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.

One Year in Review

The Ketchikan Fire Department Mobile Integrated Healthcare Program (MIH) has been providing services for just over one year, beginning on June 10th, 2024. MIH is a non-emergent appointment based service that operates Monday – Friday, 8am – 5pm. MIH is a gap fill program, aiming to provide services to Ketchikan's vulnerable and underserved patient populations. It is for this reason that the program will frequently shift priorities at staff discretion and depending on patient and community needs. Main areas of focus include follow up preventative care, substance use, and non-emergent use of emergency services. We are most proud of the relationships we have been able to build with our community partners and the trust we have established with our patients. The following data will encompass the services provided between the dates of 6/10/2024 – 7/31/2025.

Demographics

- Current number of patients enrolled: 202
- Documented patient contacts: 1000 (434 one on one appointments, 566 clinic visits)
- Average patient age: 58 (ranging from 18 years old – 93 Years old)
- Patient Sex: 62% Male, 37% Female, 1% Unknown
- Patient Race: 47% White, 38% Alaska Native, 2% Asian, 2% Black, 1% Hispanic, 10% Unknown
- Housing Status: 59% housed, 41% unhoused
- Insurance coverage: 30% Medicaid, 22% KIC beneficiary, 20% Medicare, 20% No Coverage, 6% Private, 2% VA benefits

Incoming Referrals

- 35% Self, Family/Friend
- 24% PeaceHealth Ketchikan Medical Center (primary care, social services, home health etc.)
- 22% Ketchikan Fire Department EMS
- 5% Ketchikan Indian Community (health clinic, victim services, etc.)
- 3% Ketchikan Police Department
- 11% Other

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Outgoing Referrals

- 25% No referrals necessary
- 18% PeaceHealth Ketchikan Medical Center (priority care, social services, home health etc.)
- 13% Needed services were locally unavailable
- 12% Ketchikan Indian Community (health clinic, senior services, victim services, behavioral health etc.)
- 8% Public Health
- 6% Services locally available but prevented due to barrier
- 18% Other

Services Provided

- 16% Case management
- 15% Medication compliance and medication/equipment delivery
- 11% Chronic disease management
- 10% Education
- 9% Wound Care
- 8% High utilizers
- 7% Substance Use
- 7% Risk Reduction
- 6% Food insecurity
- 4% Welfare checks
- 3% Relocation assistance
- 3% Labs and Telehealth
- 1% Transportation assistance

Community Partner Involvement

PeaceHealth

- Working with primary care providers to bridge gaps for homebound patients, we provide many services including telehealth appointments, at home lab draws, EKGs, wound care, and medication delivery/management.
- The social work team has been instrumental in assisting MIH with attaining medications for patients without coverage, scheduling appointments with primary/specialty care providers, and assisting with finding placement in assisted living.
- MIH provides care to patients who lack coverage, don't meet criteria, or are waiting to receive services from home health. As MIH continues to expand its protocols and capabilities, we will continue to work with home health, providing care as needed.

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- Priority Care has been helpful in reducing ER visits for non-emergent needs. When MIH has clinic patients with concerns beyond our scope, they are referred to Priority Care in lieu of the ER.

Public Health and The Salvation Army

- Public Health partners with MIH and Salvation Army to provide our weekly clinic patients with vaccinations and testing for STIs, HIV and Hepatitis. Patients are provided with follow-up care by way of medications and/or referrals.
- The Salvation Army provides MIH with space for our weekly clinic as well as a private room for patient privacy. This enables MIH to have a central location where vulnerable patients know they can reliably find us without the need for prescheduled appointments or healthcare coverage.

The Ketchikan Wellness Coalition

- MIH works closely with KWC's Drug Free Communities Program Director Tara Taro to bring free naloxone classes and distribution to combat the opioid epidemic. Over 500 kits (1000 4mg doses) of Naloxone distributed in the last year.
- Community Health Liaison Czarina Cabillo accompanies MIH to appointments for patients that speak primarily Tagalog to act as translator.
- Crisis Now Community Director Lisa DeLaet helped to create the MIH program with Division Chief of Community Risk Reduction Gretchen O'Sullivan and is still an active part of the team, helping MIH to better navigate community resources. KWC also provides MIH with supplies for risk reduction, nutrition supplementation, weather injury prevention, etc.

Ketchikan Fire Department EMS and Ketchikan Fire Department IAFF Local 2761

- Ketchikan Fire Department EMS line crew helps MIH with staffing as needed. They also have developed a new transport policy for non-emergent transports and lift assists to more efficiently and cost effectively meet community needs.
- Ketchikan Fire Department IAFF Local 2761 has provided financial assistance for MIH enrolled patients with great success. At our discretion, helping with relocation, lodging, medications, and medical appointments.

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PATH Shelter

- Park Avenue Temporary Home and MIH work closely through Ty Rettke's RECONNECT program to provide individuals the ability to pursue SUD treatment, enter assisted living, or return to family.
- MIH provides PATH residents with wound care, medications, case management, and nutrition supplementation.

Case Study

MIH received a referral from both our EMS crew and Ketchikan Medical Center for a 64-year-old male who was deemed a high utilizer of emergency services. This patient was unhoused and suffering from chronic pain and depression. The patient had been self-medicating with alcohol, rendering him unable to care for himself. His physical disabilities, a broken femur and hand, kept him from effectively performing daily living tasks. His weight would hover around 90lbs due to lack of appetite from his depression and not being able to attain food on his own. Other concerns consisted of hypertension, congestive heart failure, and noncompliance with his medications due to being a frequent victim of crime, or medications deteriorating due to weather. The patient was unable to utilize effective pain management due to the dangers of mixing opiates and alcohol. Surgery to fix the patient's broken femur was withheld due to the increased risks associated with chronic alcoholism. The patient had health coverage through Medicaid but was unable to effectively participate in his care plan with his primary and behavioral health providers. He could not escape the cyclical nature of the challenges he was facing.

Initially the patient refused most of the assistance we would offer. If it were not for the encouragement from our other unhoused patients, we doubt we would have been able to convince the patient to participate in the program. With the assistance of the patient's friend group to help physically move him, Ketchikan Medical Centers clinical social worker, and the Office of Public Assistance, we were able to obtain a social security card. The patient continued to struggle with attending his medical appointments, obtaining medications, and staying compliant. MIH utilized the ADA Bus + program, scheduling rides for his weekly appointments. MIH also utilized telehealth to connect the patient to providers when attending appointments in person was not an option. To prevent theft and degradation of medications, MIH purchased a safe to provide our most vulnerable patients with a secure place for storage. We allow daily access to those medications for those select patients when they choose to take them and they are very appreciative.

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Time passed, and while the patient's rate of use for emergency services continued to decline with MIH intervention, the patient's underlying issues of homelessness and chronic pain continued. The patient eventually found shelter with family, but the environment, according to the patient, was not conducive to his needs and eventually led to APS reports being filed due to patient statements and mandated reporting requirements. The patient's wants and needs exceeded the capabilities of many local resources. The exacerbation of his comorbidities led to the patient's eventual emergency medivac south. While the patient's demeanor and frequent use of expletives made us believe that the patient was not very fond of us or the care we provided, the patient's last words before being emergently flown south changed our outlook on the type of work we do, the patients we serve, and the trust we have been able to establish. "Tell (MIH Staff) I am being flown south."

Several weeks passed, and once the patient was discharged from the ICU, he began physical therapy in an attempt to return him to his baseline. It was during this time that the Pioneer Home Anchorage notified the patients clinical social worker that there was a room available, following an intake interview earlier in the year. Initially efforts were made to discharge the patient from the hospital to the Pioneer Home, but the timeline would not allow it, and he was discharged and returned to Ketchikan. PATH shelter was able to find room for the patient if he could adhere to the rules. The next month of interactions with the patient involved ensuring proper nutrition and medication compliance as to not repeat a trip south. There was daily teetertottering from wanting to go into assisted living and wanting to cease treatment altogether. The patient's depression was exacerbated by an individual who would repeatedly bring the patient alcohol, leading to noncompliance with medications, falls, incontinence, etc. It was the conjoined encouragement and support from the patient's clinical social worker, PATH staff and MIH staff, that the patient eventually regained compliance with his medications and agreed to follow the advice of his providers to enter assisted living.

MIH worked with the patient for the next few weeks to ensure proper completion of paperwork, assessments, and other requirements prior to entering the Pioneer Home. There was one delay of admission due to patient hesitation secondary to his fear of being alone. The patient agreed to go with the caveat of being able to transfer to the Ketchikan Pioneer home upon an opening. The Salvation Army was able to donate a week's worth of clothing, a suitcase was donated by Judy Zenge, toiletries and medications were funded by MIH, and Ty Rettke purchased airline tickets and escorted the patient to Anchorage through his city funded Reconnect Program.

This patient generated 44 EMS responses with 28 EMS transports, 41 hospital interactions, and 21 Police responses since 2024. During the patients' time working with MIH before entering assisted living, the

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patients call volume was reduced by 95%. We estimate that MIH spent a total of 60 hours working with/for this patient. Combining hours worked with the cost of medications, supplies etc… we estimate MIH's incurred cost for helping this patient was under $4000. High utilizers who agree to participate in the program have seen over an 85% reduction in their use of EMS. Since the start of the program, there has been a 54% reduction of patients who qualify as "high utilizers"

Awards

- 2025 State of Alaska Office of Rural Health Community Star
- 2025 Alaska Hospital and Healthcare Association Annual Champion Award for innovation in Patient Safety and Quality