How did we get here?

1. May 2015
   Fire Rescue assumes EMS transport services

2. September 2017
   Community behavioral health meeting

3. October 2018
   Coweta Cares established
<table>
<thead>
<tr>
<th>Calls for Service</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Nature Types</td>
<td>74,215</td>
<td>75,730</td>
<td>76,639</td>
</tr>
<tr>
<td>Heart Problems</td>
<td>606</td>
<td>641</td>
<td>641</td>
</tr>
<tr>
<td>Stroke</td>
<td>522</td>
<td>531</td>
<td>628</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1,518</td>
<td>1,603</td>
<td>1,662</td>
</tr>
<tr>
<td>Transports</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>All Nature Types</td>
<td>9,392</td>
<td>10,110</td>
<td>9,891</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>500</td>
<td>576</td>
<td>620</td>
</tr>
<tr>
<td></td>
<td>5.3%</td>
<td>5.7%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
## Hospital Statistics

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Patients</td>
<td>52.33</td>
<td>53.25</td>
<td>55</td>
</tr>
<tr>
<td>Total Patients</td>
<td>628</td>
<td>639</td>
<td>661</td>
</tr>
<tr>
<td>Average Hold Time</td>
<td>9:52</td>
<td>12:42</td>
<td>14:17</td>
</tr>
</tbody>
</table>
Behavioral Health Facts

43.8 million adults experience mental illness in a given year

Coweta’s population – 146,000

1 in 5 adults - 29,200 in Coweta
Current Model for Behavioral Health Crisis

1. 911 Call
2. Fire/EMS and Law Enforcement Dispatched
3. Transported to Behavioral Health Provider
4. Transported to Emergency Room or Jail
Why change the service delivery?

1. Inadequate patient care
2. Exhausting limited resources
3. Cost to taxpayers for current response
Who’s impacted?

Individuals  Families  Community  Taxpayers
Who’s involved in providing care?
A group of local partners committed to reinvesting existing resources in our community to better serve our citizens.
Proposed Model

911 Call

Georgia Crisis and Access Line (GCAL)

Mobile Response Unit

Fire/EMS & Law Enforcement

Emergency Room

Jail

Program Participants
What is Mobile Integrated Healthcare?

• Community-based health care that operates outside customary emergency response

• Specialized locally developed programs to help patients navigate through the healthcare system

• Facilitate more appropriate use of emergency care resources
Mobile Response Unit (SUV)

- Public Safety Radio
- CAD & ePCR
- Cardiac Monitor
- Telemedicine Kit
- Medicine & Supplies

Cross-trained Staff

- Paramedic
- Behavioral Health Counselor (LPC)
- Physician (Telemedicine)
Program Services

- Behavioral Health Assessment
- Home safety assessments
- Community resource referrals
- Preventive care and medication compliance
- Coordinate appointments and transportation
- Patient education
<table>
<thead>
<tr>
<th>Program Goals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HELP</th>
<th>PROVIDE</th>
<th>PREVENT</th>
<th>SAVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide definitive behavioral health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce EMS transports by 10% within one (1) year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce average cost by 15% within one (1) year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Behavioral Health Implementation Timeline

**Phase 1**
August 2018
Utilize Georgia Crisis and Access Line (GCAL)
911 Dispatchers, Fire/EMS and Law Enforcement

**Phase 2**
January 2019
Implement a mobile response unit and to help behavioral health patients.

**Phase 3**
January 2020
Expand mobile response unit and related services.
Example: Congestive heart failure
Georgia Coverdell Acute Stroke Registry (GCASR)

April 2016 -- Coweta County Fire & Rescue joined GCASR

April 2018 – Coweta County Fire & Rescue agreed to provide follow-up home visits for stroke patients
Georgia is in a geographic region called the “stroke belt,” an area in the southeastern U.S. with stroke death rates that are approximately 30% higher than the rest of the U.S.

Approximately 1/3 of stroke survivors suffer depression at any one time.

Post-stroke depression is associated with poor functional outcomes and higher mortality.
Why home visits for post-stroke follow-up?

- Provide a more thorough stroke care program
- Assess patient’s condition at his/her home
- Connect patients to community resources and support
Selection Criteria to Enroll

1. Ischemic Stroke Patient
2. Patient Discharged Directly Home
3. Patient 18 Years Or Older
4. Modified Rankin Scale Score At Discharge To Be 0 To 3
5. Patient Who Is Hypertensive and/or Hyperlipidemic and/or Tobacco User
6. Patient With Dementia Is Excluded

Patient With Dementia Is Excluded
### Comorbidities Among Georgia Stroke Patients and Adult Georgians

<table>
<thead>
<tr>
<th></th>
<th>Acute Stroke Patients*</th>
<th>Adult Georgians**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>83.8%</td>
<td>33.1%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>45.7%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>37.8%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Smoking</td>
<td>22.7%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

*GCASR 2017
**Georgia Behavioral Risk Factors Surveillance System (BRFSS) 2017
## Prevalence of Chronic Conditions and Tobacco Use Among Adult Georgians 18 Years and Older (BRFSS, 2017)

<table>
<thead>
<tr>
<th></th>
<th>High Blood Pressure</th>
<th>High Cholesterol</th>
<th>Diabetes Mellitus</th>
<th>Smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District 4 (LaGrange)</strong></td>
<td>39.3%</td>
<td>31.1%</td>
<td>11.4%</td>
<td>17.1%</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>33.1%</td>
<td>31.1%</td>
<td>11.4%</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>United States</strong></td>
<td>32.3%</td>
<td>33.3%</td>
<td>10.5%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

*Public Health District 4 Counties: LaGrange: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, and Upson*
<table>
<thead>
<tr>
<th>Discharge Disposition of Ischemic Stroke Patients at Piedmont Newnan Hospital (GCASR, 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home</strong></td>
</tr>
<tr>
<td><strong>Inpatient/Home Hospice</strong></td>
</tr>
<tr>
<td><strong>Acute Care Facility</strong></td>
</tr>
<tr>
<td><strong>Other Health Care Facility</strong></td>
</tr>
<tr>
<td>(Skilled Nursing Facility/Inpatient Rehab.)</td>
</tr>
<tr>
<td><strong>Expired</strong></td>
</tr>
<tr>
<td><strong>Left against medical advice</strong></td>
</tr>
</tbody>
</table>
Post-Stroke Program

A series of home visits for a period of 90 days

The first meeting with a paramedic will be at Piedmont Newnan Hospital

Once a patient is enrolled, the first home visit will take place within 72 hours post-discharge

Future home visits will be scheduled based on the patient’s needs

The paramedic will administer the GWTG Post-discharge Mortality & Readmission form at the 30-day, 60-day, and 90-day mark
Patient Enrollment
Post-Stroke Program Services

- Vital Sign Check
- Home Safety
- Post-stroke Care Education
- Medication Reconciliation, Adherence, and Compliance
- Coordinate Medical Appts. and Transportation
- Smoking Cessation Support
- Tele-psych Consultation with Pathways Center
- Connect Patient to Resources in the Community
## Post-Stroke Program Goals

<table>
<thead>
<tr>
<th>ENSURE</th>
<th>SUPPORT</th>
<th>CONNECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smooth transition of care that includes monitoring for depression</td>
<td>Stroke patients to follow their discharge plan</td>
<td>Stroke patients to community resources and support</td>
</tr>
</tbody>
</table>
Post-Stroke Program Implementation Timeline

**Phase 1**
- April 2018
  - Planning and Installing

**Phase 2**
- April 2019
  - Initial/Pilot Implementation
  - (up to 3 patients per month)

**Phase 3**
- April 2020
  - Full Implementation
  - (to be determined)
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Deron “Pat” Wilson, EMT-P, MBA
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Panel Q&A