



## Grady Emergency Medical Service - Mobile Integrated Health (MIH)

Grady's MIH program evolved from our Upstream Crisis Intervention Program that was developed and implemented in January 2013. At the time, the program was referred to as Community Paramedicine and was later changed to better describe the level of services provided to our patients. Both our MIH programs embed higher level clinicians with expertise in their respective fields, partnered with Grady EMS field paramedics, and deploy within our 9-1-1 system.

### Grady's MIH Advanced Practice Team:

Our MIH Advanced Practice team consists of a Grady EMS paramedic and a Family Nurse Practitioner. We respond to calls in a SUV that is fully equipped as an EMS Medical First Responder unit (12-lead EKG, ACLS medications, airway management, etc.) and point-of-care testing (Chem 8, PT/INR, Creatinine, rapid strep, etc.). The Advanced Practice program was designed with three specific deliveries of care: integration within the 9-1-1 response system, home visits to EMS and ED high users, and patients identified as high risk for hospital readmissions within 30-days post discharge.

The first initiative is the reactive response to low acuity 9-1-1 calls. Upon arrival, the clinical team will assess, perform point of care testing, diagnosis, prescribe medications, and treat conditions in the field without transporting the patient to the Emergency Department (ED). This program allows ambulances to remain in-service for higher priority calls and prevents overutilization of the ED.

The second initiative is scheduled home visits to EMS and ED high users. These patients are defined as calling 911 five or more times in the preceding month. These visits are used to connect the patient to needed resources, assist in the care of their chronic condition, provide patient education, perform fall-risk assessments, reconnect patients with primary care, review any recent discharge instructions, complete medication reconciliation, and assist with obtaining prescriptions. The goal of this program is to decrease the patient's dependence on the 9-1-1 system and ED.

***The high user program is highly successful and is the focus of much internal research. Based on our findings, we are consistently able to show a 50% decrease in 9-1-1 use for the 30-days following the first MIH visit compared to the 30-days prior to the MIH visit. We have also been able to show a 45% decrease in 9-1-1 use for the 90-days following the MIH home visit when compared to the 90-days prior to the first MIH home visit.***

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The third initiative is the coordination and integration with the Grady's current hospital programs to reduce CHF, AMI, COPD, and pneumonia patients from readmission within 30-days post discharge. During visits, our team reviews their hospital records and medications through a remote hospital chart portal. The team will review discharge instructions, complete medication reconciliation and verify the patient has all their necessary medications, verify upcoming appointments, assist with transportation challenges to appointments or pharmacy, and perform any care and diagnostic needs (order labs or mobile x-rays) within the NP's scope. The utilization of an NP allows the MIH team a broad range of patient diagnoses and flexibility in seeing complicated co-morbidity patients through referrals from physicians who are outside of the CMS criteria. The MIH team may reach out to the patient's discharging or primary physician during the encounter to reconcile any care needs and assure continuity.



## Upstream Mobile Crisis Intervention

In January of 2013, Grady EMS partnered with the regional mental health crisis response corporation to integrate a licensed clinical social worker (LCSW) in a quick response vehicle to assess and better manage a patient during an acute mental health (MH) crisis. We partner a Grady EMS paramedic with the social worker in a SUV that is a fully equipped and licensed Medical First Responder unit. This unit can respond to NAEMD (25A & 25B) calls as the sole responder or co-respond with an ambulance based on dispatch notes. This unit is also authorized to transport MH patients to an alternate destination that is not part of a hospital or ED. There are a number of MH emergency receiving facilities that will accept patients directly from our crisis unit without requiring ED clearance. Medical screening is performed by phone with an EMS physician or Fellow, and acceptance is verified before a transport begins. Utilizing an embedded MH clinician allows for better management of the patient's condition and reduces ambulance transports of MH patients to the ED **by over 91%**.

The Upstream Mobile Crisis program consists of a two pronged approach— a reactionary emergency response to a mental health crisis and a proactive system for EMS high users.

First, this unit responds to 9-1-1 calls that are triaged through the NAEMD as category 25 (psychiatric / suicide attempt). Upon arrival to the scene, the patient is evaluated for any medical condition by the Grady paramedic and then care is transferred to the MH social worker to evaluate their MH crisis. Often the patient's condition has deteriorated to a point where transport to the Grady ED or alternate destination is unavoidable. However; while at the scene, the team engages the patient, family and caregivers on how to obtain MH resources through the 1-800 number (Georgia Crisis and Access Line) before the situation escalates or the condition exacerbates to the point of requiring 9-1-1. The 1-800 number can route to our unit if the circumstances cannot be resolved over the phone or by scheduling an urgent MH appointment. The on scene MH clinician has three possible call dispositions: (1) the patient is provided a safety plan and on scene support, (2) the patient is provided a mental health appointment for the next business day, (3) the patient is transported to an emergency receiving facility. If none of these are possible, the patient will be reconnected with the EMS system and the Grady EMS paramedic will oversee the call evolution until the patient is placed in a transport ambulance.

Second, the program acts as a preventative system for EMS high users with a MH history by providing resources which aim to decrease their dependence on the 9-1-1 system. These appointments can be scheduled or unscheduled. Once a patient contact is established, the team connects the patient to resources that will provide them improved overall health. The unit assists patients with MH and medical appointments complete a medication reconciliation and assists with any medication questions, assures the patient has all their prescribed medications, provides pill organizers, assists with transportation needs through Grady's system, etc. This program is able to achieve a 50%-100% decrease in EMS use over the 90-days post the first MH home visits and decrease their EMS use by 90% or greater after the second visit.