

Most crises behind 911 calls aren't medical—they're social: hunger, loneliness and the terror of staring down homelessness.

FEATURE



911, WHAT'S YOUR EMERGENCY?

SURPRISING REASONS FOR MOST PARAMEDIC CALLS—

AND A BETTER WAY TO ANSWER THEM | BY ELAINE VITONE

PHOTOGRAPHY | TOM ALTANY/UNIVERSITY OF PITTSBURGH, EXCEPT WHERE NOTED

In 2016, a health care team at St. Clair Hospital was preparing to send home a patient, we'll call him Mr. Lee, after a three-week stay.

And they had a bad feeling about it.

Lee, who was recovering from back surgery, was incredibly slow to heal for reasons no one could decipher. He was in his 50s and lived alone, and the team sensed that there was probably more to his story, but no one could coax it out of him. As they gave him his walking papers, the doctors and nurses who'd cared for him 'round the clock for weeks had a sinking feeling he'd be headed back there soon, in an ambulance.

So the team did something a bit out of the box: they called the ambulance first.

That's how Heather Bogdon, a unique breed of health care professional called a community paramedic (CP), came to Lee's door.

In addition to the traditional, 1,000-plus hours of medical training befitting a paramedic, Bogdon brought to the case a wealth of knowledge about social and other factors that play a part in health—including the trauma of living in communities plagued by violence, the ability to navigate social support systems and expertly honed listening skills.

Bogdon's role is a reimagining of a profession originally designed for emergency care and transport to the hospital. In contrast, the CP's job is to help keep people from needing to go there in the first place, or from boomeranging back after discharge.

Lee had been a closed book in his patient room. But here in his living room, it was different. Using a delicate skill known as motivational interviewing, Bogdon ticked down a long list of questions—open-ended, get-to-know-you questions—to get a holistic picture of his well-being.

And that's when Lee opened up.

His wife had recently died, he told Bogdon. Then, he hurt his back in an accident that had also totaled his car. With no way to get to work, Lee lost his only source of income.

Bogdon asked what kind of food he had in the house.

"And he takes me in his kitchen and opens his refrigerator," she recalls. "And I'm not kid-

ding you. All he had was a bottle of ketchup." For several weeks before his surgery, he'd been diluting it to make tomato soup.

Bogdon was floored. No wonder his surgical wound wouldn't heal. His electrolytes were shot.

So now, here he was, alone and unable to take more than a few steps—no car to get him to the store, and no money to pay for anything there anyway.

"I'm like, 'How are you going to recover from surgery?' And he's like, 'I don't know.'"

When we think of 911, we typically picture someone calling because of strokes, heart attacks, accidents and the like. That is indeed what the system is designed for.

But in reality, upwards of 80 percent of the time, the crises behind these calls aren't medical—they're social: Hunger. Loneliness. The terror and absolute desperation of staring down homelessness.

"They don't know who else to call," says Dan Swayze, a former adjunct instructor in Pitt's School of Health and Rehabilitation Sciences who has studied the emergency-care workforce inside and out for decades.

Typically, EMTs and paramedics, for all their extensive biomedical training, don't know how to address the root causes of many of their calls—which is a recipe for burnout, Swayze says.

"From [paramedics'] perspective, people are misusing or even abusing the 911 service—when in fact, these patients are vulnerable."

To address these mismatches, Swayze and

Pitt colleagues began developing the CP model in 2003. A decade later, a grant allowed them to hire paramedics to do this work full time. Today, CONNECT's 11 CPs serve Allegheny County in what is probably the longest-running community paramedic program in the United States. It has served as a model for similar programs across the country, which now number more than 400.

CONNECT assists patients in finding resources and advocates for them in securing assistance for medical, housing, utilities, mental health and social support needs. They do all these house calls free of charge. Apart from location within the county, their only criterion for referral is, by design, vague: If a patient is vulnerable, and you're worried about them, give CONNECT a call.

Since the program's launch, readmission rates, patient care and patient outcomes for program participants have steadily improved. For example, over a two-year period (2013 to 2015), in which CONNECT helped 269 patients across Allegheny County, the program saved an estimated \$1.8 million in health care costs. That was an average of \$6,900 per patient.

Swayze is former chief operating officer of the Center for Emergency Medicine of Western Pennsylvania, a nonprofit dedicated to emergency medicine research, education and care. (You've likely seen them at work in the skies over Oakland. The center's clinical arm is STAT MedEvac, the air medical transport, of which Pitt's Frank Guyette, professor of emergency medicine, is medical director.)

Founded by Pitt's first emergency medicine residency director, Ron Stewart, the center was instrumental in developing the national standard curriculum. Center organizers helped design a BS degree in emergency medicine in Pitt's School of Health and Rehabilitation Sciences; it's the University's most popular pre-med program.

Swayze traces the first germ of the idea for CONNECT back 20 years. He and Paul Paris, then-chair of emergency medicine at Pitt, were lamenting the fact that EMS providers in general were underpaid and really not appreciated for their clinical skills. And further, that their organizations were compensated via incentives Swayze calls "perverse." That is: They're only paid when they take someone to the hospital.



Once they got help for Williams' dog, he let them help him.

So in the early 2000s, the pair started chatting up ambulance services across the area. They wanted to know: If you got compensated for it, would you be open to doing things outside of your traditional job description? Upstream, big-picture things like disease management and injury prevention? And their answer was: Absolutely.

In 2003, a \$150,000 RK Mellon Foundation grant seeded the research and development of the CONNECT model (initially known as Emed Health). In time, both Swayze and the CP program moved to UPMC Health Plan, where he's now vice president of Community Services. Bogdon oversees the day-to-day operations as CP supervisor.

In this era of staffing shortages and exhaustion, Swayze stresses that the center's research has shown the importance of keeping health care professionals working at the "top of their scope." That is, keep nurses doing what they're trained to do as RNs, physicians as MDs and so on. Because when there's a mismatch, "that's a dissatisfier," Swayze says.

However, expanding training for paramedics so they can become community paramedics, he says, better aligns their skill set with the boots-on-the-ground reality. Because keeping the Mr. Lees of the world out of the hospital has never truly been in anyone's scope at all.

For instance, once patients leave the hospital—" [Hospital social workers] can't possibly follow up on everyone," says Swayze. And so it's: "Here's the number to call and the application to complete—I can't do that for you. You'll need tax records—I can't gather those up."

But a community paramedic is right in your living room. They can help you hunt for those documents, assist with the paperwork for food-stamp benefits and follow up to make sure you're okay.

And, during the wait for those benefits to come together, CONNECT can bring you a 30-pound box of shelf-stable food that very day. As part of a partnership with the Greater Pittsburgh Community Food Bank, CONNECT keeps a whole fleet of these care packages, dubbed Thrive Boxes, at their offices, ready to go at any time. Since 2017, the program—which was created by Bogdon and inspired by Mr. Lee—has delivered 3,000 pounds of food throughout Allegheny County and served as a model for CP services across the country.

On average, CONNECT's patients are 65 years old and have not one, not two, but three chronic illnesses. Seventy percent have at least one mental health issue. And on average, in the year prior to CONNECT reaching out, patients have been to the emergency department seven times, and readmitted five.

To meet the demands of these complex cases, the center and Pitt came together to design a 10-week program known as CONNECT Academy. Trauma-informed care and approaches, taught by CONNECT training coordinator London Kimbrugh, are central to the curriculum.

Community paramedics-in-training learn the finer points of an extremely detailed intake process, which typically takes upwards of an hour. At the end, they're trained to present a menu of possible areas to address, then ask the patient, "What do you want to work on—and what's the most important thing to you?" Then they partner with the patient to come up with a plan that's made to order. Check-ins continue until CONNECT's services are no longer needed. "We say, Let's do this on your schedule," says Bogdon. "Let's do this based on what you say you want to do, and I'll follow your lead. We try to be very respectful of that."

Tom Platt is associate professor of emergency medicine and director of the emergency medicine program in the School of Health and Rehabilitation Sciences as well as a faculty member at the center. When he looks to the future, he hopes to see something like what the fire service is now. "They're doing a pretty good job of putting themselves out of business with sprinklers and building codes and all those kinds of things," he says. "They don't spend a lot of time on fire suppression. They spend a lot of time on fire prevention."

Say you're a congestive heart failure patient who's been discharged after a close call. A CP can swing by, not only to do the usual medical upkeep to periodically check your weight and vitals, but also to make sure you're doing all you can on your end to fend off another potentially fatal fluid buildup. Are you taking your diuretics? Are you going easy on the salt?

And if you're not, a CP will gently ask why. "A lot of times," says Platt, "the person stopped taking their 'water pill' [diuretic] because they were making the decision of food on the table or their prescription."

CPs are also a great failsafe against the all-

too-common problem that comes with a long hospital stay. After multiple sleepless nights being poked, prodded, temped and blood-pressure-cuffed amid the buzzing, beeping ruckus of their room, many patients are just plain over it and will say anything to go home. Meds? Follow-up appointments? Completely overhaul diet, routine and lifestyle? *Yeah, sure, anything you say, Doc!*

"Patients lie their tails off about what they will do after discharge," says Swayze. "Then when they leave, they have no recollection of any of that." And it's no wonder, because a hospital is a lousy classroom: It's exhausting, full of distractions, and the "students" aren't feeling so great.

"What we try to do, then, is to say: Let's have that conversation in your kitchen, where you're more comfortable," says Swayze.

As the center has looked back at CONNECT patients over time, they've found that it was extremely common to have comorbidity of two or more mental-health issues on top of whatever else they were discharged with. Some 42% of these cases were socially isolated, elderly people with nobody to care for them at home.

"Look," says Swayze, "if you have diabetes, that sucks to manage on your own. But if you have diabetes and depression and anxiety, it's an entirely different disease to try to manage. You're always going to call 911 because you're so anxious about your ability to care for this yourself, and what your numbers are saying."

Platt is on the forefront of pushing food, housing and all the various systems of care as foundational knowledge not just for community paramedics, but for all paramedics and EMTs. "It'll lengthen the course," he concedes, "but, A, they're more employable, and B, they're better at taking care of patients and understanding why things are the way they are." To train veteran paramedics to transition into the role of a CP, CONNECT's instructors have developed an elective course. They have consulted multiple communities outside our region, in Ohio, Maryland and North Carolina.

As a whole, paramedics and EMTs are by far predominantly White and male—and yet the patients they serve are not, says Swayze.

If you know your Pittsburgh history, there is a cruel irony in this.

The country's very first EMS team, Freedom



SNAP benefits take time to pull together. CONNECT Community Paramedics not only navigate that process for patients, they deliver 30-pound boxes of shelf-stable food right away, as part of a partnership with the Greater Pittsburgh Community Food Bank.



House Ambulance Service, was mostly staffed by Black men, recruited from Pittsburgh's Hill District neighborhood in a program founded by Pitt's Peter Safar in 1967. Though Freedom House was wildly successful, after eight years, a racist political onslaught succeeded in shuttering the service, founding a new one and systematically nixing the original staff in favor of an almost entirely White team.

"If you want to eliminate health disparities," says Swayze, "you've got to diversify your workforce. And if you want to diversify your workforce, you have to be willing to step up your game."

In early 2021 the team launched an initiative dubbed Freedom House 2.0, a CP training program that focuses recruitment efforts in economically disadvantaged communities. With support from the local workforce investment board known as Partner4Work, FH2.0 covers the cost of tuition, as well as bus fare, a computer, study materials, uniform and living stipend. Kenneth Hickey, a program manager of community services at UPMC Health Plan, and Emily Lovallo, Pitt assistant professor of emergency medicine, teach the course.

FH2.0 addresses barriers of a noneconomic nature, as well, providing wrap-around services like mentoring and counseling, which, in the program's short history, have unfortunately been needed. Traumatic events—including the loss of loved ones to violence—are all too common during the course of students' studies.

"Life happens," says Swayze. "You have to be prepared to help students through those moments so that they don't drop out of the program."

The original Freedom House set the standard, both nationally and internationally, in advanced life support. And with its sequel, this new team hopes to do it again.

"Because guess what?" says Swayze. "The people with lived experience often are the best clinicians for the people that we're trying to help."

Across the health care professions, stress is mounting, says Swayze: "Doctors face it. Nurses face it.

"But I'd argue it's different and more intense when the relationship is based in the home."

Paramedics and EMTs on a patient case don't just meet the kids; they see with their own eyes that an entire family doesn't have a stove or a fridge, let alone enough food to eat.

They don't just bring medical care to a stranger on the worst day of their life; they also hear about the days that rival them, like the day a couple lost their baby.

They don't just take an emergency-room "frequent flyer" to the hospital, again; they have first-hand knowledge of the reason why the 90-year-old keeps dialing 911: Because she wakes up every day knowing she's going to die alone.

There are stories these frontline professionals can share; many more stories well up in their throats and halt in a choke. "I can't talk about that one," Bogdon says, more than once as we talk.

"We've got to do a better job taking care of them," says Swayze, meaning his first-responder colleagues. "This job will mess you up."

Paramedics and EMTs sign up to put

themselves in harm's way. They often have to work two or three jobs. But they do it because they want to help, says Swayze. A common admonishment amongst the CONNECT crew is: "You can't keep reaching into your wallet to pay for things your patients need."

"That's the type of angels we're dealing with," says Swayze.

Once, Bogdon went out on a call to find an elderly gentleman we'll call Mr. Williams, an old-school host, the kind who fussed and stood up when a woman walked into a room, pulling out her chair and offering her something to eat.

Williams lived in a condemned building that he owned but would not, and could not, leave. He had no utilities, save an extension cord running from a generous neighbor's garage. He had multiple chronic illnesses, no social support, no transportation and was in and out of the emergency department all the time.

But when Bogdon asked him what was the most important thing to him right now, his answer was: his dog.

At Williams' side was a border-collie mix with a concerning lump on her side. Williams had no money to take her to the vet. He was so worried about her health that he couldn't give a thought to his own. She was all he had left.

The CONNECT crew made some calls, found a vet who'd take a pro-bono case, and gave Man and Man's Best Friend a ride to the clinic in Bogdon's colleague's pickup. Fortunately, some free samples of antibiotics cleared up the problem.

And, finally, there was hope for Williams, too.

"The guy was just so appreciative," says Swayze. "It was very easy for us to frame the discussion, like, 'We can tell you really love your dog. Can we talk about how to get you more stable so that you can both be around to support one another?' And, of course, he was willing to do that."

Soon after, the team finally had Williams signed up for the VA services he'd long been entitled to—preventive care in place of its poor substitute, the emergency department.

"This," says Swayze, "is how you navigate these folks to meet them where they are." ■