Community Needs Assessment Overview

Goals

This community needs assessment 1) Reviews current practices to identify disparities between current community resources and the population healthcare needs to delineate community healthcare gaps clearly and 2) Identifies opportunities to collaborate with community partners in additional value-based projects to reduce healthcare disparities in the communities served by Trinidad Ambulance District.

Methods

- Reviewed Analytics from Electronic Healthcare Reporting (EHR) Data
- Reviewed Key Performance Indicator (KPI) Data
- Conducted individual interviews with community partners, reviewing their current practices and resource needs. The Evaluator met with,
    - Trinidad Public Health Department
    - Mt. San Rafael Hospital
    - South Central Council of Governments (SCCOG)
    - Crossroads Detox
    - Health Solutions
    - Department of Human Services
- Reviewed Las Animas/Huerfano County, Public Health 2022-2023 Community Health Assessments.
- Reviewed the Mt. San Rafael Hospital Community Health Needs Assessment.
- Reviewed the Las Animas County Human Services Master Plan.

Service Area

Trinidad Ambulance District (TAD) serves Las Animas County, the largest county in Colorado, covering 4,775 square miles in the southern end of the state, east of the Sangre de Cristo Mountains. It was originally part of a larger Huerfano County that encompassed all of southeast Colorado. Southern Rocky Mountains The Southern Rocky Mountain ecosystem within the county generally consists of mountains and foothills.

Mountains: The most western portion of the county, bound by Highway 12 to the east, is mountainous terrain with elevations from 9,880 to 13,398 feet.

The Culebra Range of the Sangre de Cristo Mountains runs through this area, with various peaks of the range running north-south just across the county border in Costilla County. This mountain topography can be described as predominantly rough terrain that consists of steep, forested slopes and exposed bedrock.

Foothills: The foothills, with elevations ranging from 6,000 to 9,000 feet, lay to the east of the mountains and generally extend to I-25. The topography of the foothills varies from steep is some areas to gently rolling and almost flat in other areas.

Eastern Plains: The Eastern Plains ecosystem within the county consists of prairies, mesas, and canyon lands.

Prairies: The majority of the Eastern Plains ecosystem within the county consists of prairies. The prairies are relatively flat with gently rolling hills, interrupted by the occasional mesa and areas that have eroded to form canyon lands (as discussed below). Elevations generally decrease from west to east and range from approximately 6,500 feet to 4,400 feet.

Mesas: There are several large mesas in the southeastern part of the county, including Raton Mesa and Mesa de Maya. Fisher's Peak, located at the western end of Raton Mesa and just south of Trinidad, stands 10,400 feet above sea level, in great contrast to the 6,000-foot elevation Trinidad below. Mesa de Maya, located in the southeast corner of the county, rises 1,000 feet over the surrounding prairies in some places.

Canyon Lands: There are areas in the county, most surrounding the Purgatoire River and a few surrounding the Apishapa River, where steep canyons have been eroded through several strata of rock. These canyons extend up to five miles across and, in some places, are over 500 feet deep.

Trinidad Ambulance District has an outstanding team of certified paramedics and emergency medical technicians who are dedicated to providing the highest quality emergency medical services to Las Animas County. They consist of members of the community who are proud to be a part of what makes our community great.

Demographics and the Social Determinants of Health

The population of Las Animas County has fluctuated over the past 100 years. In 1900, the population was approximately 22,000, growing to a high of almost 39,000 in 1920. In the next decade, however, the population began to decline and continued to do so over the next 60 years, reaching the century low of 13,765 in 1990. The 2000 Census figures show that this trend has reversed, and the population in Las Animas County has begun to grow again. From 1990 to 2000, the population of the county increased by 10.5 percent. Although a 10.5 percent increase in population may not seem to be cause for alarm, population projections for the next 25 years indicate that the county's population will increase by 32.9 percent by the year 2025, with a total of almost 24,500 people increasing the county population by one-third of what it is today.

The majority of people employed in Las Animas County work in the service industry (39.25 percent) or the retail trade industry (21.04 percent); thus, 60.29 percent of the workforce is employed in one of the two industries. The agricultural industry employs almost 8 percent of the workforce, while transportation employs approximately 7 percent. Around 5 percent of the workforce is employed by the public administration and construction industries. Current unemployment in Las Animas County is 4.0%, with a per capita income of $17,561.

Housing vacancy rates in the county have been steadily decreasing since 1992. With the projected population growth, it is expected that this trend will continue. 63 percent of the housing is over 50 years old. Most of these older homes are in need of some form of repair, and many are in very poor condition.

The two primary transit providers in the region include the Las Animas Council of Governments and the Las Animas County Rehabilitation Center (which provides client-specific transportation services). Although transit services are available to the entire population, due to limited services, they have been geared towards the transit-dependent population, which includes primarily the elderly and people with disabilities.

The Colorado Transit Needs and Benefit Study estimated that the two primary transit providers serve less than 10 percent of the local transit demand.

TAD works with eight fire departments within Las Animas County, including;

- Fisher's Peak Fire Protection District
- Stonewall Fire Protection District
- Cokedale Municipal Fire Department
- Hoehne Fire Protection District
- Branson Volunteer Fire Department (VFD)
- Kim Area Volunteer Fire Department and Ambulance Service (Provides own ambulance transport)
- Spanish Peak Bon Carbo Fire Protection District
- Trinidad Municipal Fire Department

Many are supported by volunteers, and not all are actual fire districts funded through mill levies that have a tax base for their departments. Currently, approximately 500,000 acres of the county are not covered by a fire district at all. Fire departments are the primary first responders that support TAD in emergency medical responses. Many residents expressed that there is a lack of fire protection in many areas of the county. Response times can reach one to two hours. Most citizens agree that there is a lack of fire protection. Some citizens expressed the need for more fire department training. TAD has developed a very progressive Quick Response Team (QRT) program in response to these issues to support fire departments with expedited emergency medical response. The district has six Quick Response Teams (QRTs) in communities throughout the county, including;

- Fishers Peak
- Stonewall
- Bon Carbo
- Cokedale
- Hoehne
- Spanish Peaks / Agular

All QRTs are under the direction of TAD and are financed and insured by the district as well.

Nearly every community in the county identified access to healthcare services including emergency services as a major concern in the Counties Master Plan.

The introduction of a Community Paramedic Program will seek to leverage community partnership as a tool to address access to care for those marginalized by geographic isolation.

The 2018 Las Animas Community Health Assessment identified five major themes stemming from the 2018 CHA process are below,

1. Access to & Affordability and Utilization of Healthcare.
2. Substance Use / Abuse
3. Elderly Services
4. Nutrition & Access to Healthy Food
5. Obesity

Recommendations for addressing these issues were included in the CHA. This Public Health Improvement Plan incorporates recommendations across all five themes but focuses specifically on the following two topics:

1. Behavioral Health/Substance Use
2. Healthy Eating & Active Living

The issue of non-emergent healthcare transportation was hinted at throughout the health department CHA and the hospital's CHA as it relates to accessing and utilizing healthcare. it was also discussed in the county Master Plan.

Service Gaps & Underserved Populations

Behavioral Health Services

The 2018 Public Health Assessment identified behavioral health as the county's number one health concern, with nearly 15% of the county's population reporting poor mental health. This is 4% higher than the state average. According to the hospital's CHA, there is only one mental health provider for every 630 persons seeking mental health services.

The age-adjusted suicide rate in Las Animas County is 38.06 completed suicides per one hundred thousand residents, and this is a rate 84.04% higher than the Colorado State Average. Nearly 44% of suicides in Las Animas County are completed with a firearm (250% higher than the Colorado state average). It is reported that 14% of high school students in Colorado have formulated a suicide plan.

The state of Colorado is ranked 47th in the United States for addressing mental illness, with 1 in every 10 Colorado residents reporting a complete inability to access needed behavioral health services. This disparity in access to mental healthcare services is substantially more profound in rural communities. Colorado is among the top ten states for completed suicide in persons over 65 years of age. The lack of available Veteran healthcare services in the community also contributes to a suicide rate much higher than the national average for veterans.

Substance Use Disorder

The County's 2018 Public Health Assessment behavioral health, including mental health and Substance Use Disorder (SUD), were identified as its major health concern. According to the hospital's CHA, 19% of adults in Las Animas County admitted to “excessive drinking,” and 58% of all driving deaths in the county involved driving impaired by alcohol.

Opioid Use Disorder (OUD) is a national problem, yet Colorado’s overdose rate continues to outpace the national average. The CDPHE estimates that 224,000 persons in Colorado misuse prescription drugs. A CDPHE study noted that this problem is greater in communities with larger elderly subpopulations. According to statistics reported by the Center for Disease Control (CDC), female deaths in Las Animas County from Substance Use Disorder (SUD) are over 600% higher than the national average and 182% for males.

The same report noted that death from Cirrhosis and other liver diseases was 67% higher for females and 38% higher for males in the community as well. Death related to heavy drinking was also noted to be 46% higher for females and 28% for males. Las Animas County is among the top 5 Colorado Counties for opioid-related deaths.

The community's lack of providers (and poor health behaviors contributed to a higher prevalence of diabetes, high blood pressure, and high cholesterol in the county's adult populations. The rate of these diseases was over 10% higher than the State average. All three of these chronic diseases pose serious health risks to those diagnosed with them and are associated with heightened healthcare costs and an increased risk of medical complications and/or death.

Vulnerable Populations

The 2019 - 2024 Las Animas Huerfano County Public Health Improvement Plan, indicated by the assessment, relates to health equity and social determinants of health with an LPHA score of 4.0 compared to 6.3 at CDPHE, with a median LPHA score of 6. Patients discharged from hospitals have limited access to healthcare and rehabilitation services and have a higher risk of 30-day and 90-day readmission rates. Studies show many of these patients can be safely transitioned home with support from community health workers.

Often, these services can be provided by Home Healthcare Agencies. Given the large geographical area served by TAD and its relatively rural nature, few Home Healthcare Agencies are able to provide services. operations, citing healthcare worker shortages, employee costs, and regulatory expenses as primary reasons. Often, patients are discharged from hospitals not fully understanding their discharge instructions.

Patients struggle to integrate their instructions with the occupational realities of returning home to rural communities with limited access to outpatient services. This results in higher rates of anxiety, discomfort, falls, and, ultimately, readmissions. This is complicated by the fact that there is only one primary care provider for every 1810 residents. The reported wait time for a patient to see a care provider in Las Animas County is 30 days. In the last year, between 12%-19 % of patients have reported not having a prescription filled, secondary to rising medication costs. Other factors, like the ability to afford copays or lack of reliable transportation, also play a role in accessing health care for patients in Las Animas County, according to a 2014 public health study. The study also calculated that the community requires seven additional primary care providers to address the community's current healthcare needs. Additionally, the area is extremely limited in the availability of specialty care providers available in the community.

There are three demographic factors increasing the healthcare challenges in the community. First, the community has higher rates of unemployment at 7.7% (4.7% for Colorado), Income $41,945 ($68,811 for Colorado), and households living below the poverty level 11.6% (7.2% for the Colorado). Next, 42.1% of the population is Hispanic, according to the latest US Census data. This is nearly 200% higher than the state average. Persons of Color (POC) sustain statistically higher rates of healthcare-related complications, including hypertension, diabetes, and obesity. Systemic racism within the healthcare system and a lack of culturally sensitive practices deepen these disparities in rural communities. Finally, 39% of the community is over 55 years of age. This has potentially negative implications for the size of the workforce available. Also, the prevalence of chronic disease is typically greater in populations of advanced age, impacting the level of healthcare needs.

Understandably, the population appears to have much higher levels of comorbidity and chronic disease. The population reports to have higher levels of diabetes 16.2% (6.9% for Colorado), Hypertension 36.5% (25.8% for Colorado), and hyperlipidemia 42.6% (31.3% for Colorado). These factors support an immediate need for the adoption of both Motivational Interviewing (MI) and Trauma Informed Care (TIC).

Systemic Overutilization of Acute Care Services

The Las Animas Emergency Medical Services community struggles with the market disparity from the provision of non-excludable, underfunded, and community-wide ambulance treatment and transport resources. Community-wide overutilization of expensive forms of transport, such as ambulance transportation, to expensive destinations, such as Emergency Departments, for minor medical issues has driven up the cost of providing services and left many agencies with the difficult decision to reduce services. Of the patients transported, more than 50% of them are released from the ED within a few hours of arrival. The Centers for Medicare and Medicaid Services (CMS) has identified the need for change, announcing in 2019 that they will engage a Medicaid Fee for Service Innovations Grant to reduce the unnecessary utilization of EDs and ambulances.

Trinidad Ambulance District Community Paramedic Program Overview

The Community Paramedic (CP) program consists of a group of highly experienced paramedics known as Community Paramedics (CP) with additional specialized training in acute and sub--acute care of the ill and/or injured. The additional education is taught through accredited educational facilities.

The CP course is based on the Community Paramedic International Curriculum. This program emphasizes an approach based on the biopsychosocial model of medicine to ensure that the needs of the whole person are addressed.

CPs are trained to work closely with a variety of community partners, including the patient's physician, home health agencies, public health, DHS, regional hospitals, and behavioral health providers.

The program seeks to improve patient outcomes and satisfaction while reducing the cost of care. CP providers use the existing TAD CP scope of practice in an expanded role. In this role, PACT CP providers assess underserved community members and marginalized populations to identify and address individual patient-specific gaps in services.

CP program-focused projects

Physician Oversight Program (POP)

This program works under the direction and oversight of the patient's physician to improve patient access to care regardless of geographic or transportation limitations. Telehealth and other services are utilized to connect physicians, Community Paramedics, patients, and the patient's support system through a synergistic, physician-led collaboration.

Mental Health Assessment Program (MHAP)

This program allows CPs to work with law enforcement agencies and local mental health providers. Working within the Behavioral Health Administration (BHA) Crises Response framework. The program safely and effectively navigates patients to appropriate destinations for mental health and Substance Use Disorder (SUD) services.

Indirect Mental Health Assessment Program (iMHAP)

This program was developed to address the unintended consequences that arose from SB 20-217, also known as the Enhance Law Enforcement Integrity law. This bill eliminated some of the qualified immunity protection for law enforcement agencies and fostered the concept of "officer-induced jeopardy," whereby a law enforcement officer commits an unforced tactical error by putting themselves in a situation where they must use deadly force.

This has drastically reduced the times when a law enforcement officer in our community is willing to directly engage with a person in behavioral health crisis if no other party is at risk. This has left providers without a way to engage directly with patients in crisis. To address this issue, TAD will provide FBI crisis and hostage negotiation level I, II, and III training to CPs. This has given our providers the knowledge, skills, and abilities to indirectly engage with clients in behavioral crises by leveraging the transtheoretical model of change. The program utilizes telephone, messaging services, and social media platforms to indirectly engage with patients it otherwise would be unsafe to work with. The goal is to allow time and space for the development of trust through empathetic engagement. This empowers the client to play a role in the strategy plan for their own success.

HOME Program

This program is designed to work with local first responders and ambulance resources. The CP responds to Alpha and Charley level calls to increase the options available to patients.

Medication-Assisted Treatment (MAT) Support

This program identifies clients with Substance Use Disorder (SUD) and screens them for possible enrollment in a MAT program. The program will leverage CPs working with Telehealth MAT providers to provide MAT services. The CP team will also collaborate with the MAT team to assist with ongoing mission-critical and supportive services.

Public Health and Education Program Outline

The Public Health and Education Program focuses on four areas to support public health:

Harm Prevention

Works with our community partners to identify high-risk populations and develop programs to reduce their risk, such as fall prevention, food insecurity, and Narcan Distribution.

Public Education

Works with schools, Area Agencies on Aging, and healthcare providers to provide educational programs to teach reduction in risky behaviors and a heart-healthy lifestyle.

This includes providing community CPR programs, stop the bleed classes, and diabetic management.

Improved community access to healthcare

Works with community partners to increase access to care by identifying patients without health insurance and directing them to agencies that will assist with enrollment in the healthcare exchange, CICP, Medicaid, and Medicare. the health insurance application process.

Immunizations

Work with local health partners to develop effective preventative and POD immunization programs as needed under the direction of Public Health.

Public Education

The CP program's public education is conducted through TADs internal education and training Division. TAD is always looking for opportunities to provide community CPR programs as well as advanced healthcare provider courses to healthcare partners.

Improved Community Healthcare Access

The CP program seeks to improve community access to healthcare by identifying clients without health insurance coverage. The program seeks to identify these individuals in two ways.

One method is through referrals made by TAD ambulance crews. Agency members shall make an internal referral after encountering a person they feel may be without insurance or underinsured. The CP contacts the individual and helps them find a community partner who will walk the client through the medical insurance application. The CP follows up with the individual to verify that coverage has been implemented. If the client is still without coverage, the CP works with the party to look at alternative coverage options. Once an individual has secured a healthcare funding source, the CP works with local physicians to connect the individual with a primary care provider.

The Second way the PACT program seeks to identify underinsured populations is through community health functions.

The PACT program partners with the public health department, local grocery stores, physicians, pharmacies, and other community partners to provide prudent lifestyle information on:

- Diet
- Exercise
- Risk factors for disease
- Immunological prevention

The provided information is clear and easy to understand. Ideally, program partners encourage participation in long-term healthy choices by providing discounted products and other health-related items. Community health fair screenings identify patients at high risk for:

- Diabetes
- Hypertension
- Heart Disease
- Pulmonary Disease

Patients with an identified risk factor are encouraged to seek additional intervention from their primary Medical Provider right away.

If the patient does not have a Primary Care Provider, the CP works with local providers to establish access to primary care. CPs follow up to ensure the patient has been seen by a primary care provider and is under ongoing care. CPs identify community members without health insurance coverage during community health events. CPs work with the Department of Public Health (DHS) to sign up identified non-covered clients with Medicare, Medicaid, CICP, or the Colorado Healthcare Exchange. The CP can then refer the person to a primary care provider for future medical needs and care.

Community Immunization

CPs continue to work closely with public health departments to implement proactive COVID-19 and other immunization strategies. Patients transported by TAD or within the CP program who are in high-risk groups that may benefit from immunization are identified. CPs seek opportunities to work with public health agencies to provide mass immunization clinics (POD), fairs, and other outreach programs including Point of Care (POC) immunization for persons who are homebound.

Physician Oversight Program Outline

The Physician Oversight Program (POP) seeks to reduce the number of patients who are readmitted to the hospital under 30 days for the same diagnosis.

It provides physicians oversight on a team that can enter a patient's home to provide assessments, treatment, and evaluation of the patient's environment. Team members will be under the physician's order and supported by telemedicine. Increasing the physician's understanding of the patient's overall circumstances and ability to comply with treatment plans adds value to the physician's care and reduces the patient's rate of readmission. This may help a patient with a chronic history of non-compliance with treatment plans or other poor patient outcome factors. Being in the home allows CPs to identify prominent factors in poor response to treatment, like risks for falls, poor medication compliance, or medication errors. The patient's increased understanding of written discharge instructions is an additional benefit. The CP will review each point of the instructions with the patient. This review can lead to better patient outcomes, increased patient satisfaction, and decreased cost of care.

Admitting a New Patient

The CP admits the following five categories of patients:

- Any patient with an acute diagnosis that, in the opinion of the physician, might benefit from intermittent observation by the CP. The team will visit the patient every 3-6 days for up to 3 weeks at the physician's request.
- Level I, II, and III heart failure patients may need additional assistance in managing their disease or complying with a treatment plan. This program has proven to be the most advantageous for level II and III heart failure patients.
- New onset or chronic diabetics that the physician feels could benefit from the assistance of the PACT program.
- Patients experiencing exacerbations of reactive airway disease. Experience shows a patient may be better controlled with the assistance and oversight of the CP team.
- Newborn patients coming into the District's environment after being released from the NICU. The CP can work with the physician to identify patients requiring supplemental oxygen and work with community partners to get oxygen ordered and delivered as needed.
- Any patient treated under one of the CMS bundled payment models.

If a patient does not fit in one of these categories, but the physician feels they may benefit from involvement by the CP, the provider should contact a CP representative for a consultation.

A provider soliciting CP services is requested to have an authorized representative contact the District's on-duty Community Paramedic at the CP's seven-digit access number. The provider or their representative must be able to supply the following information:

- Patient demographic sheet
- Last available complete H&P
- Signed physician's order for every visit requested
- Special orders, exams, labs, or tests the physician wishes to have performed

A provider's office may send a digital copy of the request via secured email to the on-duty community paramedic's approved email address. The email and digital attachments must be secured and HIPPA compliant.

A provider may activate a response by calling the TAD CP program's direct line. The request must be followed by a signed provider order for every visit.

Program Limitations

The CP program is a short-term, sub-acute approach to empower patients in understanding their disease. The program should help the patient identify care gaps and develop strategies to address those gaps. The program is not intended to provide long-term care or chronic intervention. Most patients should be able to graduate from the program within 21 days of admittance.

This program is not intended to be the sole source of care for homebound patients. Homebound services are best provided by a home healthcare agency. The CP can provide supplemental services in support of the home healthcare agency. Such requests must be made through the patient's provider.

First Interaction

A CP member will set up a patient induction appointment within 24-48 hours of a physician sending an order for service. During the first visit, the Community Paramedic will go over the patient's intake paperwork, including the patient's rights, complaint process, service expectations, what to do in case of an emergency, and other information.

The CP will conduct a home risk assessment, Screening Brief Intervention and Referral to Treatment (SBIRT), and Social Determinants of Health (SDoH) screening. The CP also reviews the patient's discharge instructions with the patient and available members of the patient's support system. The CP will ensure the patient and support system understand the signs and symptoms associated with complications of the illness.
The CP will outline important levels, values, or findings the patient must monitor. The CP will work with the patient's provider and the medical director to provide any care or treatment the patient may need (within the current scope of practice). The CP will also leverage Telehealth as needed. If the patient needs treatment not provided by CP or telehealth, the CP will work to get the patient navigated to the appropriate care.

Patients and care providers will be given a 10-digit direct access phone number to the on-duty CP. The patient will be advised to call for any of the following reasons:

- Critically abnormal changes in their condition
- Complications or changes in the medical condition the CP is supporting.
- Questions related to the medical condition the CP is supporting.
- The patient does not feel well and would like a CP evaluation.

When requested, the CP will conduct a welfare check on the patient. The patient may later be advised to call their primary care provider if the patient's complaint or complication is not related to the condition being treated by CP. This will only be done after the CP has evaluated the patient and offered telehealth.

After assessing a patient and before leaving, the CP will check with the patient to see if they have any additional needs or requests. The CP will also advise the patient or caregiver to call the CP with any changes. The patient and caregiver will also be reminded to call 911 for any life-threatening incidents. After the initial patient visit, the CP will contact the Public Service Access Point (PSAP) and place a note on the address. If a 911 emergency medical call is activated from the patient's address, the CP on duty will be dispatched with the ambulance and fire department.

After the initial visit, the CP will complete an Electronic Medical Record (EMR) with the information provided to the patient's physician.

Ongoing Care Visits
The Ongoing Care Visits empower the patient to manage his or her own care by:

- Educating patient and family on the patient's medical condition and ways to manage it.
- Increase medication compliance and reduce the risk of medication mistakes.
- Reduce the risk of falls and injuries.
- Increase patient's accountability for their healthcare and well-being while improving satisfaction with the care provided

To facilitate these goals, home visits will be provided on a sliding scale up to the limits that follow:

- Week One - 2 visits
- Week Two - 2 visits
- Week Three - 1 visit

If objectives have not been met within this time frame and the patient's physician identifies a benefit to the patient's continued enrolment in the program, the CP team may choose to extend the patient's care.
Each visit will start with a physical assessment. Then the CP and patient will discuss the patient's strategies from the previous visit. The patient will rate the success in meeting their goals using their strategies using a scale of 1 - 10. Where one indicates not at all successful and ten indicates fully successful at implementing strategies.
If previous goals have not been met, the patient will work with the CP to establish new strategies to obtain those goals. If the previous goals have been met, then the patient and the CP must work together to establish new ones.
In both cases, success will be rewarded, and ongoing challenges will be identified. Medical challenges will be addressed using MI as outlined in the flow sheets and guidelines or using telehealth. When this is not possible, the patient will be transported to a higher level of care.

Suspension from Program
Patients who are transported to the hospital will be suspended from the program.

If the patient's provider wishes, the patient can be readmitted to the program when they return home.
If a patient continually refuses to comply with their treatment plan, goals, and strategies, and after consultation with the patient's provider, they may be suspended from the program. A patient can be re-enrolled in the program within 30 days if they show adherence to the treatment plan. Failure to readmit to the program within 30 days will be grounds for dismissal from the program.

Program Costs
The CP program anticipates offsetting a portion of costs with sales tax revenue, grant funding, and capitated contracts. This will help supplement the costs to patients.

Patients will be required to pay a fee based on the CP sliding ability to pay formula for every visit. In both cases, the patient may be billed for additional costs such as laboratory equipment, medical products, and transport miles. TAD requests that providers share this program with their patients and encourage them to consider participation. Participation can reduce the cost of care to patients and improve their ability to meet the challenges of catastrophic illness.

Mental Health Assessment Program Outline
This program works with community partners to 1) identify patients experiencing possible mental health crises, 2) Provide Motivational Interviewing (MI) to de-escalate the crises, 3) Conduct a medical screening to rule out organic causes for the crisis, and 4) Evaluate for possible placement services. The program seeks to navigate the patient to the appropriate service for definitive intervention.

Requesting a Mental Health Assessment Program (MHAP) Response
The first goal of TAD is to ensure the safety of our crews, allied health agencies, the patient, and the community at large. To that end, no member of our agency will knowingly enter a volatile scene until it has been secured by a law enforcement officer (LEO).
Once the scene has been secured, the LEO must check for dangers and hazardous conditions. The patient should be supported in the least restrictive manner possible to reduce the risk of danger to all parties on the scene.

MHAP Assessment Process
If LEO is on the scene when the CP team arrives, the LEO should provide the CP with information on the patient.
This information should include:

- Patient's presentation upon LEOs arrival
- Statements made by the patient, including those statements that could be reasonably construed as suicidal Ideation (SI) or homicidal ideation (HI)
- Hearsay or conjecture that could reasonably be construed as a sign of SI or HI
- Signs or statements of alcohol intoxication or recreational drug use
- Signs consistent with an inability of the patient to care for themselves or meet their basic needs
- Additional information that LEO on the scene feels is relevant

The CP will follow the MHAP Screening checklist to determine if the client has a need for further medical evaluation. The CP will then conduct a Columbia Suicide Severity Rating Score (CSSRS) assessment to identify the appropriate services for the patient. If the patient is found to have a medical need, they will be evaluated by a board-certified physician utilizing telehealth or be transported to the closest, most appropriate emergency department. If the client selects in for MHAP-based Treatment in Place (TIP), they will be evaluated by an intervening professional via Tele behavioral health evaluation. If the client is identified to be a danger to themself or others or is gravely disabled and is unwilling to voluntarily seek inpatient treatment, the tele behavioral health provider will complete an M-1 hold form, and the CP will complete an M-2 hold form notifying the patient of their rights.

The team will then seek appropriate placement for the patient, or the patient will be transported in a secure transport vehicle to the Crisis Stabilization Unit (CSU). Once the patient has been accepted by a facility, the CP will complete a CP-to-nurse report over the phone. The patient will then be transported via a secure transport vehicle to the appropriate alternative destination.

If the patient can be safety planned or otherwise does not meet the criteria for an Emergency Mental Health Hold, then they will be provided with additional resources.

If the client is unable or unwilling to participate in a tele-behavioral health evaluation and the provider feels the client is at risk for behaviors consistent with a risk to self or others, they should consider placing the client on an M-0.5 Secured Transport Hold.

Alternate Destinations and Outcomes

If the patient is found to have no medical complaint, they will be evaluated for ETOH and other recreational substances. If the patient is found to be clinically intoxicated, they cannot receive a behavioral health evaluation. Instead, the CP will conduct a DETOX evaluation utilizing the same checklist.

If the client selects in for direct transport to a DETOX facility, then the patient should be transported to a Detoxification Center.

If the patient selects out for transport to a DETOX center or a bed can not be found, then an appropriate Emergency Department (ED) should be considered. If the client refuses voluntary transport to a DETOX facility or ED, then an Application for Emergency Commitment (EC hold) should be considered.

A patient refusal should be considered if all of the following criteria are met:

- The patient does not appear to be a danger to themselves or others
- They have no medical need
- Patients is 18 years of age or older (including emancipated minors)
- The patient's mental status exam is intact
- No signs of clinical intoxication from recreational drugs, ETOH, or other mind-altering substances.

Patients should be free to make choices for themselves if all of the criteria are met. If the patient refuses transport, a Release of Care (ROC) must be completed, and contact with online medical control should be considered.

Program Limitations

The MHAP program is designed to be an acute response to a mental health crisis. This program is not intended to substitute the care provided in an ED or a behavioral health facility. The goal of this program is to navigate the patient to the safest, most appropriate destination.

This program is not intended to prevent patients from being seen in an emergency department. Additionally, the CP is not qualified to determine if the patient is safe to remain at home. TAD feels that every patient in a perceived mental health crisis may benefit from the immediate intervention of a qualified and licensed intervening mental health professional.

Community Paramedic Tiered Response:

This policy outlines a secondary or tiered response system where the CP will respond to certain calls for service for three purposes:

- The CP can act as a force multiplier for the overall emergency healthcare system by releasing ambulance resources back into service earlier than would be accomplished if they stayed and completed the Release of Care (ROC) process.
- The CP can provide needed expertise, resources, referrals, and assistance to clients struggling to access care on a given request for service, including but not limited to detailed Release of Care instructions, thus reducing the risk often associated with transitions in care.
- The patient would benefit from transportation to an alternative destination via transport in the ACT vehicle or other alternative means.

Food Insecurity Safety and Help (FISH) Program

Food insecurity is a growing problem across Colorado. It is estimated that 566,440 people in Colorado are facing hunger. 1 in 10 people in the District is reported to be food insecure. EMS providers are uniquely positioned to identify food insecurity and navigate downstream efforts to address this. This program seeks to support local food pantry efforts and is not intended to duplicate any current food insecurity services offered. When a TAD provider identifies an individual or family that may be experiencing food insecurity, they request a Community Paramedic (CP) for a Food Insecurity Support and Help (FISH) screening. The provider does not attempt to validate a client's need. The CP will deliver or ensure the delivery of the food bag(s) as soon as possible. While accounting for the operational needs of the District, effort should be made to ensure the food is delivered within 24 hours of the original request for screening.

There is no need to screen the patient for financial need as food insecurity can impact all socioeconomic groups. After the food box (s) has/have been delivered, the CP will contact one of the approved local food pantries and provide them with the client's information for further follow-up.

Addressing Language Barriers

Some members of the community served by TAD have a primary spoken language other than English.

The District also has a limited number of persons within the District with visual and auditory deficits. TAD has a four-level approach to ensuring ongoing effective communications with these populations.

1) All of our CP providers have received significant training in the social determinants of health, cultural awareness, understanding, and surmounting barriers to accessing care.
2) Every member of our organization has 24-hour a day, 365 days a year, access to the Certified Language Line. This line allows for telephonic or video-based communications with translators from over 240 languages, including American Sign Language.
3) TAD has adopted the use of the Colorado Department of Human Services Hospital Communications Card. This card was designed with the support of the Colorado Commission for Deaf, Hard of Hearing, and Deafblind. This card also provides additional resources that can be reached via their website or a seven-digit access number.
4) Every CP is provided, and every ambulance is equipped with an Apple iPAD with a program called "Translate" that provides real-time translation from English to 11 other languages and two English dialects. It is a two-way application, so the patient can also speak back to the provider, and that will be translated back to English. This is done in both written and audio formats.

Quality Management Plan

The TAD Quality Management Plan is based on the Health and Human Services (HHS) model for Community Health Workers (CHW). The program is designed to monitor the following parts of the PACT program:

- Reduction in admits/readmits
- Improved patient outcomes
- Increased patient satisfaction
- Tracking industry benchmarks
- Review quality of care
- System-wide cost control improvements
- Sentinel events
- M&M reviews
- Organizational risk
- Loss Prevention

Disclosure

This is a program based on the collaborative efforts of everyone involved. TAD recognizes that changes will need to be made over time. If you have suggestions for improvement, please let one of the CP members know. Your input is valued.