CONFERENCE PRESENTATION

Mobile Integrated Health: **Redefining Care Delivery** Across Oregon

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What You Will Walk Away With

OBJECTIVE 1

Understand how MIH improves community access to care — reaching people earlier, reducing avoidable ED use, and addressing behavioral health, chronic disease, and rural access gaps.

OBJECTIVE 2

Learn practical ideas you can adapt locally — real-world MIH models, partnerships, and workflows from ORMIHC and Mercy Flights.

OBJECTIVE 3

Connect MIH to long-term population and community health outcomes — care coordination, equity, prevention, and value-based care.

Why MIH Matters Now in Oregon

65%

of Oregon counties are rural or frontier

40%+

of ED visits are potentially avoidable

1 in 5

Oregonians face behavioral health challenges

Growing

demand for community-based care models

EMS is evolving from emergency response to **community health infrastructure.**

What Is Mobile Integrated Healthcare?

LEGACY MODEL

Traditional EMS

- Reactive — responds after crisis
- 911-driven activation
- Transport-focused
- Episode-based care

THE SHIFT

Mobile Integrated Health

- Proactive — reaches people early
- Referral and community-based activation
- Treat-in-place and connect to resources
- Relationship-based, ongoing care

MIH brings care directly to homes and communities using specially trained EMTs, paramedics, and community health workers.

Oregon's Unique Landscape

Rural & Frontier Geography

Vast distances, limited providers, and geographic isolation define healthcare access for many Oregonians.

Behavioral Health Crisis

Rising demand for mental health and substance use response outpaces available resources.

ED Strain & Hospital Capacity

Emergency departments face overcrowding from non-emergent and repeat visits.

Health Equity Gaps

Underserved communities — rural, tribal, unhoused — face disproportionate barriers to care.

How MIH Expands Access, Equity & Early Intervention

Identify

High-risk patients flagged through referrals, 911 data, or hospital discharge

Engage

MIH Providers visit patients at home, build trust

Intervene

Treat in Place, Chronic disease management, behavioral health support, SDOH resources

Sustain

Ongoing care coordination, reduced ED reliance, improved health outcomes

A proactive, relationship-based model — reaching people before crisis, connecting them to resources, and sustaining better outcomes over time.

SECTION DIVIDER

LEARNING OBJECTIVE 1

How MIH Improves Community Access to Care

LEARNING OBJECTIVE 1

Chronic Disease & High-Utilizer Stabilization

Chronic Disease Management

In-home visits for diabetes, CHF, COPD — medication reconciliation, health education, vital sign monitoring.

High-Utilizer Intervention

Identify frequent 911 callers and ED visitors — create personalized care plans to break the cycle.

Care Coordination

Connect patients to primary care, specialists, pharmacy, and social services — closing gaps in a fragmented system.

Treat-in-Place & ED Diversion

Care at home — Patients receive treatment where they are, avoiding unnecessary ambulance transport and emergency department visits.

Reduced 911 call volume — Proactive outreach and follow-up decrease repeat emergency calls and non-emergent system demand.

Lower costs — Reduced expenses for patients, EMS agencies, and the broader healthcare system through smarter resource utilization.

Improved patient satisfaction — Care delivered in a familiar, comfortable environment builds trust and supports better outcomes.

Behavioral Health Crisis Response

A community-centered approach to mental health and substance use crises

Alternate crisis response — MIH provides a non-emergency pathway for behavioral health crises through de-escalation, assessment, and direct connection to care.

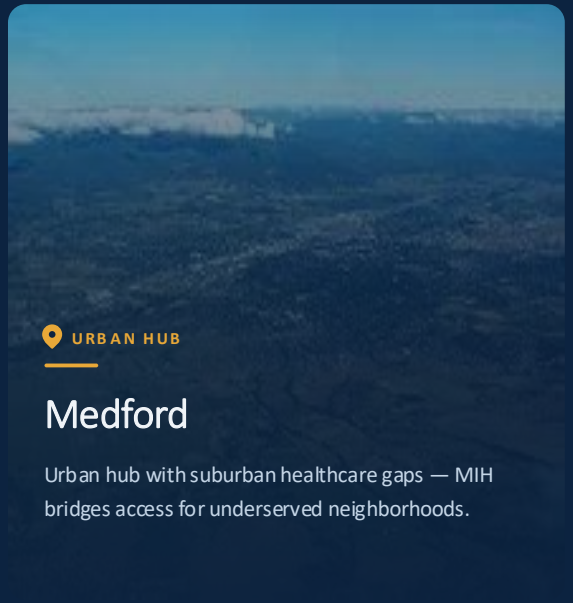
Reduced multi-agency burden — Fewer police, fire, and ambulance responses needed for non-emergent behavioral health calls, freeing resources for true emergencies.

Trauma-informed care — Community paramedics trained in trauma-informed approaches, motivational interviewing, and compassionate crisis engagement.

Warm handoffs — Seamless connections to behavioral health providers, peer support specialists, and community resources for sustained recovery.

Meeting people in crisis where they are — not in an emergency department.

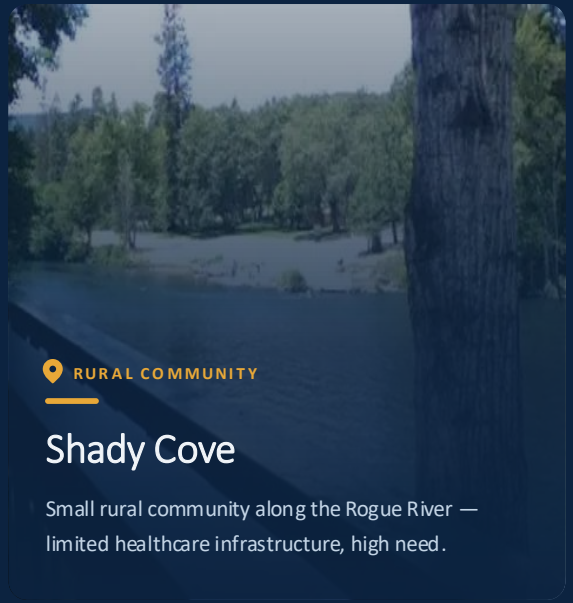
Rural Access: Reaching Every Corner of Southern Oregon



URBAN HUB

Medford

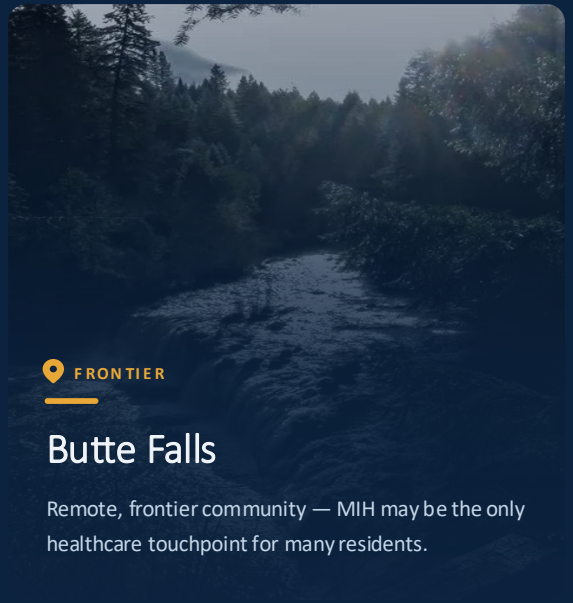
Urban hub with suburban healthcare gaps — MIH bridges access for underserved neighborhoods.



RURAL COMMUNITY

Shady Cove

Small rural community along the Rogue River — limited healthcare infrastructure, high need.



FRONTIER

Butte Falls

Remote, frontier community — MIH may be the only healthcare touchpoint for many residents.

MIH meets people where they are — **in their homes, in their communities, on their terms.**

Access Impact at a Glance

Qualitative outcomes driving MIH program impact across Oregon

Reduced

Avoidable ED visits through treat-in-place care delivery

Earlier

Intervention before medical crises escalate to emergencies

Expanded

Reach into rural and frontier communities across Oregon

Integrated

Behavioral health woven into EMS response models

Data collection and outcome measurement remain a priority for Oregon MIH programs.

COALITION OVERVIEW

OREGON MOBILE INTEGRATED HEALTHCARE COALITION

Statewide Coordination. Shared Standards. Collective Impact.

Who We Are: ORMIHC

A **non-profit coalition** bringing together healthcare providers, EMS agencies, and community stakeholders across Oregon.

Dedicated to supporting and advancing **MIH initiatives statewide** — from Portland to the most remote frontier communities.

Mission: Foster collaboration, share best practices, and advocate for policies enabling MIH growth.

Members include **fire departments, ambulance services, hospitals, CCOs**, public health agencies, and community organizations.

32 new certified community paramedics added to Oregon's workforce Since 2022 — growing the pipeline for community-based care.

ORMIHC PILLARS

Shared Standards, Advocacy & Data Alignment

Shared Standards

Developing consistent protocols, training benchmarks, and quality measures across Oregon MIH programs.

Policy Advocacy

Supporting legislation like Senate Bill 161 to strengthen workforce development, funding, and program sustainability.

Data Alignment

Building shared data frameworks to demonstrate outcomes, justify funding, and guide program improvement.

A unified voice for MIH across Oregon — stronger together.

Policy Environment & Value-Based Care

Key legislative milestones and strategic alignments advancing MIH across Oregon

2022

HB 4052 (2022)

Mobile Health Unit Pilot Program — addressing health equity for priority populations.

LEGISLATION

Senate Bill 161

Workforce development, training, and funding for MIH/CP programs.

2025

HRSA Grant (2025)

OHSU/ORH 4-year grant: MIH toolkit, TA framework, CP scholarships, Wheeler County pilot.

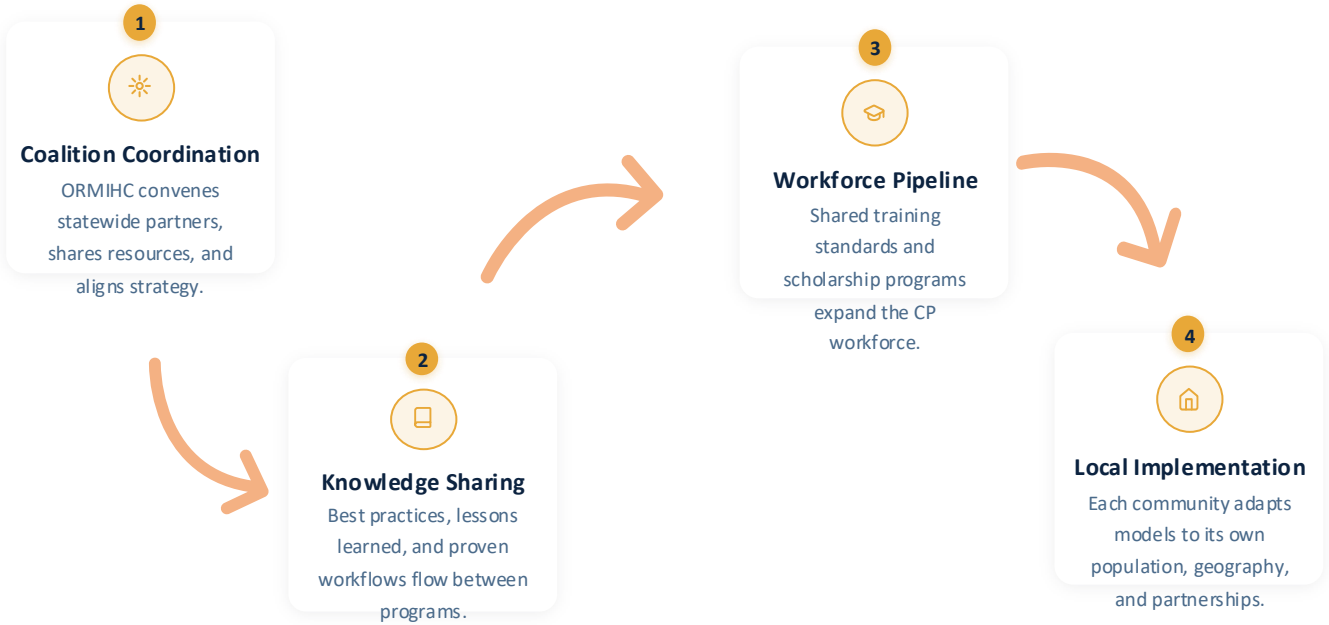
STRATEGIC ALIGNMENT

Value-Based Care Alignment

MIH reduces costs, improves outcomes — aligning with CCO and payer priorities.

Statewide Collaboration Accelerates Local Success

A connected cycle where coalition-level coordination drives community-level impact



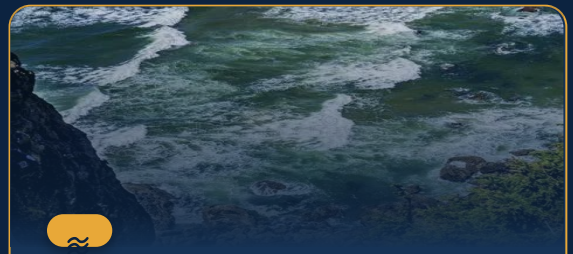
Statewide infrastructure empowers every local program to launch faster, learn faster, and sustain longer.

MIH Across Oregon : Statewide Innovation in Action

Umatilla County

UCFD1 & Good Shepherd Health Care System

A collaborative CP program serving **90,000+ residents** across **5,500 square miles** in Umatilla & Morrow counties. Community Paramedic Jessica Marcum was honored by AMIHP for locating a vulnerable patient, connecting them to housing and care — **zero hospital readmissions** since.



Western Lane

Western Lane Fire & EMS Authority

Free MIH service on the Oregon Coast (Florence area). Post-hospital home recovery support, connecting patients to their full healthcare team through **referral-based in-home visits** — bridging the gap between discharge and lasting wellness.

Scappose Fire

Scappose Rural Fire Protection District

Columbia County fire district integrating **MIH into EMS operations**, bringing community-based care to a growing northwest Oregon community — proof that departments of all sizes can embrace the MIH model.

From the coast to eastern Oregon — MIH is taking root across the state.

KEY LESSONS

What These Programs Teach Us

Hospital-EMS Partnerships Work

Umatilla County shows how fire districts and hospital systems can co-build CP programs that bridge discharge gaps and reduce readmissions across vast rural geographies.

Free, Accessible, Community-First

Western Lane demonstrates that MIH can be offered as a free community service — lowering barriers and building trust with patients recovering at home on the coast.

Any Size, Any Setting

Scappose Fire proves that MIH does not require a large agency — even smaller fire districts can integrate community health into their EMS mission and serve local needs.

Every Oregon community has the potential to build an MIH program that fits its people, its partners, and its geography.


MERCY FLIGHTS
Nonprofit mobile healthcare services
CASE STUDY
MERCY FLIGHTS
A Case Study in MIH Implementation — Southern Oregon
SERVING COMMUNITIES SINCE 1949
| MIH PROGRAM LAUNCHED 2016

CASE STUDY

Mercy Flights MIH: Program Overview

Pioneering community-based care in Southern Oregon since 2016

Mercy Flights Inc.
75+ year nonprofit air and ground ambulance service based in Medford, Oregon.

MIH Program Launched in 2016
Pioneering community-based care delivery in Southern Oregon — one of the state's earliest programs.

Multi-Disciplinary Team
Community paramedics, EMTs, and care coordinators with specialty training in chronic disease, behavioral health, and social determinants.

In-Home, Personalized Care
Healthcare delivered in the patient's home — meeting people where they are, on their terms.

National Recognition
Featured on *Viewpoint*, a nationally distributed television program, in 2023.

Medford, Oregon · Serving Jackson County & Beyond

Service Lines & Workflows

MERCY FLIGHTS
Nonprofit mobile healthcare services

MERCY FLIGHTS MIH

Referral & Triage

Referrals from hospitals, CCOs, 911 data, self-referrals — each patient triaged for appropriate MIH service level.

In-Home Care

Home visits for chronic disease management, medication education, vital signs, and health coaching.

Behavioral Health Response

Alternate response to behavioral health crises — de-escalation, warm handoffs, reducing multi-agency response.

Post-Hospital Follow-Up

Post-discharge visits to prevent readmissions — medication reconciliation, care plan adherence, resource connection.

Every workflow starts with a referral and ends with a healthier community

Partnership Ecosystem

Building a connected network of care across Southern Oregon

MERCY FLIGHTS
Nonprofit mobile healthcare services

Hospitals & Health Systems

Referral pathways, discharge planning, readmission prevention.

CCOs & Payers

Value-based contracts, shared savings, population health alignment.

Behavioral Health Providers

Warm handoffs, co-response models, crisis stabilization.

Fire & EMS Agencies

Integrated dispatch, shared protocols, mutual aid.

Community Organizations

SDOH resources, housing, food security, transportation.

Public Health & Government

CHA/CHIP alignment, grant partnerships, policy support.

No single agency can do this alone — MIH succeeds through intentional, sustained partnerships across sectors.

Outcomes & Impact

Mercy Flights MIH — Measuring What Matters

MERCY FLIGHTS
Nonprofit mobile healthcare services

Reduced ED Visits

Fewer avoidable emergency department encounters through proactive in-home intervention.

Improved Patient Outcomes

Better chronic disease management, medication adherence, and health literacy.

Cost Savings

Lower system costs through treat-in-place, diversion, and readmission prevention.

Patient Satisfaction

High patient and family satisfaction with personalized, in-home care delivery.

Continued data collection and outcome measurement remain priorities for program growth.

STORIES THAT ILLUSTRATE IMPACT

A community paramedic visits a patient with unmanaged diabetes — connecting them to a primary care provider, a pharmacist for medication management, and a food bank for nutrition support. Within weeks, the patient's blood sugar stabilizes. The cycle of 911 calls and ED visits stops.

A life is changed — not in an emergency room, but at a kitchen table.

♥ The kind of story MIH teams see every day.

LEARNING OBJECTIVE

LEARNING OBJECTIVE 2

Practical Ideas You Can Adapt Locally

Start Small & Build Partnerships

Start Small

- Pick one population (e.g., frequent 911 callers, post-discharge CHF patients)
- Design one workflow end-to-end before scaling
- Use existing staff and resources to pilot
- Measure outcomes from day one — even simple metrics matter

Build Partnerships That Matter

- Identify champions in hospitals, CCOs, behavioral health, fire/EMS
- Formalize referral pathways and data-sharing agreements
- Align with community health assessments and CHIPs
- Co-design *with* community — not just *for* community

You don't need a big budget to start — you need a clear problem, one partner, and the will to begin.

Staffing, Training, Documentation & Funding

Staffing Models

Paramedics, Community paramedics, EMTs, CHWs, care coordinators — match your team to your community needs.

Training

Community paramedic certification, motivational interviewing, chronic disease protocols, trauma-informed care.

Documentation & Data

EHR integration, outcome tracking, referral documentation — build the evidence base for sustainability.

Funding Pathways

Grants (HRSA, state), CCO contracts, fee-for-service, shared savings models, legislative appropriations.

SECTION THREE

LEARNING OBJECTIVE 3

Connecting MIH to Long-Term Population Health

MIH as Prevention, Equity & Value-Based Care

Prevention & Stabilization

MIH intervenes before crises, stabilizes chronic conditions, and reduces system strain.

Equity & Vulnerable Populations

Reaching rural, tribal, unhoused, and underserved communities that traditional healthcare misses.

Value-Based Care Alignment

MIH reduces costs, improves outcomes, and supports population health — exactly what payers and CCOs need.

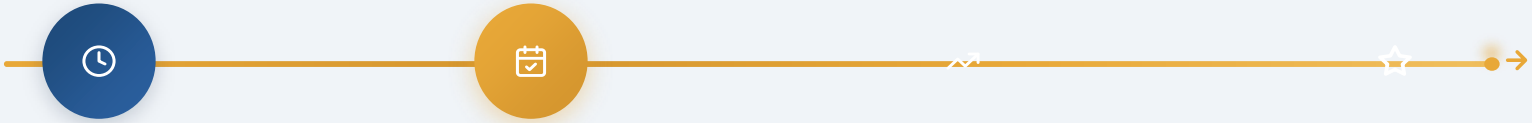
CHA/CHIP Integration

MIH programs align with Community Health Assessments and Community Health Improvement Plans, embedding EMS into public health strategy.

Connecting proactive care to population-level outcomes across Oregon

The Future of MIH in Oregon

A roadmap from today's momentum to tomorrow's vision



NOW

ORMIHC coordination, Mercy Flights, along with other programs, deliver care daily.

NEAR-TERM

ORMIHC toolkit rollout, Wheeler County pilot, expanded CP training scholarships via OHSU/ORH.

GROWING

Legislative support, sustainable funding models and data infrastructure for outcomes.

VISION

MIH is embedded in every Oregon community — EMS as community health infrastructure, not just emergency response.

From emergency response to **community health infrastructure** — the future is now.

Thank You

Questions & Discussion

Join us. Partner with us. Build MIH in your community.

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