Emergency Services and Office for the Aging Collaborative

Becky Preve: Director Franklin County Office for the Aging

Background

- In 2014 Franklin County Office for the Aging and Adult Protective Services formed the Multidisciplinary Team for Elder Abuse and Neglect

- Emergency Medical Services engaged in the MDT and partnered with Office for the Aging to address consumer needs
  - Emergency Medical Services includes – dispatch and 1st responders (police, paramedics, fire personnel)

- Strategic Plan identified partnership opportunities within the emergency services and first responder systems.

Building a Partnership

- Training is provided by AAA to all dispatch staff regarding screening for social issues (i.e. lack of food, pet issues, lack of heat, financial insecurity, out of medications, etc.)
- Cross system informational sessions were held to discuss mental health, alcohol and substance abuse services, and legal services
- Training provided by AAA, health care and mental health services providers to first responder staff regarding services and supports available in the community
- Creation of intensive case conferencing for high utilizers of the emergency response system

Building Capacity

- All clients receiving services via NY Connects or Office for the Aging Services were surveyed for emergency contacts and special needs
- Information was built into the 911 dispatch system, allowing dispatch staff to see in real time any pertinent information, including possible cognitive or physical limitations
- Emergency services database built capacity to directly notify Office for the Aging in cases that did not necessitate EMS or police intervention. The service is available 24/7 ensuring that all shifts have access to the social support
- Follow up provided back to EMS system on outcomes, providing a team effort approach on person centered care

Continued Capacity Building

- Emergency Medical Service providers were also included in direct trainings, and work closely with Office for the Aging staff
- Continuum of care follows dispatch, to first responders, and to Aging Services staff
- Cross over has allowed for advocacy with acute care facilities and with families facing decisions regarding high level of social care needs
- Partnership has also allowed hard to reach consumers access to services they may not have been aware of

Importance in DSRIP Goals for NYS

- The purpose of DSRIP (Delivery System Reform Incentive Payment) is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years.

- NYS DOH required the formation of Performing Provider Systems (PPS) to support the collaboration necessary for successful implementation of DSRIP projects.

- The DSRIP program addresses social factors that impact health, requiring engagement and collaboration with many stakeholders, including community-based organizations, from diverse sectors.

Outcome Measures from Partnership

- Dispatch staff immediately began utilizing the on call function to access Office for the Aging for social concerns

- Clients that were utilizing 911 for social interaction, or for non emergent reasons were identified and referred to Office for the Aging via the NY Connects System, thereby reducing reliance on EMS staff and generating savings

- As a result of training, First responders are engaged is assessing home living environments, and caregiver supports, directly impacting referrals for services through the network

Case specific outcomes

- An older couple living in their own home were in the EMS database system as they were in their 90's and one had significant medical issues, the other one had very advanced dementia

- There was a 911 dispatch to the home due to a fall and transport was provided to the hospital for the medically frail wife. Office for the Aging was notified of the concern for the husband with advanced dementia and immediately went to the home and action was taken to ensure the safety of the spouse in the home.

- The client was transitioned to a local adult home, and his wife was placed in a skilled nursing facility

Direct impact on DSRIP initiative

- Medicaid client with underlying mental health issues utilized the 911 call system over 90 times in a six month period. Calls included numerous hallucinations and paranoid delusions. Estimated ER visits exceed 15.

- A case conference was held with the client, first responders, adult protective services, and a peer support program. By offering services via the "warm line" and by adding a friendly visitor the client ceased calling 911 and was no longer transported to the emergency department.

- The result was significant savings to the Medicaid system, and a better outcome for the client and reduced costs and time for first responders.

EMS and OFA Collaboration

- A emergency responder on a 911 dispatch call paged Office for the Aging regarding a client that they had transported to the Emergency Department four times in a two week period.

- There were numerous social concerns with the home, and OFA staff were able to conduct a home visit, develop a plan for home care services and supports, and were paged the next time the client called 911.

- They were able to jointly respond with emergency responders, accompanied her to the emergency department, and were able to advocate for an admission and further workup with a transition to a higher level of care.

Dispatch Intervention

- An older woman living in a remote area repeatedly contacted 911 stating that her phone had been shut off. Dispatch staff noted that she appeared to have some confusion and requested OFA evaluate the client.

- Staff went to the home and determined that she had not been paying her bills, and had fairly advanced cognitive issues. Staff were able to work with her family, provide legal assistance, and guardianship was obtained by her family.

- Home care services were initiated and the client has not utilized the 911 systems since the intervention.

Community Collaboration

- January 2018 - a large scale flood hit regions of the county, the emergency operation center opened and utilized Office for the Aging to assist with emergency sheltering.

- Additionally, an older woman in a flooded home was refusing to leave the residence, and first responders, unsuccessful in convincing her to leave due to safety issues, reached out to Office for the Aging who successfully worked with customer and personally assisted in helping her relocate with her cats.

- During any weather emergency the agencies work in collaboration to make sure cross systems interventions are provided to vulnerable individuals.

Value of MDT Program from the Emergency Services Perspective

- Reduction of repeat EMS calls and unnecessary transports, which improves the availability of agencies to respond to true emergency incidents, and reduces costs associated with transports. In some areas of the County, this could be 45 miles, one way – A 90 mile round trip for agencies, equivalent to approximately three hours (including loading/unloading) per transport per patient.

- Ability of First Responders to report unsafe living conditions or deteriorating mental health conditions directly to an agency that can provide timely follow-up evaluations.

Value of MDT Program from the E-911 Dispatch Perspective

- Reduced call-volume from repeat callers, keeping lines open for true emergency calls to be dealt with more efficiently.
- Standard methods of communication with Office for Aging staff that provides alerts to possible deterioration of health and/or mental health conditions.
- An avenue to report inadequate living conditions (i.e. no heating capabilities, no electricity, no potable water, unsanitary conditions)

Value of MDT Program from the E-911 Dispatch Perspective continued

- Use of a "Voluntary Registration for Special Populations Emergency Response" form to obtain demographic and emergency information from clients, that is then entered into the Site Information Management System (SIMS) at the 911 dispatch center.

- The ability to input and maintain information related to existing clients (SIMS) enables dispatch staff to respond additional help if necessary, or to make notifications to alternate contacts. It also provides enhanced medical and/or accessibility information to First Responders.

Why Replicate?

- Social and medical models of care must intersect to meet Health Care Triple Aim – the right care, in the right setting, for the right price

- Person centered care includes collaboration across health and social systems. Partnerships such as this allow services to be engaged in a proactive manner, and not reactive. These partnerships save health care dollars, and allow individuals the opportunity to age in place with appropriate services and supports.

- Partnerships allow for holistic care for the entire population.