Ketchikan Fire Department
Mobile Integrated Healthcare
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The purpose of this document is to provide insight into the efforts of Ketchikan Fire Departments Mobile Integrated Healthcare Program during the first month of operation and outline gaps in care our community members face. This is not intended to be a slight or defamation of any other agency. This is a combination of the factual aspects of MIH and patient experience. The accounts provided in this document have had all identifiable patient information removed.

MIH was given a referral from KFD EMS. The patient was living alone in their apartment while being cared for by their daughter and grandson who would take turns stopping by every day. MIH found that they were noncompliant with not only their antibiotics but had not been taking their heart medications for months. It was believed this was due to a possible underlying mental disorder. This also resulted in severe swelling in the patients feet causing them to be unable to walk in their home, even with live-in family assistance. MIH relayed this information to the family who helped in making KIC appointments. Unfortunately, MIH had to help carry this patient out of the home to utilize private transport as the appointment was made “same day” and they could not be transported by any of the senior/disability vans. The patient has now recovered from their UTI, is compliant with all their medications, and was diagnosed with a low-grade dementia. Because MIH identified these issues, involved family education, and assisted in filling transportation needs, this patient is able to walk again while living comfortably at home.

MIH was given a referral from KFD EMS for a High-Utilizer patient who was intoxicated at work and fell downstairs, injuring their ankle. Through multiple visits with them, MIH built rapport and uncovered the patient suffers from schizoaffective and bipolar disorder and battles with alcohol and substance use disorder. Despite MIH articulating a care plan and assisting the patient in getting help through public resources, the patient relapsed and became homeless in Ketchikan, again. They stated they struggled being in Ketchikan with no structured support system or SUD clinics. The patient expressed a desire to return home to their mother and dog where they had a doctor they trusted. They were connected to community partner PATH for the Reconnect program and were successfully flown home to undergo treatment.

MIH was referred to a patient from KMC Diabetes Center for the purpose of education. The patient speaks English but understands medical terms better in Tagalog. A translator from community partner KWC was able to accompany MIH on visits to this patient to help facilitate a better level of understanding. When first contact was made, they were not able to check their BGL levels on their own or administer insulin. They also stated they fall often, having to walk to the ER or call the ambulance for assistance with their insulin. Initially, this patient needed

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private transport by MIH, but is now able to utilize prescheduled transport via Para Transit since they do not require assistance from the driver. By the third visit, the patient was utilizing an assistive device to prevent falls and was able to check their blood sugar, administer their own correct dose of insulin and record their results in a log for future appointments at KMC which they can now attend on their own, unassisted.

MIH was referred by KFD to another High-Utilizer patient with end-stage diseases needing help with medication compliance. The patient was found to be struggling with their regiment by either forgetting to take or taking too much of their medication. This would be detrimental to their health and jeopardize their chance for a liver transplant. They stated they had people checking in on them but had a friend coming to stay with them next week who could help care for them. MIH had appointments with them every other day, creating a medication log system to help with compliance, bridging the gap until their friend could arrive to facilitate in home care. That patient is now possibly a candidate for organ transplant, which would not be possible if non-compliance with medications continued.

MIH received referrals from KMC and KFD EMS for a patient who was chronically homeless, chronic drinker, and had high utilization of emergency services. This patient needed emergent intervention for weakness, pain, and chronic diarrhea several times a week. To specify, this person was physically disabled having to rely on activating 911 to transport to ED every time they had diarrhea and needed assistance cleaning themselves because they were too weak and sick to care for themselves. They were staying in an abandoned shed where they developed a pneumonia, continued substance abuse, and conditions in the shed continued to deteriorate. Through community partnerships, particularly the Case Managers at Peacehealth, MIH was able to advocate for this patient and find placement in a long-term care facility where patient has been able to make a full recovery, now able to care for all their normal daily needs.

MIH receives multiple inquiries from community members requesting assistance with movement of non-ambulatory pts. When applicable, MIH will help with prescheduled movement of pts from their home to their personal vehicle, where they can then be transported by family/friends to their appointments. MIH will meet pts back at their residence to move pt back following their appointment. MIH does not currently have a dedicated vehicle to facilitate transportation of these underserved populations.

At this time, MIH is compiling a list of community partners and individuals who will speak to the depth of how the transportation crisis has affected them.

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Below are three patient outcomes that were less than desirable due to obstacles encountered while working with community partners and a lack of services:

The first instance regarding a patient who was abandoned in Ketchikan following being sexually abused, financially defrauded and kidnapped. This information was discovered during initial MIH interview following a request for contact from KMC. The patient was determined to be extremely vulnerable and gravely disabled. They were a danger to themselves and others on account of their late-stage dementia, unmedicated seizure disorder, inability to sleep due to hallucinations, inability to charge their spinal stimulator, inability to eat, and absence of corrective lenses needed for driving their large vehicle. They were brought to KMC ER where they were soon after, discharged despite intense advocacy from both MIH and KMC staff for admission. The patient was found the next week where MIH facilitated a telehealth appointment for KMC. The patient was determined to be severely cognitively impaired by the physician at that time. Patient was placed under an involuntary hold by KPD and MIH, then brought to the ER again where they were observed for a day before being discharged. APS has contacted MIH regarding this patient and plans to come to Ketchikan to try and locate and interview pt. Since losing contact with the patient, MIH is unsure of outcome currently as patient continues to be severely cognitively impaired and transient within Ketchikan. MIH suffered a great deal of strife and interpersonal turmoil professionally and personally from the ED trying to advocate for this patient.

The second instance was with a high utilizer of emergency services. This patient was homeless and struggled with chronic alcoholism and suicidal ideation. MIH was contacted by KIC to locate the patient and connect them to KIC to tell them that they had found placement at the Anchorage Pioneer Home. MIH found the patient, arranged transport and appointments at KIC Behavioral services for this person. MIH and community partner KIC advocate for admission to KMC for detox until the patient can undergo their interview for admission into the Anchorage Pioneer home as the patient must undergo evaluation/physical prior to Pioneer Home placement. It is Peace Health policy that they will not admit patients unless there is a confirmed bed for placement. The patient was advocating for themselves stating they wanted to seek help with their recovery and leave Ketchikan stating, “I will F-ing die if I stay in Ketchikan, I need to get out of here”. KIC arranged for evaluation via telehealth in the ER. The patient was reportedly too inebriated to complete the consultation for detox placement and was promptly discharged from the ER as they no longer had a confirmed bed placement. This resulted in the bed being revoked at Anchorage Pioneer home. The patient is once again homeless in Ketchikan, drinking, and requiring emergency services to meet their needs.

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The Third instance where MIH observed a less than desirable outcome was for a patient who had been sober for several years but relapsed with their alcohol use. This person was transported by the ambulance to the ER because the patient wished for detox services. The patient was discharged home approx. 12 hours later. MIH contacted the patient approx. 5 hours post discharge, actively going through alcohol withdrawal and no longer capable of walking due to weakness secondary to their withdrawals. At the time of visit, the patients' symptoms were consistent with needing admittance into a detox center for observation while going through alcohol withdrawal, a process which could potentially be fatal. The patient advocated for themselves, wanting to go somewhere locally for a few days for assistance with detox and sobriety, but refused to go anywhere if the service was not available locally. MIH was able to bridge the gap in detox care this patient experienced by working with KIC. One individual involved in the patients care stated "I can't believe they discharged this person.". KIC behavioral or social services had not received any referrals, and the patient was not informed of any options locally for services. While this experience highlights the importance of local substance use inpatient care, it also reinforces themes of complacency we have experienced in our practice.