication reconciliations[1], patient/familial education on patient conditions, and mental health checks as needed.

A care plan is then established with patient input. Having identified the needs of the patient, MIH will contact local resources to assist the patient with a direct line to what they require. Typically, this entails the scheduling of necessary appointments, or relaying of in-home information to give providers insight that helps redesign care plans for the benefit of the patient. We are in a unique position where we can tell the providers what the home situation is really like, and this directly makes things better for our patients because we can mobilize the correct resources for them. This most commonly takes place on our first visit. Our average time spent with a patient per visit is 85 minutes.

Something that will be detailed more in-depth in this document is that MIH is also assisting patients with arranging transport to and from their appointments. A resource that is lacking for our most vulnerable patients.

MIH currently (as of 7/12/24) has 13 actively enrolled patients in our program, and 7 graduated patients. Graduated patients no longer need consistent MIH intervention but will be

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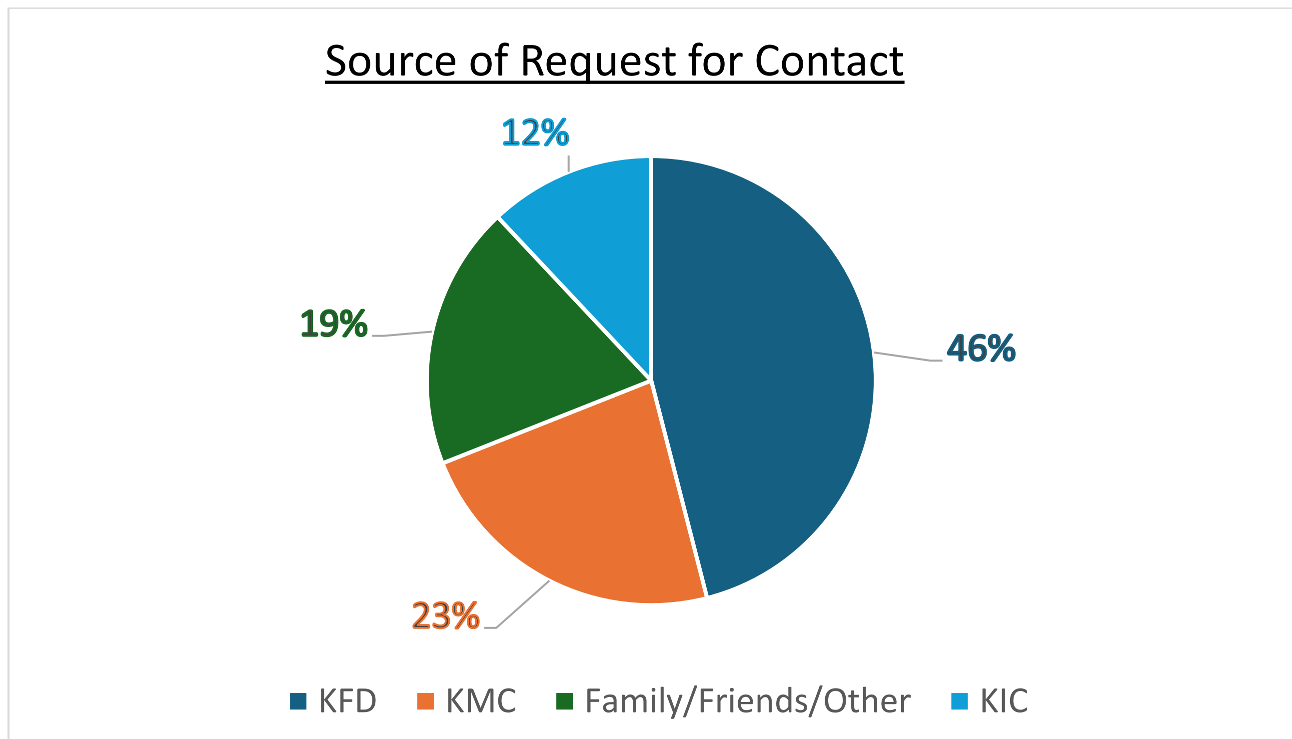
followed up with to ensure a continuum of care. Some examples that could lead to a patient's graduation are as follows:

- No longer relying on emergency services for basic needs.
- Risks have been reduced and safety plans established.
- Patient connected to appropriate resources.
- Patient deems MIH involvement unnecessary.

We have been very content with the number of requests for contact that the EMS crews have provided us with but were anticipating more from KMC overall. We also were anticipating less from KIC but have been pleased with their partnership and teamwork for patient care. Our continual growth in the community is allowing for many more patient interactions and interventions.



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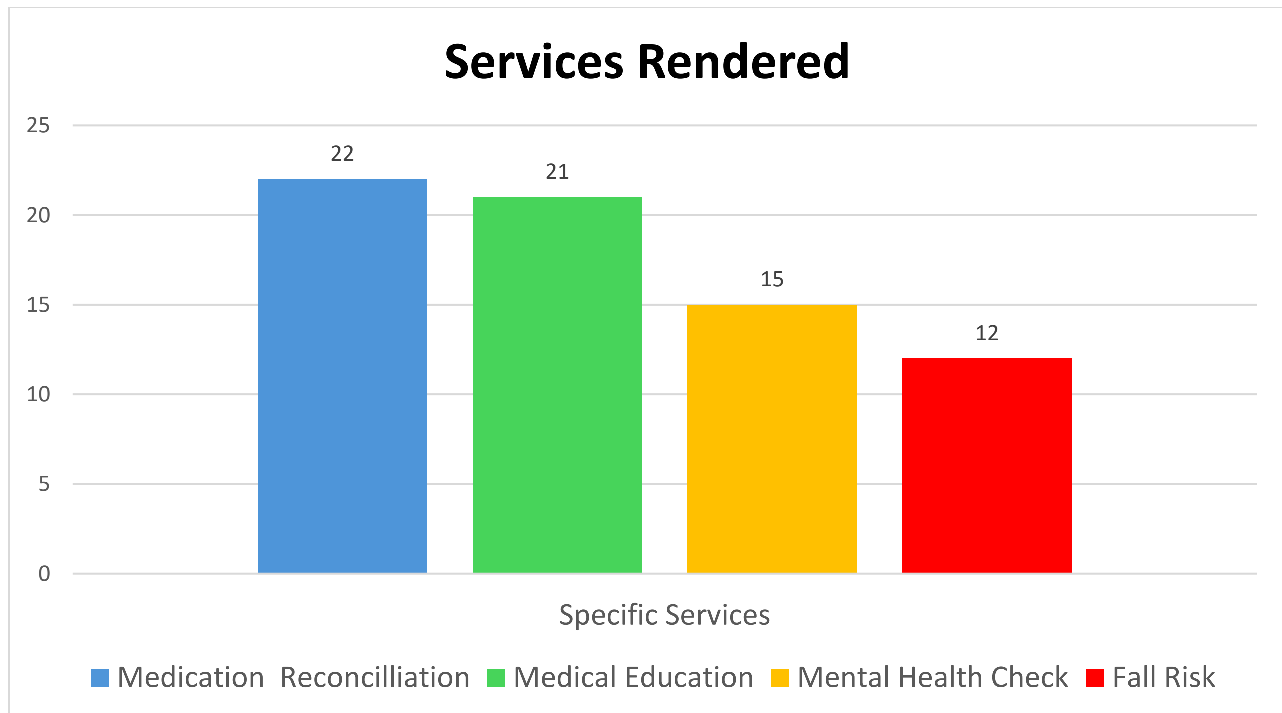
Throughout our patient visits we have been tracking both services provided and services not available in Ketchikan. Within the 27 contacts, we have performed:

- 22 medication reconciliations
- 21 medical educations
- 12 fall-risk assessments
- 15 mental health checks

We are evaluating other specific points of data but have decided to keep it limited to these for now to maintain consistency in our early stages of development.



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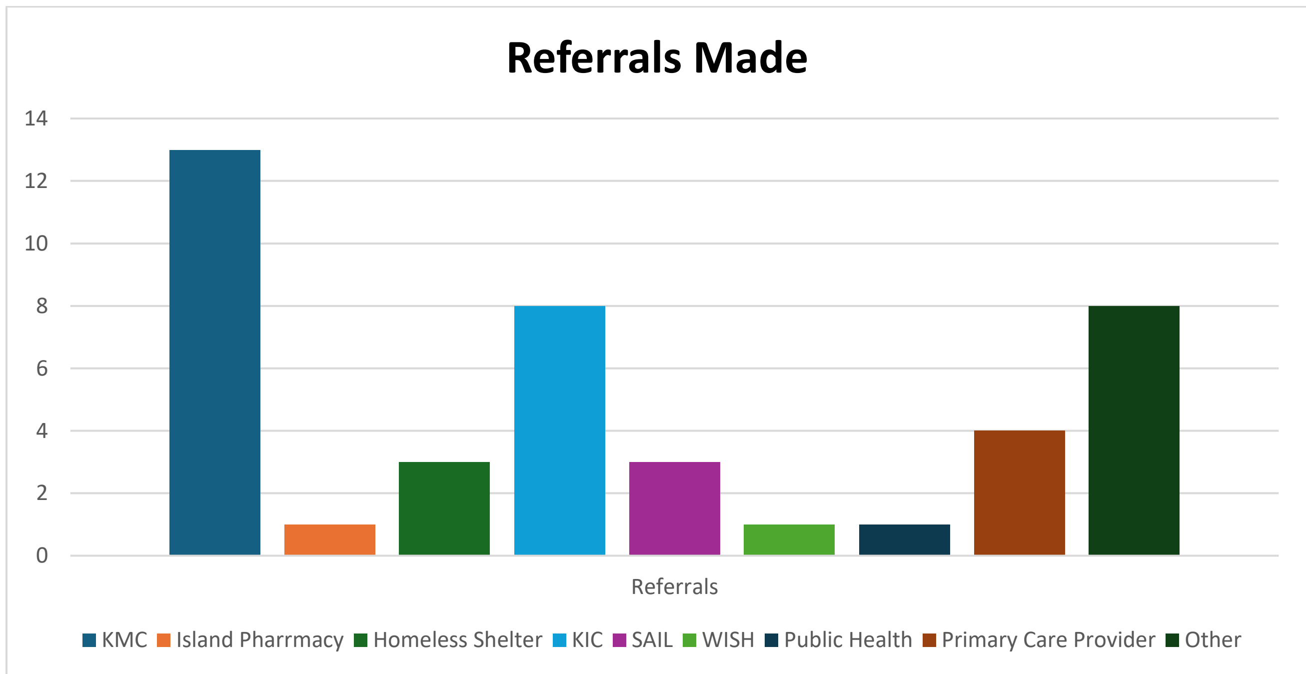
MIH has also tracked outbound referrals/appointments for patients. Overall, we have arranged most of our patient's care with KMC. We did not specify within the data set though if it was a specific department underneath KMC as we have essentially worked with every department at KMC for patient care. Our "Other" section is made up of community partners that we initially did not have at the start of the program, such as Rendezvous Senior Center, who have proven themselves to be an invaluable member of the community. Also, some patients received multiple referrals as they required significant and immediate intervention.



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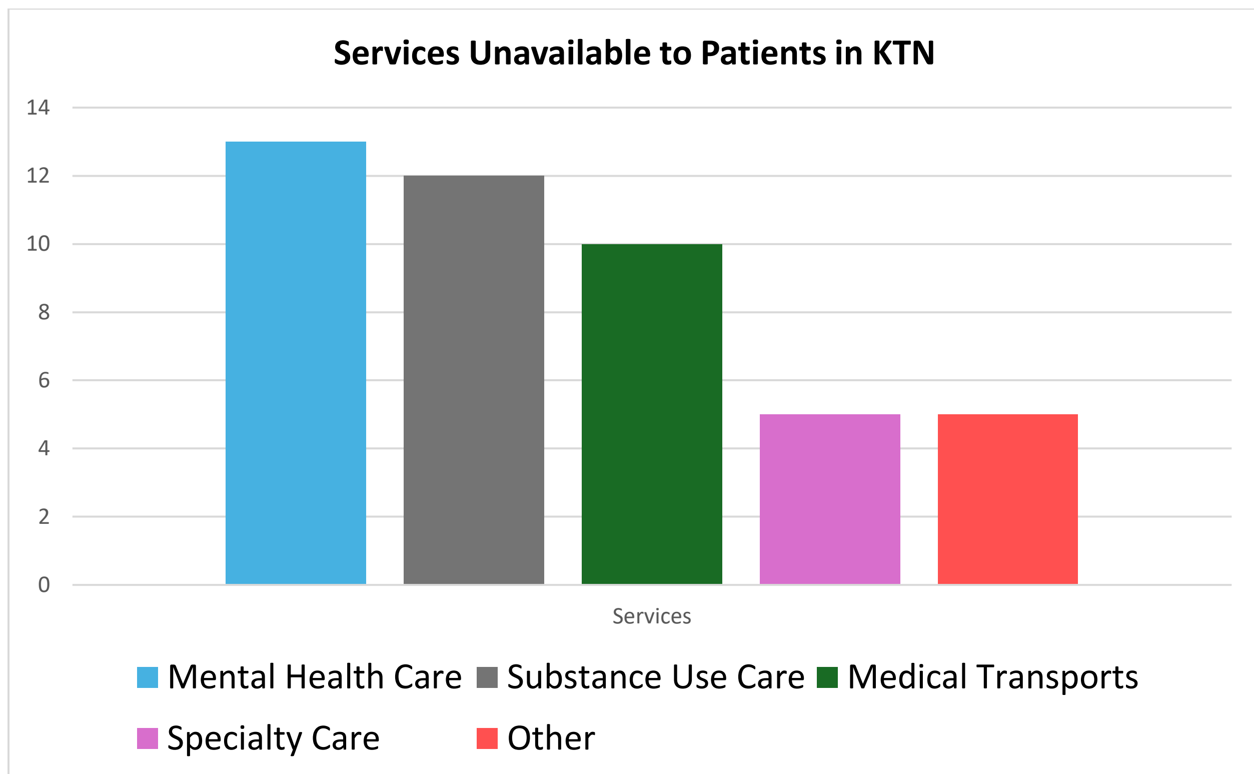
Importantly, our processes have allowed us to identify gaps in Ketchikan's community healthcare network. We will speak more on these topics throughout this document but will provide the raw numbers that spurred this research. According to the data, our most profound need is Behavioral Health and Medical Transportation. We did have one patient who was receiving support for their substance use but did not have any mental health care. "Specialty Care" refers to a specific practice that is not present in KTN like Hepatology[2] or Neurology[3]. The "Other" was more general, such as Skilled Nursing, disability equipment needs, etc. We believe going forward it will be important to track this data as we have identified it as a critical hole in the medical/social structure of KTN.



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Interfacility Transport Report

Within our practice, one of the most prolific elements affecting our community's healthcare has been the lack of ability to transport people to meet their healthcare needs. In our working with the community partners, especially such as all sections of KIC, Hospice, Homehealth, SAIL, Island Pharmacy, and others, we have found a resounding echo regarding a need for transport of our homebound/vulnerable populations.

As of now, the ADA Paratransit, Senior Center/CCS, KIC van, and Wheelchair accessible taxis share the same reasonable policies that they will bring people to their destinations safely but will not assist them in or out of their homes/up or down stairs due to safety and litigious reasons. This is a common practice nationally for these kinds of services. The issue arises when any individual is home/bed-bound and requires transport to their physician/surgical center/healthcare appointment.

To date, we have physically assisted (carried to some degree) 5 patients to family's personal vehicles for transport. We have had significant difficulties regarding our care and the current transportation systems. We had multiple instances of being able to find a critical health need for patients, arranging appointments for them with an appropriate provider, but not having any way of transporting them. We specifically had multiple times where we helped create patients KIC appointments, but then have no ability to transport them because none of the services provide "same day" transport due to their already intensive workload. Furthermore, cab-vouchers are scarcely provided due to

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economic taxation on agencies, and even then, MIH would have to be the ones to go pick the vouchers up and deliver them back to the patient for them to use. That is, if the patient is even mentally or physically well enough to take a cab ride independently. This issue is not isolated to KIC but the Paratransit and Senior Services Van as well. We have multiple testimonies from patients who express strong dissatisfaction because their needs are not being met.

A common issue that arises is that if a patient requires paratransit services, but does not medically qualify for ambulance transport, they effectively become stuck wherever they end up. We have had countless reports from disabled patients and their families that if the ambulance brings that patient to the Emergency Room, there is no structured way to bring that person home other than taking an ambulance back. To date, every social and health agency we have interacted with in Ketchikan has identified lack of appropriate transportation as a critical issue that impacts public health and safety.

If a person requires medical monitoring, is bed-bound, or a family member isn't available to facilitate transport, then the only other option available in the City/Borough of Ketchikan is to go by 911 ambulance for a non-emergent transport. The City of Ketchikan is staffed for 1 full time 911 ambulance, and both Tongass Service's operate on a volunteer "on-call" basis. Any time these non-emergency transports take place, the very thinly stretched emergency response system is taken up for quite some time. As of 7/12/24, one month into the program, 15 of our 28

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patient contacts required Medical-Transport services that were not available in Ketchikan (54%).

Frequently, our Program will interact with patients who require multi-disciplinary care plans, but because of the limited abilities from the current transport services, they simply will not receive care. This leads to exacerbated health conditions and poor patient outcomes, furthering the tax on the healthcare resources in Ketchikan for all community members. Sometimes the only option for these patients who do not meet transport criteria for Medicaid/Medicare, is to transport via ambulance which ultimately results in multiple ends of economic complications for that person, the Fire Department, and ultimately the City/Borough. To be clear, this is not a statement adjudicating some kind of poor service from our current transport agencies, just that a specific need is present in our community that is not being addressed appropriately by what is available.

In comparison, the CARES program of Juneau (MIH equivalent), operates two wheelchair vans, assisting patients with transport to appointments that they arrange for them. The CARES program is also a “gap fill” program like us, connecting patients to larger, more structured resources that can routinely fill their needs. The difference being, CARES has a reliable and cost-effective method for connecting their vulnerable patients to appropriate resources. While bringing new much needed resources to Ketchikan is an honorable goal, our patients need to be able to get to those resources to benefit from the services they provide.

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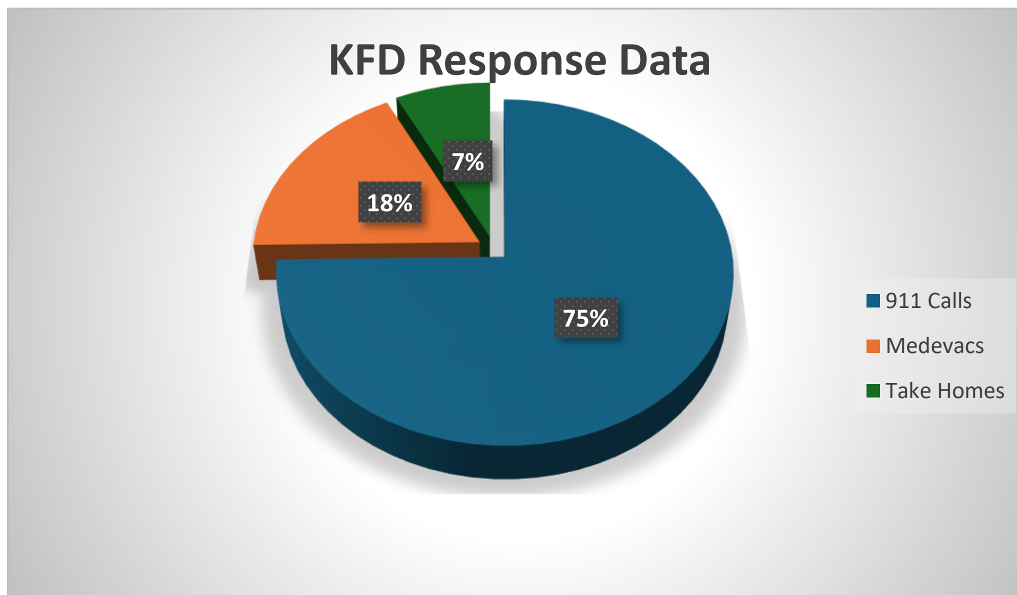
In this instance, ***there are multiple private non-emergent <u>medical-transport ambulance/van agencies that provide the specific type of service we are describing available in Juneau</u> that CARES can connect patients with once they have provided initial service*. *Since we do not have those agencies in Ketchikan, the Fire Department and MIH must keep "filling the gap" in an expensive and ineffective way.***

MIH assisted KFD Command Staff in recognizing this gap as one of the most common denominators in poor patient outcomes, and illustrated the impact of how this gap is affecting not only the Fire Service Operations, but the overall welfare of our community. This resulted in the KFD Command staff creating an SOP for Interfacility Transports with special thanks to Lt. William Schulz for his diligence on this subject. This helps make sure that the one staffed 911 ambulance is being utilized in an appropriate manner, and during times when coverage is available. This still leaves a gap in the community for patients who need assistance from their homes to anywhere else. It is the MIH Program's recommendation that the City of Ketchikan, Borough of Ketchikan, and City of Saxman collaborate on a long-term solution seeing as how this systematically affects all our communities' vulnerable populations. Some possible pathways include:

- Allowing for a private interfacility agency to enter that can arrange for these transports.
- Municipal entities provide additional funding to the City of Ketchikan FD to support their existing interfacility transport capabilities and extend this service to the Borough/City of Saxman.

- Municipal Entities provide funding to North or South Tongass to operate a full-time interfacility transport ambulance and extending these specific services to the City of Ketchikan/Saxman.
- Requesting Peacehealth to either provide the services themselves, contract them through a private agency, or extend funding to the Fire Department to further facilitate the existing transport structure.

Interfacility Transport Data



Within just the 2nd quarter of 2024 (3/1-6/11), there have been 150 total IFTs.

- 20 are transporting medevac teams from the airport to the hospital.
- 86 are transporting medevac teams from the hospital to the airport.

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The remaining 44 are non-emergent transport from Peacehealth elsewhere.

- 31 are to private residence (14 of which are from our High Utilizer list)
- 8 are to the Pioneer Home.
- 5 are to “other” - these are for non-residential transports.

We do not have information on how many of these transports meet “medical necessity” specifically for transport by ambulance, which means any number of these transports may not be covered by insurance and are costing the city and its citizens.

With the total EMS calls from this specific quarter being 594, that means 25% of volume is non-emergent IFT’s being provided by a 911 service.

As of 2022, the operational cost of an ambulance run for KFD is $3,366.16, meaning already this year, we have incurred approx. $294,008 from just non-emergent take home transports from the hospital (estimating from 88 transports). This data is only pulled from City of Ketchikan runs; no information is available to MIH regarding North/South Tongass take-home transports.

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High Utilizer Data Report

High Utilizers[4] is a specific target demographic of the MIH program. At the beginning of the program, MIH identified that given the limited healthcare resources available in Ketchikan, excessive and inappropriate use of Emergency resources can easily become a public safety risk. Our team identified the major factors associated with high utilization include:

- Inability to transport to preventative care.
- Poor Chronic Disease Management
- Poor access to Behavioral Health (addiction/psychiatric services)
- Lack of ADL[5] (Assistance with Daily Living) support

The MIH team often finds itself arranging for or transporting patients POV due to poor access to transport resources. MIH is tracking instances where we can arrange patients for appropriate preventative care but are not able to get them there due to lack of transportation options.

Given that specialty care is limited, proactive recognition and treatment of the social/economic/home-based factors have provided immense relief to our patient populations. In the sense of preventative care, it is not conducive to project "calls prevented" as it becomes very difficult to determine what that means for a plethora of reasons. What we do have is testimonials from patients and patient's families who can attest to the changes that MIH has provided to improve the quality of life, and ultimately the health of our patients.

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Chronic Disease Management is without a doubt a national concern on all healthcare levels. The diseases nationally targeted most highly include Congestive Heart Failure, Diabetes, Hypertension (High Blood Pressure), and COPD. MIH has been working with all partner agencies identifying patients who may have or are actively having complications regarding their chronic diseases, then going to the patient in their home to identify factors affecting their ability to cope with these conditions. Familial education on chronic conditions and home safety evaluations have proven to be one of our strongest tools, allowing us to confidently graduate patients once we correct underlying complications within the home.

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High Utilizer Data Set Study

To track MIH impact on High Utilizers of emergency services, the top 12 utilizers were identified at the beginning of the program and were cared for alongside routine patient referrals.

Housed?	EMS Use 3/01/24-6/11/24	# of EMS use that is IFT pre-MIH	EMS Use 6/11/24-7/11/24	Note
Yes	11	5	0	Coordination with Hospice assisted correction.
No	9	0	3*	Assisted KIC in detox/long-term placement.
Yes	7	3	0	No MIH contact currently.
No	7	0	2*	Patient displaced from KTN with Shelter closing.
Yes	5	2	0	Homehealth Corrected in-home complications.
No	5	0	5	Placed in Long term Care
Yes	5	0	0	No MIH contact currently.
Yes	4	2	0	Appropriate transport mode articulated.
Yes	4	0	4	Relocated home through the PATH
Yes	4	0	0	Corrected in-home problems causing 911 use
Yes	4	2	Deceased	
No	18	0	Data exempt	
40	**61**	**12**	**14**	

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Of our Top 12 High Utilizers, EMS has had a total of 61 calls over the course of a 3-month period PRIOR to MIH intervention.

- One patient was excluded due to being an extreme outlier.
- Another patient's data was excluded due to passing on the day before MIH interaction.

Of the 10 remaining patients, 3 are homeless.

- It is worth noting that none of the 7 housed patients meet the criteria of "semi-permanent" housing.

40 (67%) of these calls were from patients who are housed.

- Of these 40 calls, 12 (30%) were non-emergent take homes performed by 911 ambulance (higher than the agency average of 7%)

In coordination with PeaceHealth Social Services, we found a profound correlation between high utilization of EMS and hospital services. All but one of our high utilizers was also one of theirs. In our first month of operation, we were able to facilitate a permanent reduction in Emergency utilization (hospital and ambulance) for two of our patients. Two patients were not reduced in average call volume, but notably only called for 911 outside of MIH working hours. (noted with *)

While the initial data is promising, MIH will continue to track data as high utilization "comes in waves." Typically, our vulnerable populations will have a life change (hospitalization, change in home status, relapse, etc.) that causes a rush of activations and subsequent care from MIH.

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Residential Needs Report

At the time of writing, the Pioneer Home of Ketchikan has a waitlist of 41 (5 Female, 36 Male). The Manor has a waitlist of 10, with one open bed. The last remaining bed is on the second floor and therefore limits who can occupy it due to disability. KIC Senior Housing status is unknown currently but is worth noting that they do not provide ADL[5] assistance and are not licensed as an ALF. MIH has identified multiple patients to date that require intensive, long-term care, but are not able to be placed due to systemic overload. There are multiple levels of ADL in healthcare, and most are not available in Ketchikan. ***When our patients' basic needs are not met, they must rely on emergency services to help them***. Please refer to the patient experience who was one of our High Utilizers due to the fact they were homeless, and needed transport via ambulance to the ER multiple times because they were physically incapable of cleaning themselves after they would defecate.

The first "tier" would be in-home health assistance. This is often the weekly "house call" provided by a Nurse, or Certified Nurse Aide providing in home assistance a few times a week. Currently Homehealth and Hospice from Peacehealth has approximately 45 clients, 30 Home Health / 15 Hospice Care. Despite the majority of their staff being part-time providers, they are striving to provide a service as effectively as they can to these patients but have expressed difficulties regarding such an intensive workload. These providers are exceptional, and we fully advocate for any support to their teams. We have personally seen wonderful care

for the residents of Ketchikan by them, but we simply need more. At this time, we will leave specific recommendations regarding their care capabilities to them but will support any ideas put forward.

The next "tier" of homecare is an Assisted Living Facility (ALF) such as the Pioneer Home or The Manor. An ALF has full-time staff available 24/7 to provide basic assistance to patients as needed (i.e., medication administration, bathroom assistance, feeding, etc.). Given the waitlists for the previously mentioned facilities, there is an exceptional need for these services in Ketchikan. It is also worth mentioning that there are 3 others registered ALF's in KTN, but they only have capacity for 1 person each.

Often, life-time residents of Ketchikan who require any kind of long-term ALF services will be displaced to a facility outside of Southeast Alaska until a place opens for them in their hometown. This process may take years. Since there are no registered ALFs in Metlakatla or Prince of Wales Island, Ketchikan often becomes the first stop if available. Often those people are displaced to Seattle or Anchorage. To provide context to relative resources available, we found there are 557 registered ALFs in the Anchorage Municipality compared to 5 of our home area. Of these 557 ALFs, there are 3,273 beds. Given Anchorages population of approx. 287,145 that means there are about 90 people to every ALF bed. In Ketchikan, adding the approx. populations of POW, Metlakatla and KTN totaling 21,500 (based on last census) that is approx. 1 bed per 347 people. Almost 5 times less access for this service.

While this is a natural part of Alaskan healthcare, we recognize the emotional toll this often has on patients and family members. MIH recommends the Cities of Ketchikan/Saxman and the Borough itself find space for another ALF agency to open, and possibly look for additional funding for agencies providing services already.

The most intensive level of care is a Skilled Nursing Facility (SNF). A long-term SNF would house patients while providing 24/7 medical care needs such as physical therapy, wound care, and chronic disease management. Currently, PeaceHealth does offer Skilled Nursing through its New Horizons Facility, one of the 18 Skilled Nursing facilities in the State. They are censused for 29 beds, with 23 currently occupied and 4 on a waitlist. After many informative discussions with PeaceHealth faculty, we learned that filling those last 6 beds creates logistical challenges that create more issues than just an empty bed. Typically, male and female patients are split, or some patients who do not need to use a toilet due to medical reasons with others who do use toilets. Some residents require isolated rooms due to medical conditions. We will pointedly say that MIH has no specialty understanding of managing SNF resources but has trust in current management's capabilities.

New Horizons reports they are operating at ~75% "long-term" patients, meaning patients will remain in their care indefinitely. Of the remaining "short-term" patients, their intensive care can last upwards of 100 days. MIH was advised that there are less than 20 new admittances a year due to multiple factors like this. There is only 1 reported non- Ketchikan Borough/City resident staying in

New Horizons at the time of writing. The gravity of that statistic is that this is the end point, home destination for the rest of these people. No number could be provided, but there are multiple Ketchikan residents who are receiving SNF services elsewhere, waiting to return to Ketchikan once they are appropriately rehabilitated or logistical space opens in New Horizons. The vast majority are of patients come from the Med-Surg department for post hospitalization discharge rehabilitation, but do not have a clear path of housing/treatment after that. An issue that MIH identified from the beginning of inception is that once these patients are discharged, they end up with as little, or less resources as they came to the hospital with, resulting in 911 activation and readmission. MIH has come upon many of the same conclusions as New Horizons. MIH will echo New Horizons' sentiment that more ALF and SNF beds need to come to Ketchikan to provide residents a means to stay within their community and not be displaced away from their friends and family.

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Behavioral Health

There is much already spoken and written about regarding Behavioral Health services in Ketchikan. MIH will simply add to the discussion that it is, and always will be, an indescribably important aspect of healthcare in Ketchikan. Our data shows that at least half of our patients are actively suffering from lack of Behavioral Health Resources, and many of our patients live with either substance use disorder and/or mental health conditions.

Not having a robust Behavioral Healthcare system in Ketchikan has had complex, widespread negative effects that no individual agency has been able to articulate the depth and repercussions of. Similarly, losing the low-barrier warming shelter has had deeply disheartening effects on our community.

Our community will work diligently forward. MIH is eager to work closely with our incoming Community Partners and we welcome the essential services they will bring to Ketchikan with warm hearts.

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Title 47 Involuntary Hold SOP

Paramedics across the country hold the ability to place patients who are a danger to themselves or others under involuntary holds. Within the State of Alaska, the legislation was changed within the last 2 years to include EMT's, Paramedics, and Firefighters as "Health Officers" who can invoke involuntary holds on at-risk individuals. Previously, only Peace Officers, Physicians, or Mental Health Professionals could invoke this legislation which would ultimately result in EMS transport. MIH has interacted with multiple patients so far who qualified for an involuntary hold but there was no Ketchikan FD Policy or specific guidance regarding the state legislation for Paramedics on this. Those situations were handled in a safe and legal manner with Police assistance.

To expand on the mission of caring for vulnerable populations of Ketchikan, MIH created the SOP, the training, and assisted in the implementation for KFD staff to perform involuntary holds on these at-risk patients to ensure our most at risk constituents can be cared for safely. Ketchikan Fire Department is the first EMS agency in the state to adopt this legislation in adjunct with our current Standard Operating Procedure.

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In Summation

MIH data is promising but remains in infancy. Our team started with multiple perspectives on community issues ranging from lifetime experience, to brand new transplants. Consistent hypotheses across these perspectives were transportation complications causing health disparities, an ongoing behavioral health crisis secondary to lack of resources, and chronic high utilization issues believed to be from our homeless crisis. Our data has supported multiple facets of these issues and revealed more areas of interest.

High Utilization is directly linked to both lack of transportation services, and our behavioral health crisis. Furthermore, the chronic transportation problems suggest a correlation with Fire Department call volume and mis-utilization. Surprisingly, the data also revealed that high utilization problems are more strongly linked to transportation issues and inaccessibility to healthcare for all residents than the homeless crisis itself. Lastly, on a larger scale, MIH has identified complications in our healthcare networks ability to place patients in appropriate housing. It is MIH's suggestion that this may also be linked to Ketchikan's housing crisis.

In short conclusion, MIH carries these suggestions for all municipalities to consider:

- Investment in Senior/Assisted Living Facility Housing
- Procurement of a more robust non-emergent transport system

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- Allowing another low barrier warming shelter to come into Ketchikan.
- Investment in a 24-hour sobering center.
- Expanding funding into infrastructure to alleviate chronic housing and economic issues.
- Retention, and supporting possible expansion of incoming Substance Use/Mental Health facilities.
- Expansion of MIH operations, staffing, and hours of operation.

With Thanks.

We would like to extend a deep gratitude to our partners. The very root of our job is connecting us and our patients to others in the community. The most beneficial to our development has been the Ketchikan Wellness Coalition. Every single individual working under that organization is devoutly laboring to improve the health and welfare of Ketchikan and we are deeply grateful for their ambitions. It is an example that should be followed. There have been immense hurdles that without support from our Medical Director Joe Livengood, Chief of Risk Reduction Gretchen O’Sullivan, and Fire Chief Rick Hines, we would have tumbled perpetually.

The late author Walter Elliot wrote, “Perseverance is not a long race; it is many short races, one after the other.” We strive to win many races, knowing there will be losses. Our team is dedicated to the safety and care of our community, taking as many steps forward are needed.

Definitions

1. **Medication Reconciliation** is checking what medications the patient has prescribed, doesn't have but is prescribed, and what medications are being taken per doctors' orders. MIH will then provide that list to the patient to give to their primary care provider for a closed loop of care.
2. **Hepatolog**y is the specific science and practice of liver functions and diseases.
3. **Neurology** is the specific science and practice of Brain and Central Nervous System functions and diseases.
4. A **High Utilizer** is someone who has activated 911 or used the Emergency Department services 2 or more times in a calendar year.
5. **ADL** refers to Activities of Daily Living. Such activities as cleaning or feeding oneself, dressing, functional mobility, and other criteria are used to determine a person's level of disability.