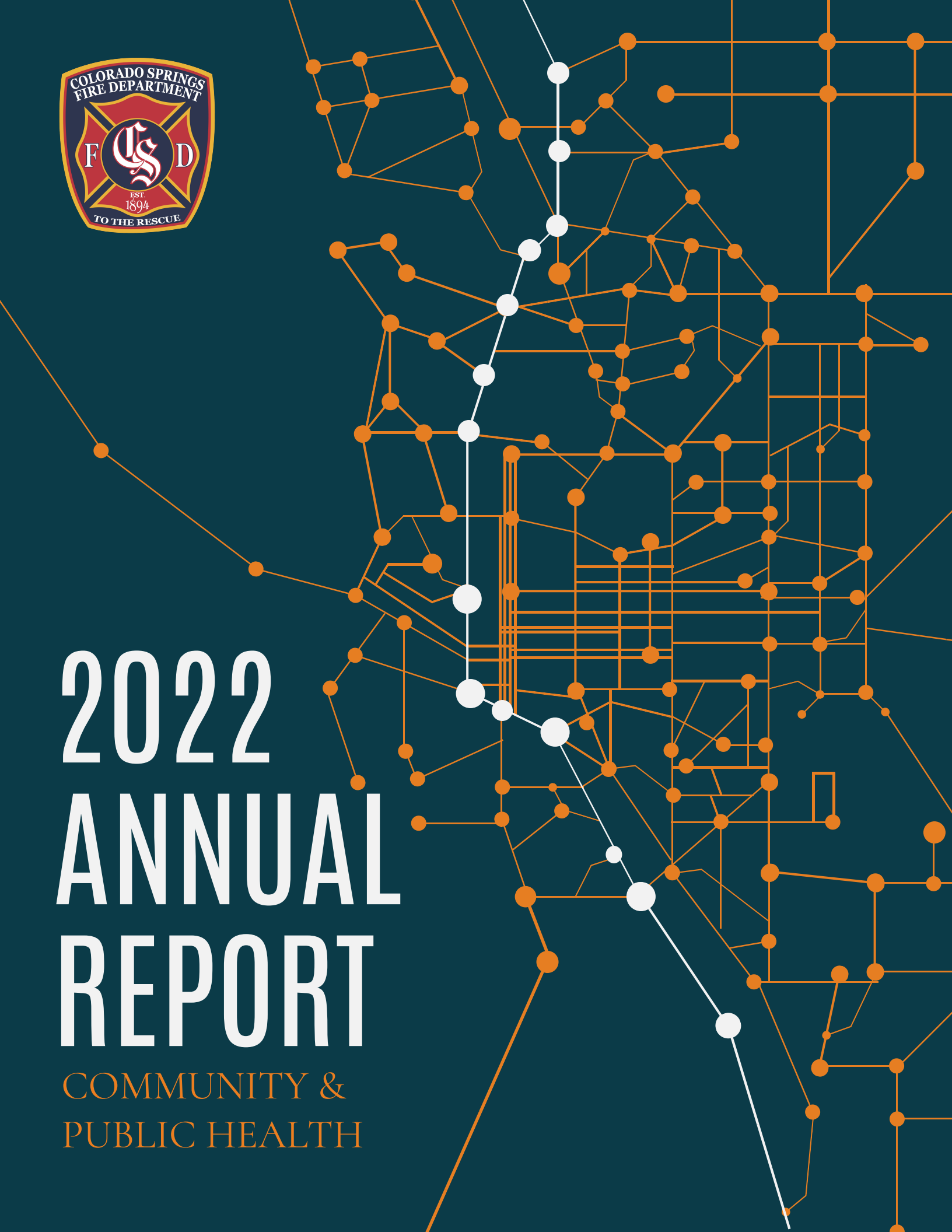
COLORADO SPRINGS FIRE DEPARTMENT

F C D

EST. 1894

TO THE RESCUE



2022 ANNUAL REPORT

COMMUNITY & PUBLIC HEALTH

Table of Contents

LETTER FROM OUR ADMINISTRATOR

2022 marked my fifth year as the Colorado Springs Fire Department Community & Public Health Administrator. As I look back, I am amazed by the amount of positive change that has occurred across our division, our department, and our city. In 2018, we only had two programs: the CARES program and our CRT program which was staffed with two units. Five years later, our division includes four navigation programs, two mobile response programs, and our CMED pilot graduated to program status under fire operations where it quadrupled in size with continued growth on the horizon!

During this same time period, Colorado Springs experienced explosive growth. The city we love and serve is not only the 2nd largest city in Colorado, it is now the 38th largest in the United States – and we continue to grow. As a large city, there are many important needs to address, so every division must have a guiding star. For this reason, our division has chosen to stay on course by asking "how does this impact the emergency response system?" The reality we face is that a backup anywhere in the response system is a backup everywhere. If any part is compromised, a cascade effect leads to a decrease in available units with a corresponding increase in response times. It is apparent that a high percentage of individuals that chronically encounter the emergency system share common traits: substance use disorder, mental illness, physical health issues, and homelessness.

The roots of our division date to 2012 and are firmly planted in providing intensive navigation to high utilizers of 9-1-1 and emergency departments as well as an alternative response program that provides appropriate dispositions for those in a mental health crisis. While these historic programs are important and effective, they are reactionary programs – but what if we could be more pro-active? What if we could get "upstream" and deal with root causes before they reach a critical phase? What if we could identify community needs, as well as opportunities to assist at-risk members before they engage with the emergency response system? What if we built a continuum of response to those who are at risk and align those responses with our partners in fire, police, the emergency departments and across our community? Engaging in early intervention and navigation provides the opportunity to change an individual's interaction and trajectory, thereby decreasing the burden across the system. It is this "upstreamist" spirit of engagement that provides the greatest impact to those in need.

It is no accident that our division slogan is "Look, Listen, Connect," for this is the mindset that allows us to see opportunities, hear from community partners and connect across our city to drive positive change. Today, our Community & Public Health Division provides intensive navigation services for elders having difficulty aging in place, community members struggling to appropriately access 9-1-1 and hospital services. We provide street outreach and intensive navigation service to our homeless community, and we are actively navigating at-risk inmates transitioning from the jail into the community with an aim to decrease recidivism.

As I look ahead to the future, we have a clear opportunity to get "upstream" and deal with root causes by engaging in street medicine, overdose response in conjunction with intensive navigation and community paramedicine. We have identified the major barriers that prevent those who are homeless, substance involved, or with chronic illnesses from engaging in appropriate care. Moving forward, we will begin bringing medical, physical, and substance use treatment directly to at-risk community members. In doing so, we will bring life changing care to each person while decreasing the burden across the emergency response system.

CPH NAVIGATION IN 2022

4 PROGRAMS

402
MEMBERS NAVIGATED

51%
CONTINUE TO WORK WITH US

> 5,400 Resources Provided

10,024
INTERACTIONS ON BEHALF OF THE CLIENT

67
MEMBERS HOUSED

CPH DEMOGRAPHICS

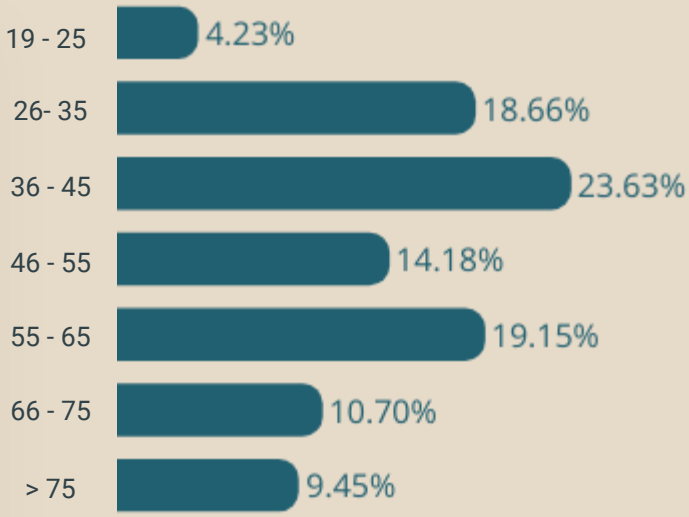
GENDER

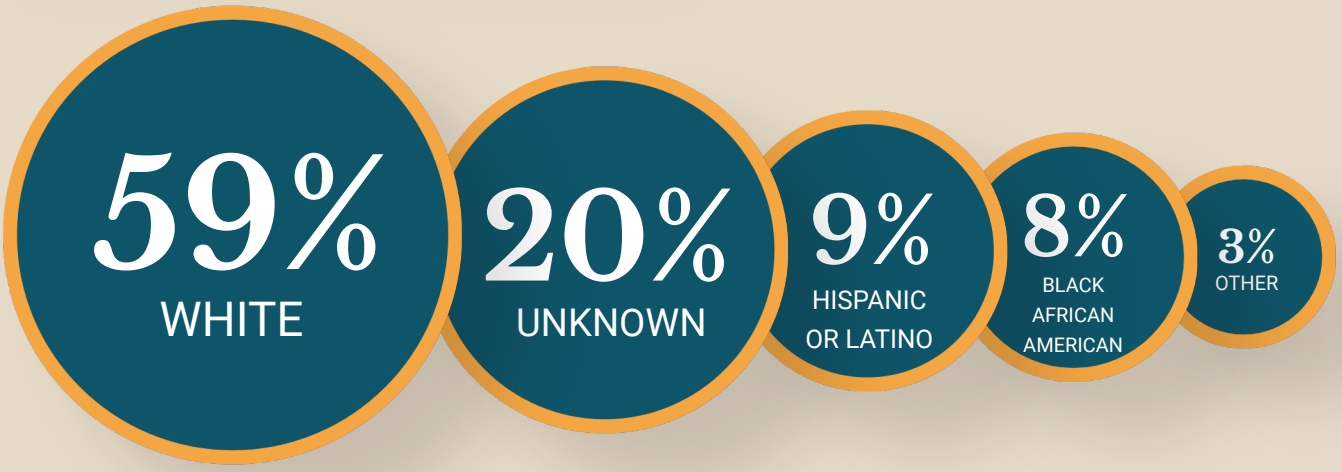
64% MALE

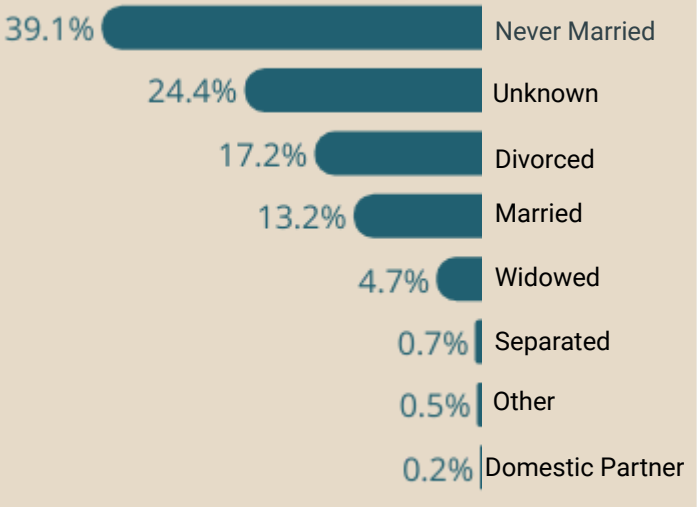
1% NONCONFORMING

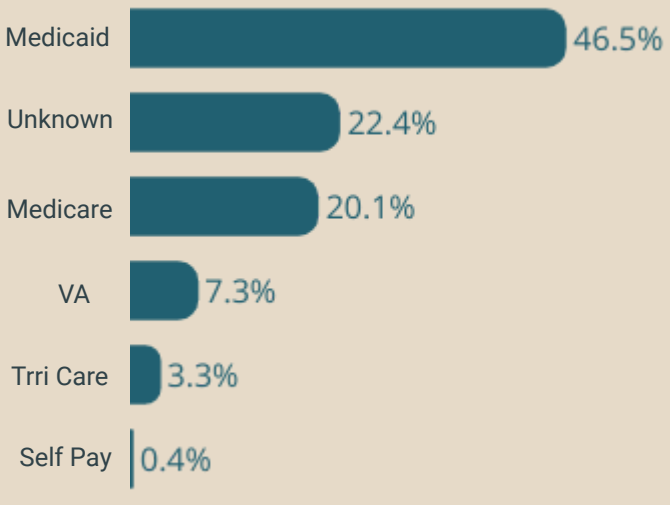
35% FEMALE

AGE GROUPS

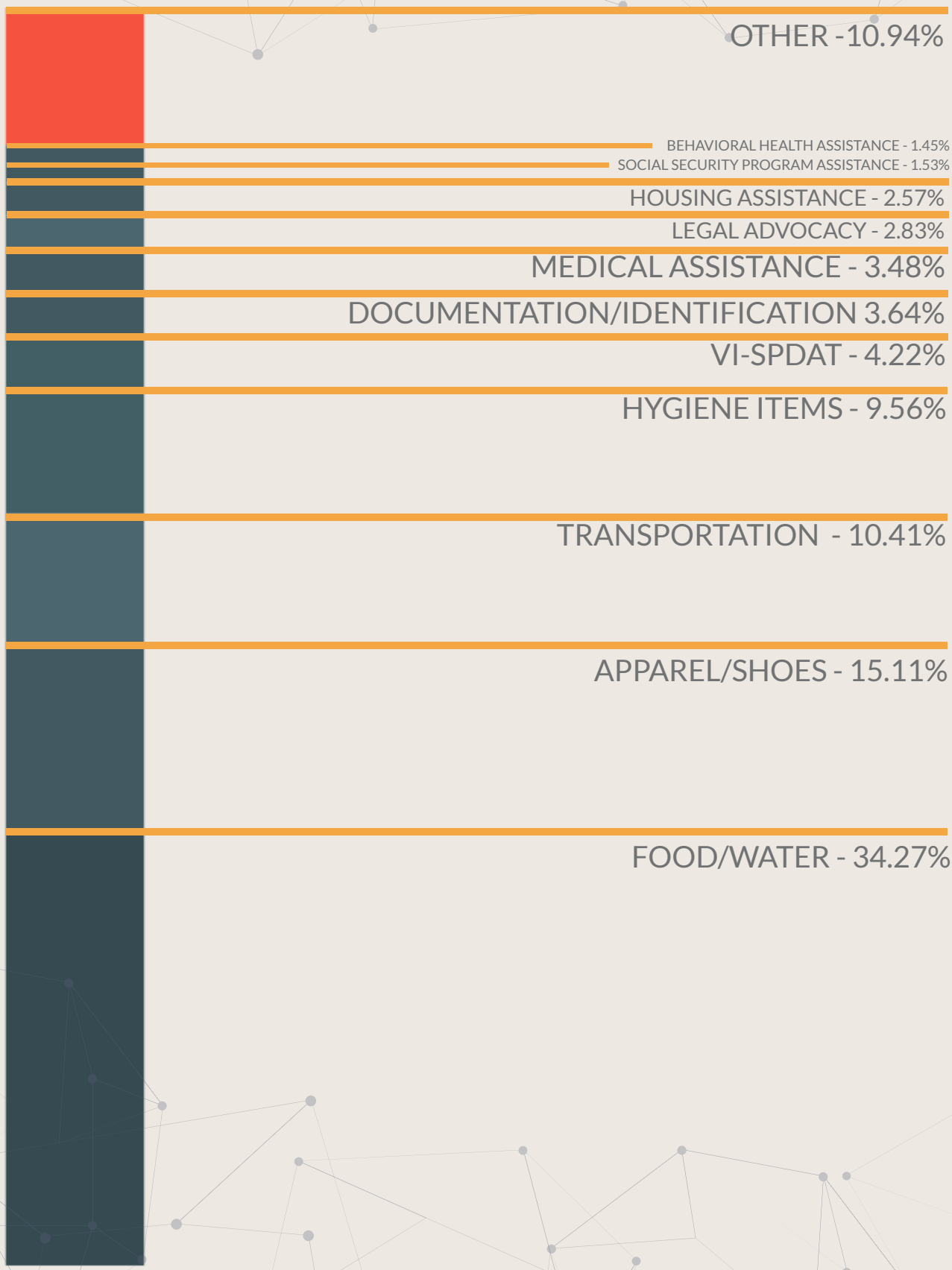








CPH RESOURCES



HIGH UTILIZER PROGRAM (CARES)

The CARES Program (also known as super utilizer)endeavors to assist frequent users of the 9-1-1 system and the emergency departments (six visits to the ED or six 9-1-1 calls within a 6-month period) in Colorado Springs with their physical, medical and behavioral health needs through outreach, assessment, connection to community resources and care navigation.

Referred patients are offered the opportunity to participate in a voluntary intervention designed to find resources and address barriers to healthcare access; this intervention can last for up to 12 months. Commonly identified barriers include lack of adequate housing, food, transportation options, primary care physicians (PCPs), medical specialists, insurance, and behavioral health treatment.

The CARES team consists of intake providers, medical navigators, and behavioral health clinicians. The navigation teams are designed to provide integrated intensive interventions to members who consent to treatment. This allows community resource providers to keep vulnerable populations healthy rather than only providing reactive emergency services.

CARES

120
MEMBERS NAVIGATED

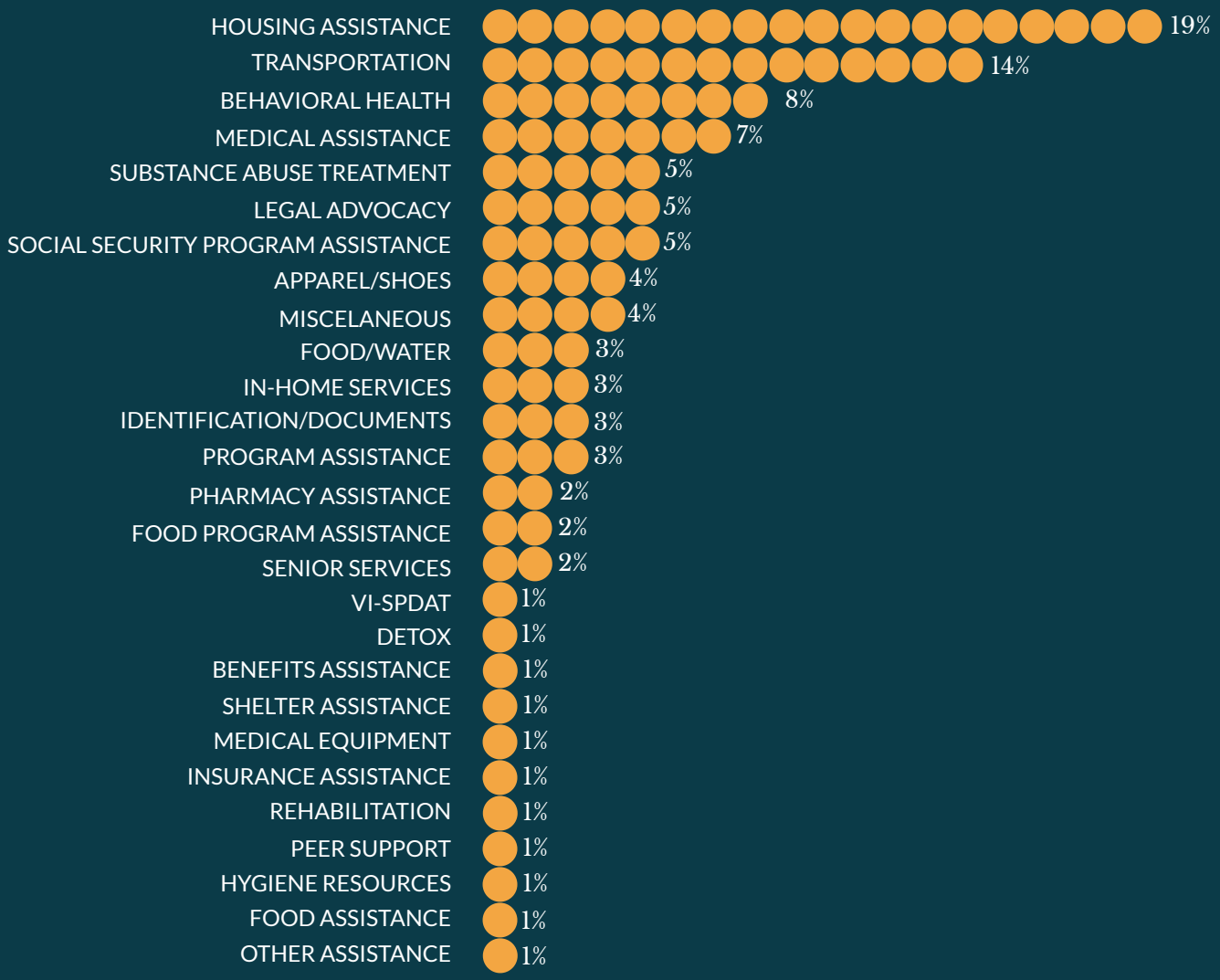
22
MEMBERS COMPLETED THE PROGRAM SUCCESSFULLY

46%
ED REDUCTION

256
RESOURCES PROVIDED

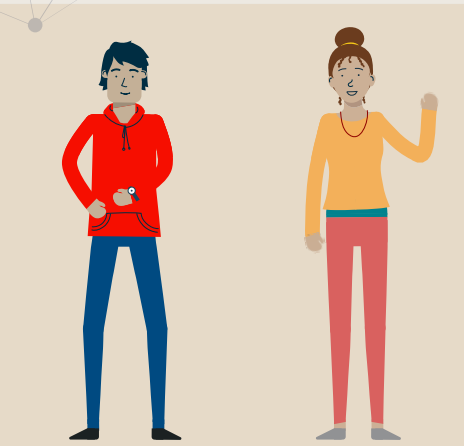
22
MEMBERS HOUSED

RESOURCES


HOUSING ASSISTANCE 19%
TRANSPORTATION 14%
BEHAVIORAL HEALTH 8%
MEDICAL ASSISTANCE 7%
SUBSTANCE ABUSE TREATMENT 5%
LEGAL ADVOCACY 5%
SOCIAL SECURITY PROGRAM ASSISTANCE 5%
APPAREL/SHOES 4%
MISCELANEOUS 4%
FOOD/WATER 3%
IN-HOME SERVICES 3%
IDENTIFICATION/DOCUMENTS 3%
PROGRAM ASSISTANCE 3%
PHARMACY ASSISTANCE 2%
FOOD PROGRAM ASSISTANCE 2%
SENIOR SERVICES 2%
VI-SPDAT 1%
DETOX 1%
BENEFITS ASSISTANCE 1%
SHELTER ASSISTANCE 1%
MEDICAL EQUIPMENT 1%
INSURANCE ASSISTANCE 1%
REHABILITATION 1%
PEER SUPPORT 1%
HYGIENE RESOURCES 1%
FOOD ASSISTANCE 1%
OTHER ASSISTANCE 1%

CARES DEMOGRAPHICS

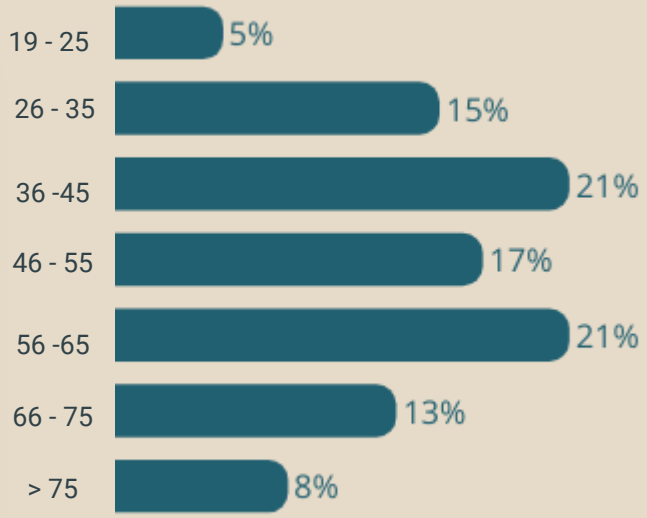
GENDER

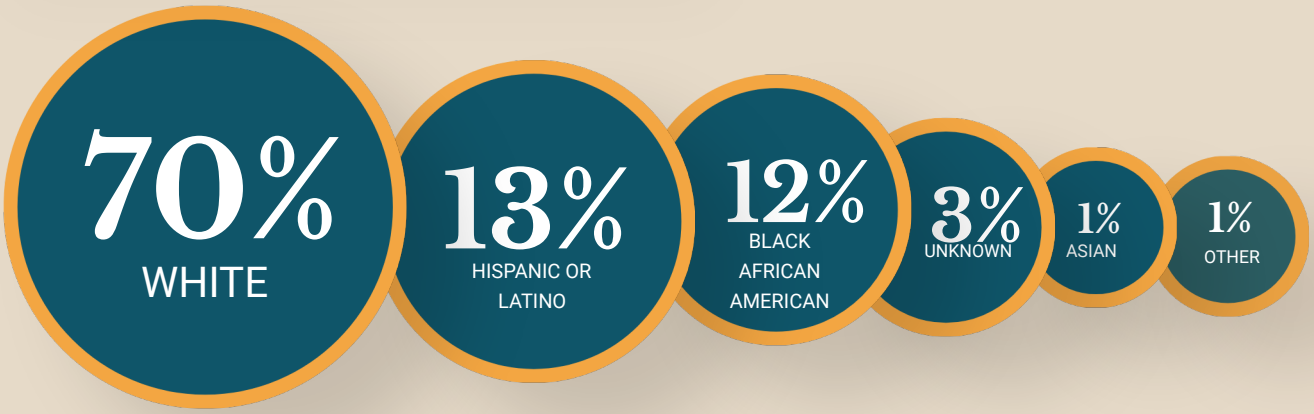


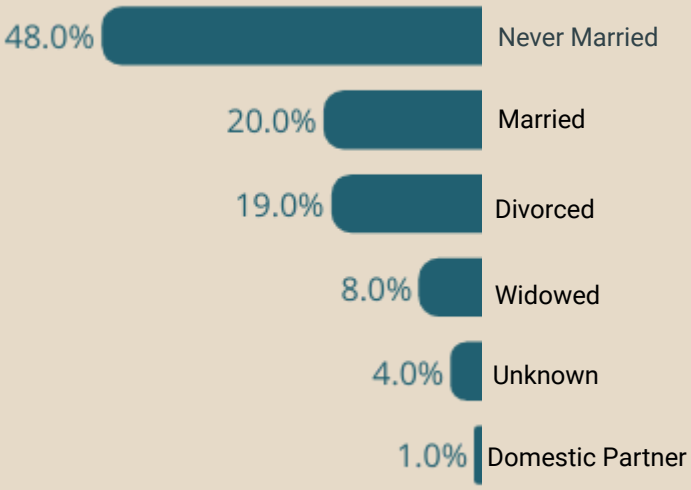
53% MALE

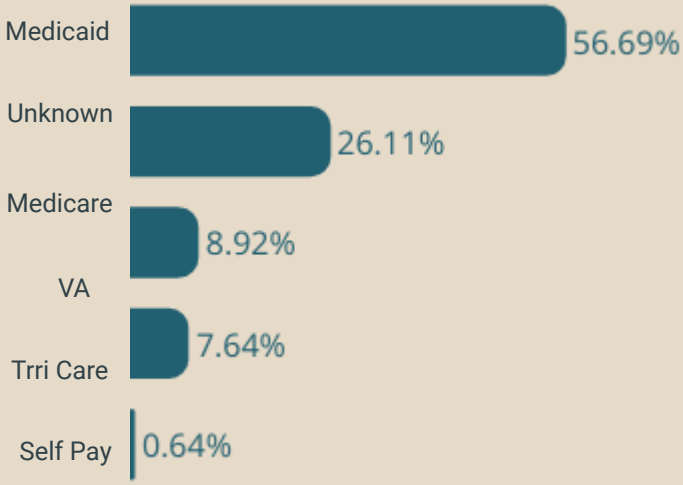
47% FEMALE

AGE GROUPS









HOMELESS OUTREACH PROGRAM (HOP)

Our Homeless Outreach Program was created to understand the true needs of those experiencing homelessness, define solutions for those needs and begin connecting them to services that address their need for housing, health care and mental health care. The initial pilot program identified the value of having consistent outreach teams that have skills in paramedicine and mental health.

Our current Homeless Outreach Program (HOP) provides targeted, intensive outreach to high needs utilizers in the downtown Colorado Springs area with a goal of providing the resources and navigation necessary to increase every homeless person's access to healthcare, housing, and improved quality of life.

Our team will provide resources, direction, and support to any homeless individual they encounter. For those individuals who are ready to move forward with navigation, the team will enroll them in our program, assess their social determinants in addition to their medical and mental health needs. We will then use techniques like motivational interviewing to assess what their underlying goals are and create an individualized care plan to help them reach those goals.

By connecting all members of the homeless community to the proper supports, we can help them regain control of their lives, find appropriate shelter, employment, and the medical/behavioral resources needed to maintain a healthy life.

HOP

2,684

FACE-TO-FACE INTERACTIONS WITH HOMELESS INDIVIDUALS

4,602

RESOURCES PROVIDED

11

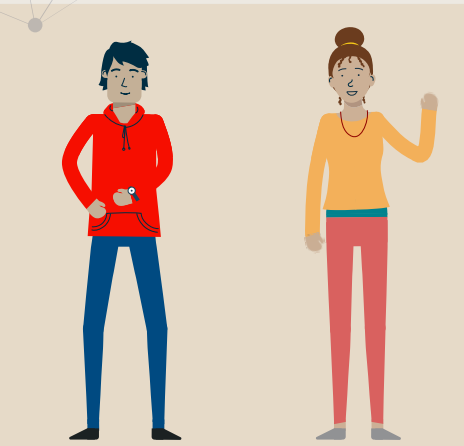
MEMBERS HOUSED

41

MEMBERS WERE ENGAGED IN 2022

HOP DEMOGRAPHICS

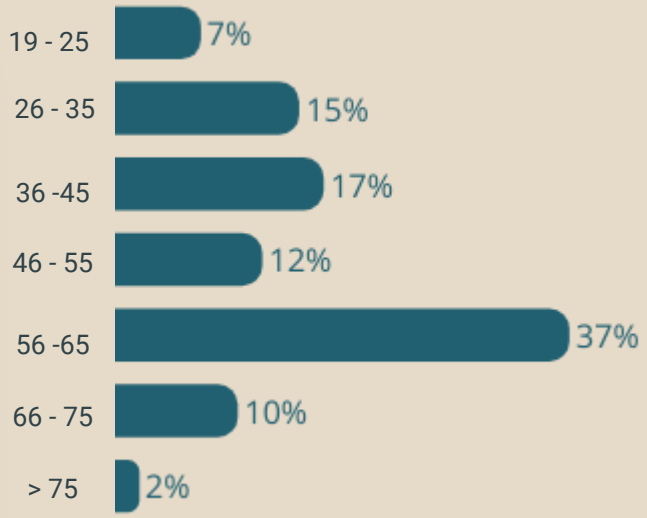
GENDER

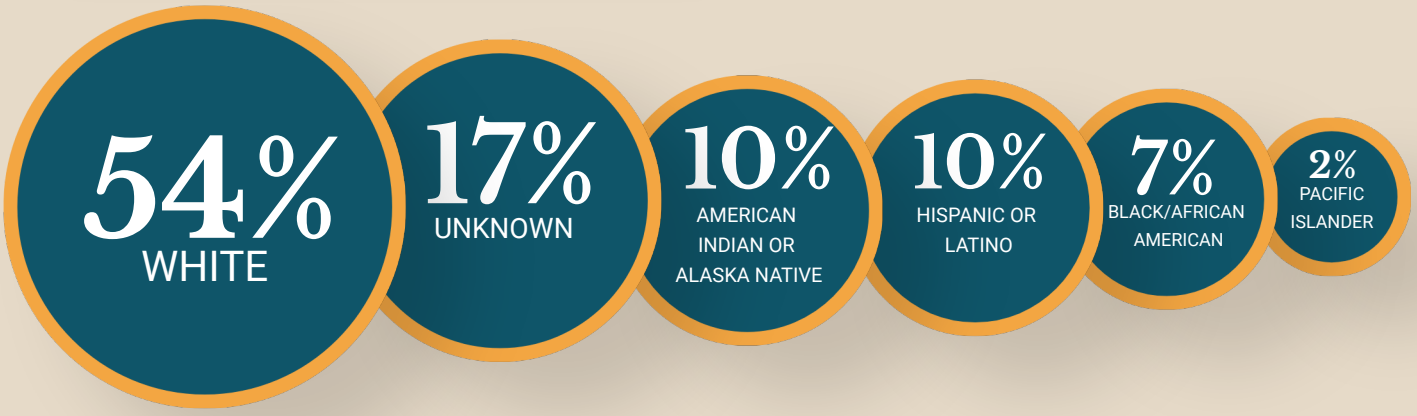


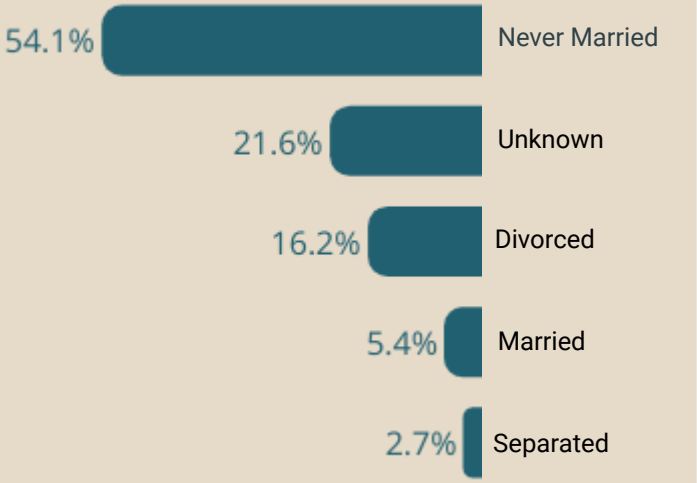
73% MALE

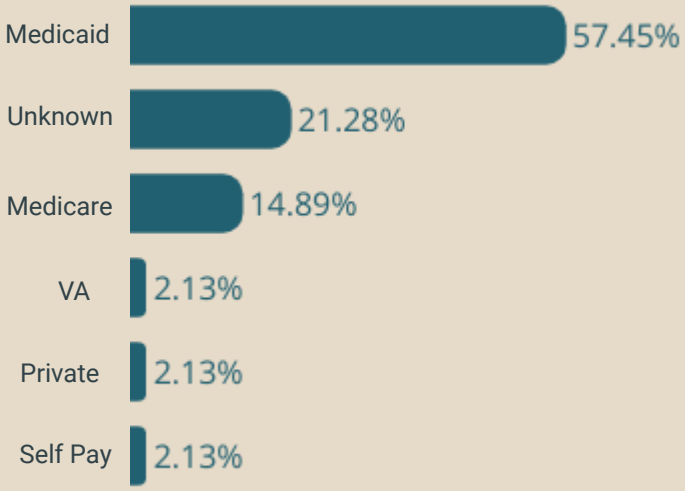
27% FEMALE

AGE GROUPS

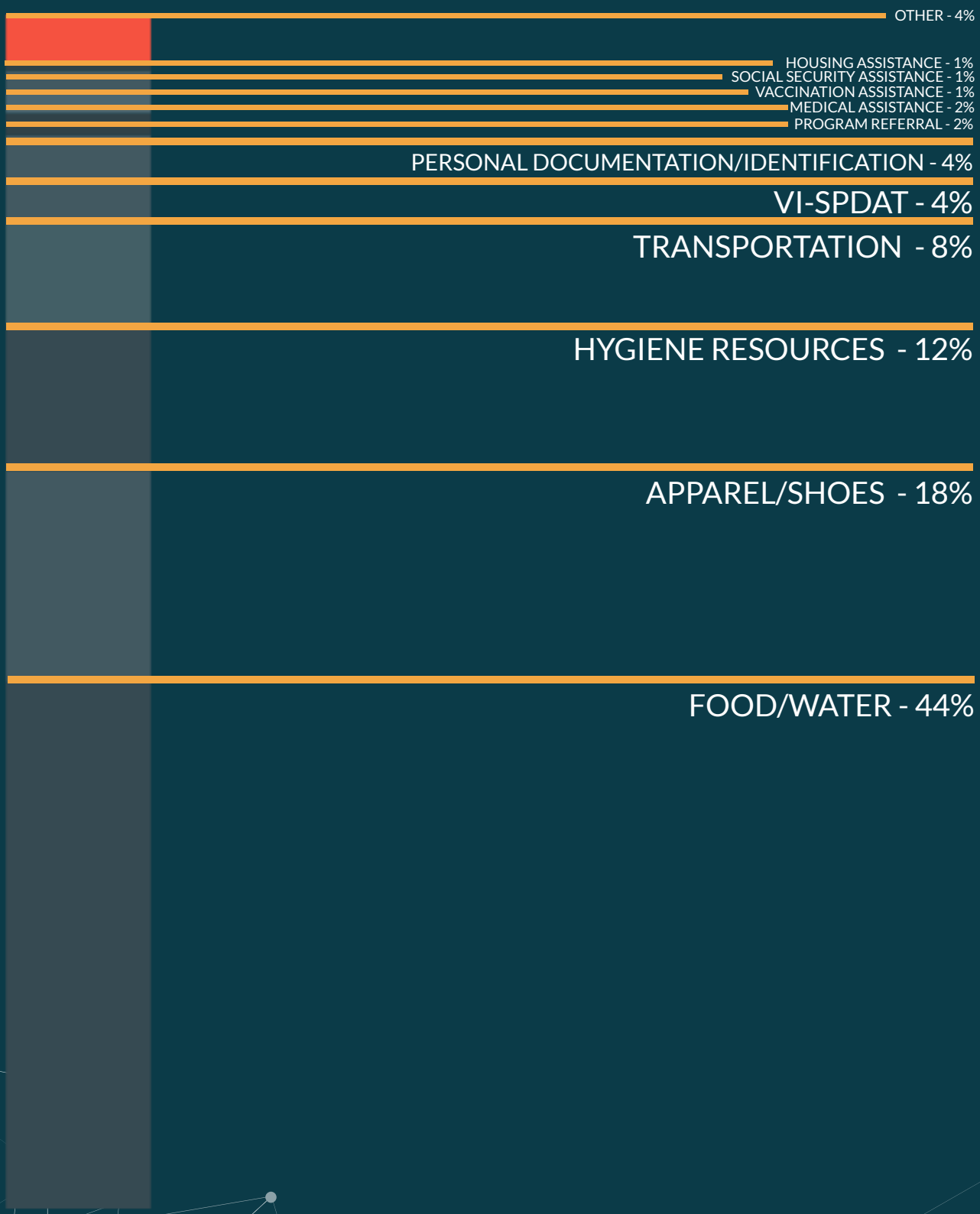








RESOURCES


OTHER - 4%
HOUSING ASSISTANCE - 1%
SOCIAL SECURITY ASSISTANCE - 1%
VACCINATION ASSISTANCE - 1%
MEDICAL ASSISTANCE - 2%
PROGRAM REFERRAL - 2%
PERSONAL DOCUMENTATION/IDENTIFICATION - 4%
VI-SPDAT - 4%
TRANSPORTATION - 8%
HYGIENE RESOURCES - 12%
APPAREL/SHOES - 18%
FOOD/WATER - 44%

AGING IN PLACE PROGRAM

The genius of the Aging in Place Program is that it maximizes the first responder's role, as they are often first to recognize when a senior citizen is struggling to age in place. For instance, CSFD often receives 9-1-1 calls for "lift assist," indicating someone has fallen in their home and cannot get up. While in the home assisting the elder, first responders may observe home and living conditions that indicate the elder is in need of home care, nursing care, or other community-based support and services.

The Aging in Place Program (APP) offers a way for CSFD to immediately begin to connect elders and their families with resources and support. Through CSFD referrals to APP, CPH plays an important role in leveraging first responder and co-responder roles to quickly identify elders in need, assist them in connecting to resources, teach them the necessary skills to continue appropriate self-care, and observe their success.

Elders are then graduated back into independence to age gracefully and successfully, or assisted in finding proper placement if they are unable to age safely in their home.

APP

48

MEMBERS WERE ENGAGED IN 2022

102

RESOURCES PROVIDED

9

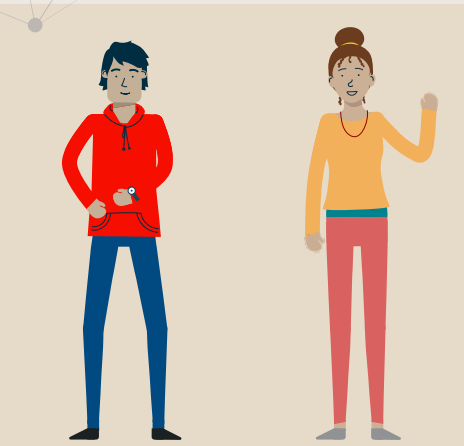
MEMBERS HOUSED

41%

OF SENIORS WITH INCREASED HOPE CALLED LESS TO 9-1-1

APP DEMOGRAPHICS

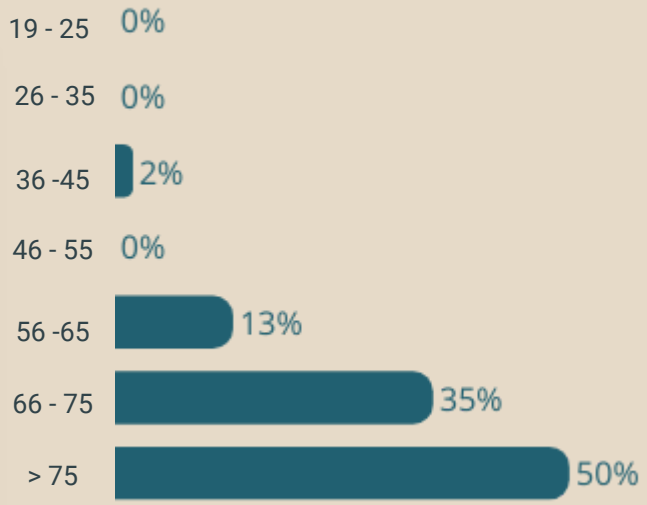
GENDER

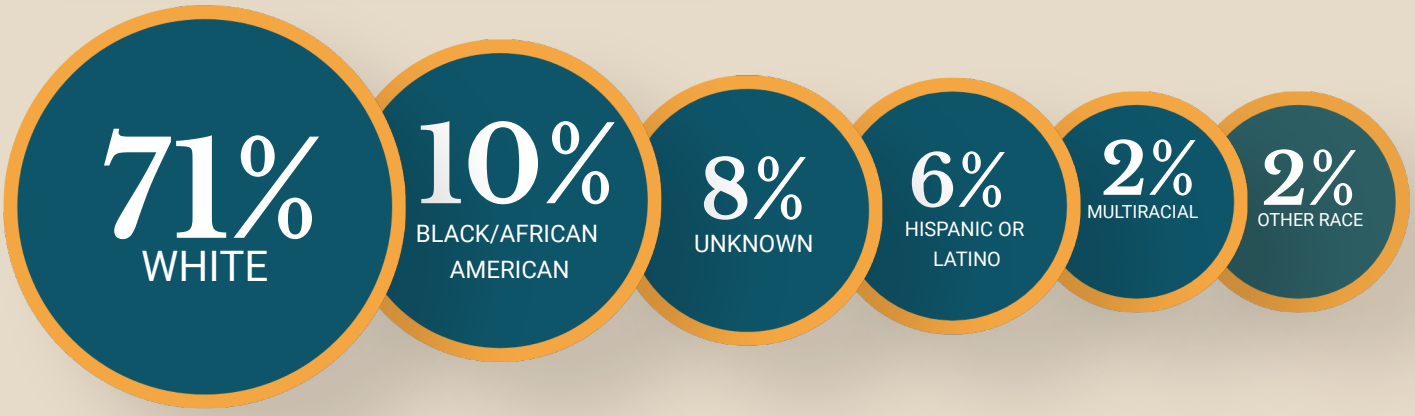


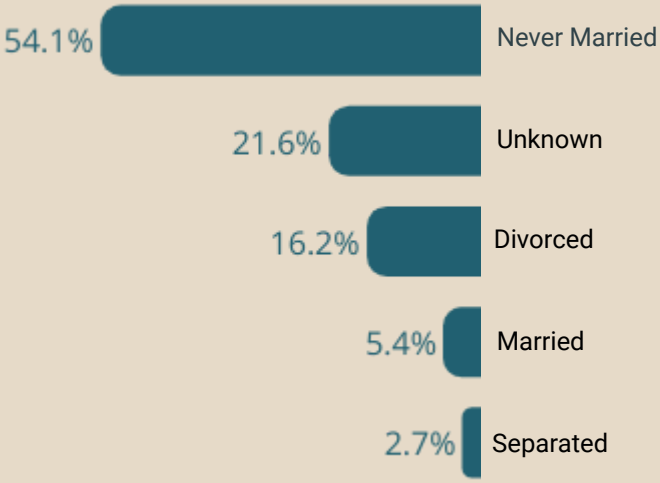
31% MALE

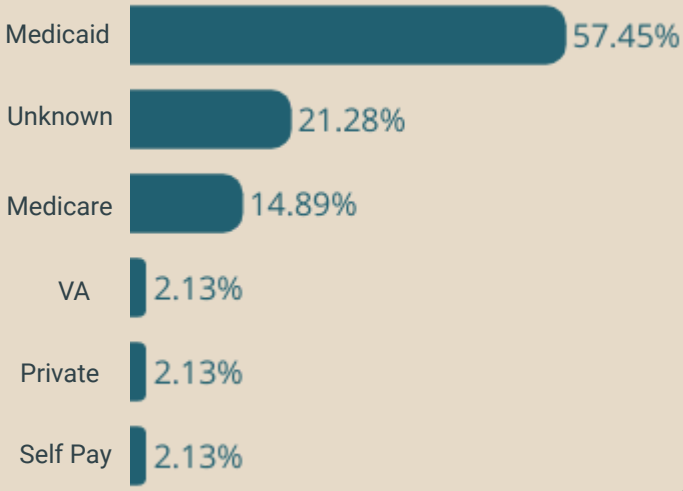
69% FEMALE

AGE GROUPS

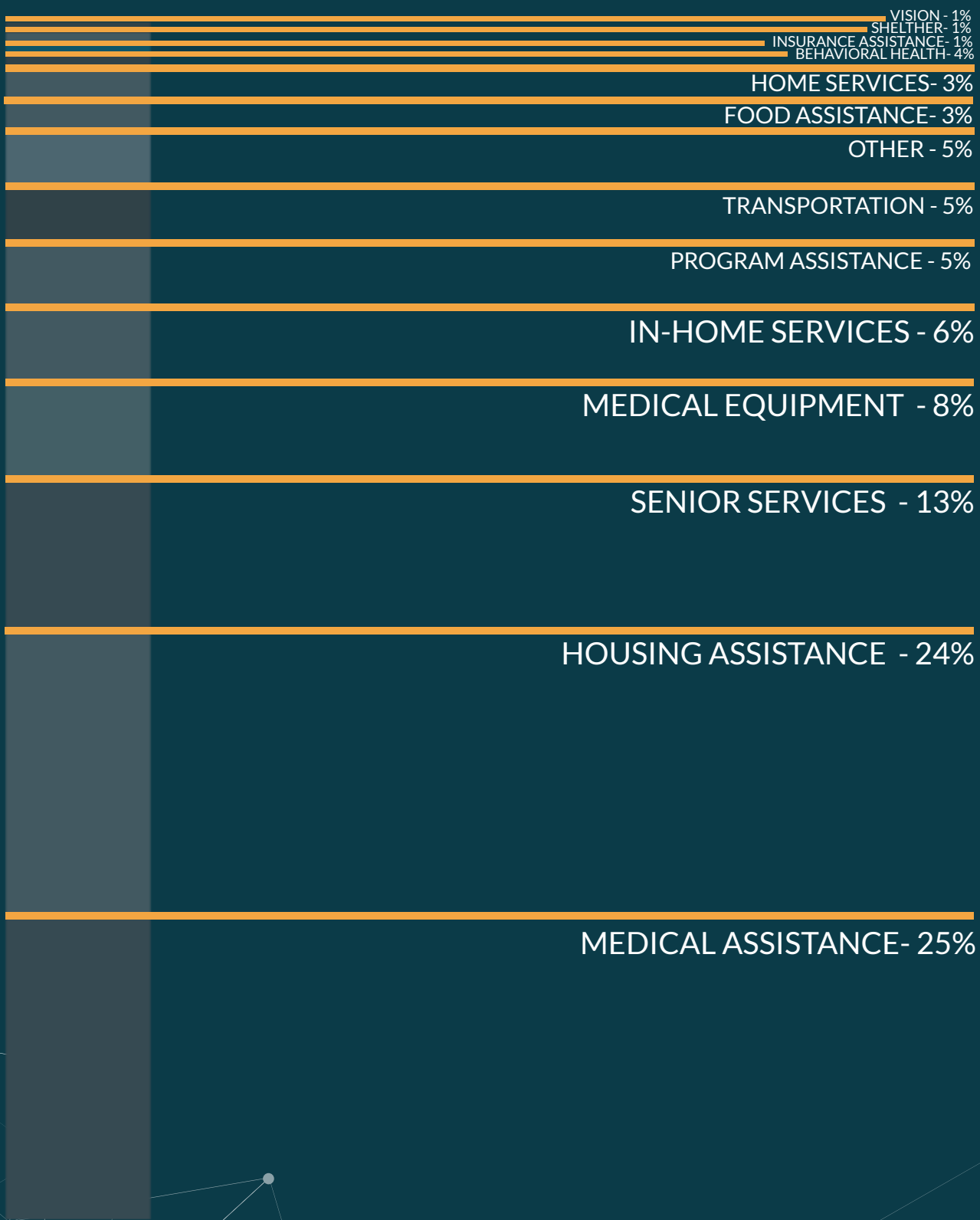








RESOURCES


VISION - 1%
SHELTHER- 1%
INSURANCE ASSISTANCE- 1%
BEHAVIORAL HEALTH- 4%
HOME SERVICES- 3%
FOOD ASSISTANCE- 3%
OTHER - 5%
TRANSPORTATION - 5%
PROGRAM ASSISTANCE - 5%
IN-HOME SERVICES - 6%
MEDICAL EQUIPMENT - 8%
SENIOR SERVICES - 13%
HOUSING ASSISTANCE - 24%
MEDICAL ASSISTANCE- 25%

AGING IN PLACE COLLABORATIVE

In 2022, the Aging in Place Program received funding from Silver Key to improve the quality of life for our aging population. An impact analysis was conducted and our aging in place population whose Hope scale increased yielded a reduction of emergency/medical services .

Key findings:

- The average number of calls the CSAP Cares program seniors made decreased 33% in first 6 months.
- The overall number of calls made between the 20 clients decreased pre to post.
- ED visits decreased 6 months post initial hope score both overall and average number of visits.
- Total ED visits 12 month post initial hope score increased overall, yet admissions to the hospital also increased during the post period.
- Combining ED visits and admissions highlights that unnecessary visits to the ED (ED visits without admission) decreased in both 6 month and 12 month post initial hope scores.
- Decreases in 911 and unnecessary ED visits were more significant 6 months post initial hope score than 12 months after the initial hope score, indicating recency and frequency of touchpoints with support agencies may be needed to sustain reductions in service utilization.
- Among seniors with increased hope, 41% less seniors called 911 both 6 and 12 months post initial hope.
- Seniors with increased hope made 36% less calls 6 moths post initial hope score and 30% less calls 12 months post initial hope score.
- Seniors with unchanged hope reduced average calls 6 months post post but increased average calls 12 months post.
- Seniors with declining hope made 30% more calls 6 months post their initial hope score ED visits decreased in the 6 months post initial hope score among those with improved hope score and among those with unchanged hope score but increased 12 months post initial hope score.

Comprehensive Senior Assistance Program Impact Analysis Prepared for the CSAP Collaborative. (2023). https://www.silverkey.org/wp-content/uploads/2023/02/Silver-Key-CSAP-Impact-Analysis-report-for-NextFifty-Initiative.pdf

TRANSITION ASSISTANCE POGRAM (TAP)

The Transition Assistance Program (TAP) provides intensive community navigation services for inmates of the El Paso County Criminal Justice Center (CJC) identified as high risk/high need. This category of vulnerable individuals includes inmates reporting chemical dependence, mental illness, those in need of chronic medical care, those who are transient/homeless or are high utilizers of jail services.

This program is comprised of two teams, each staffed with a Behavioral Health Clinical Navigator and a Recovery Navigator, who assist community re-entry by creating and managing individualized member treatment plans. Throughout program enrollment, there are ongoing assessments to determine appropriate care, build connection to community providers and resources while simultaneously delivering vital case navigation. This enables vulnerable inmates to receive the resources they need to stay healthy, connect to the community, and decrease recidivism.

Through intensive navigation, the TAP program enables members to make lasting connections to needed services, empowers a better quality of life and makes our community a safer, healthier place.

TAP

170

MEMBERS WERE ENGAGED IN 2022

514

RESOURCES PROVIDED

17

MEMBERS HOUSED

25

MEMBERS COMPLETED THE PROGRAM

TAP DEMOGRAPHICS

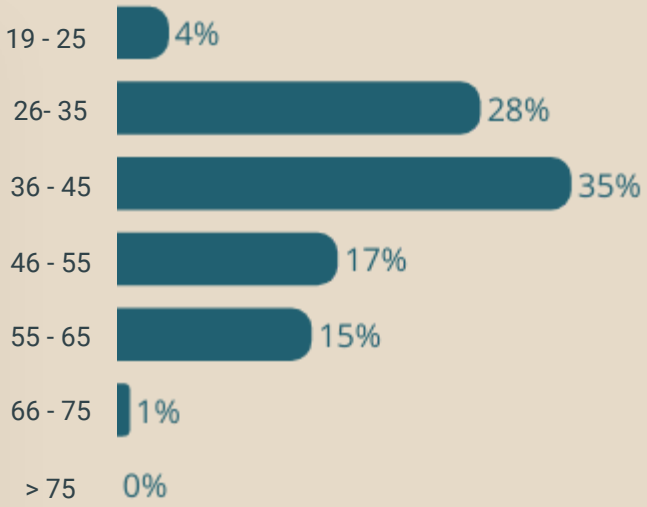
GENDER

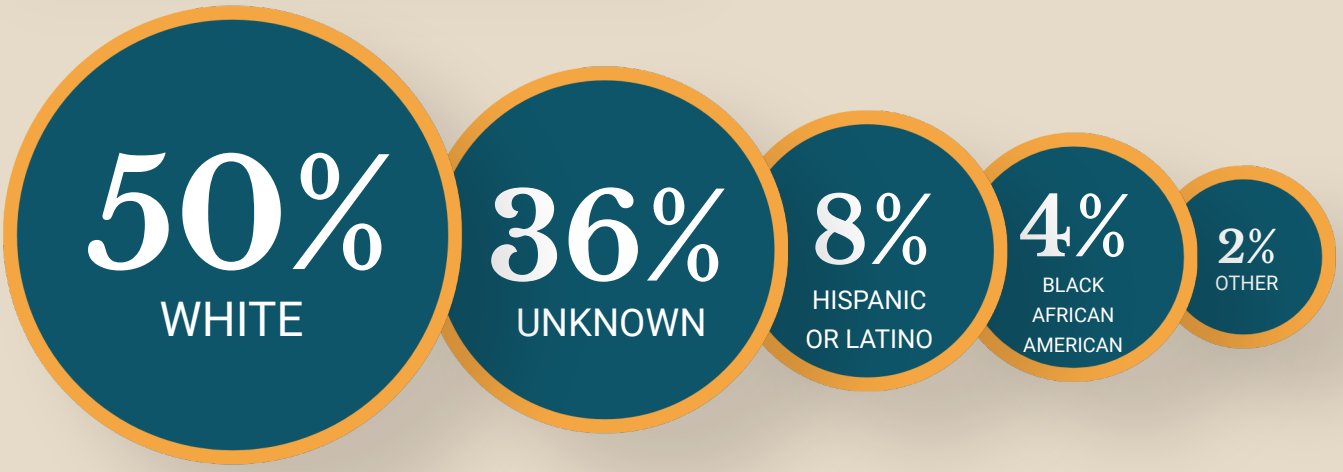
84% MALE

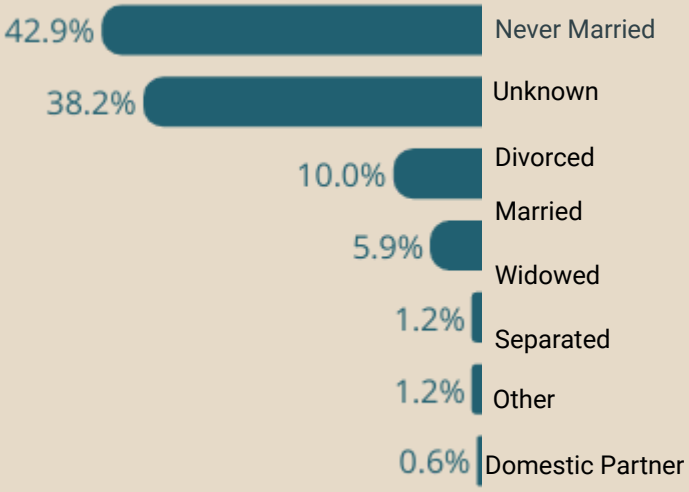
1% NONCONFORMING

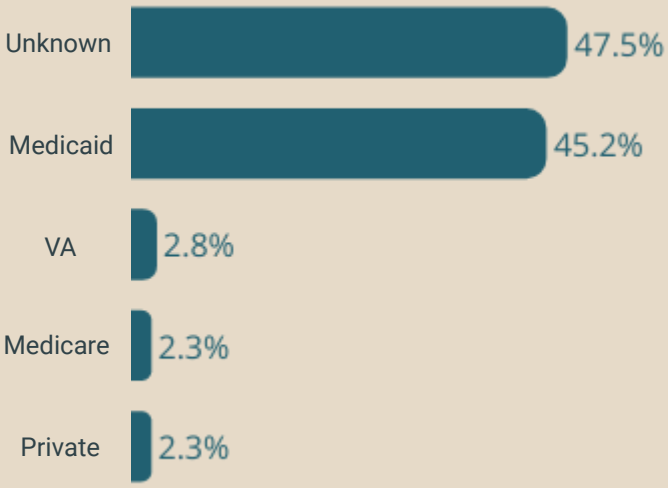
15% FEMALE

AGE GROUPS

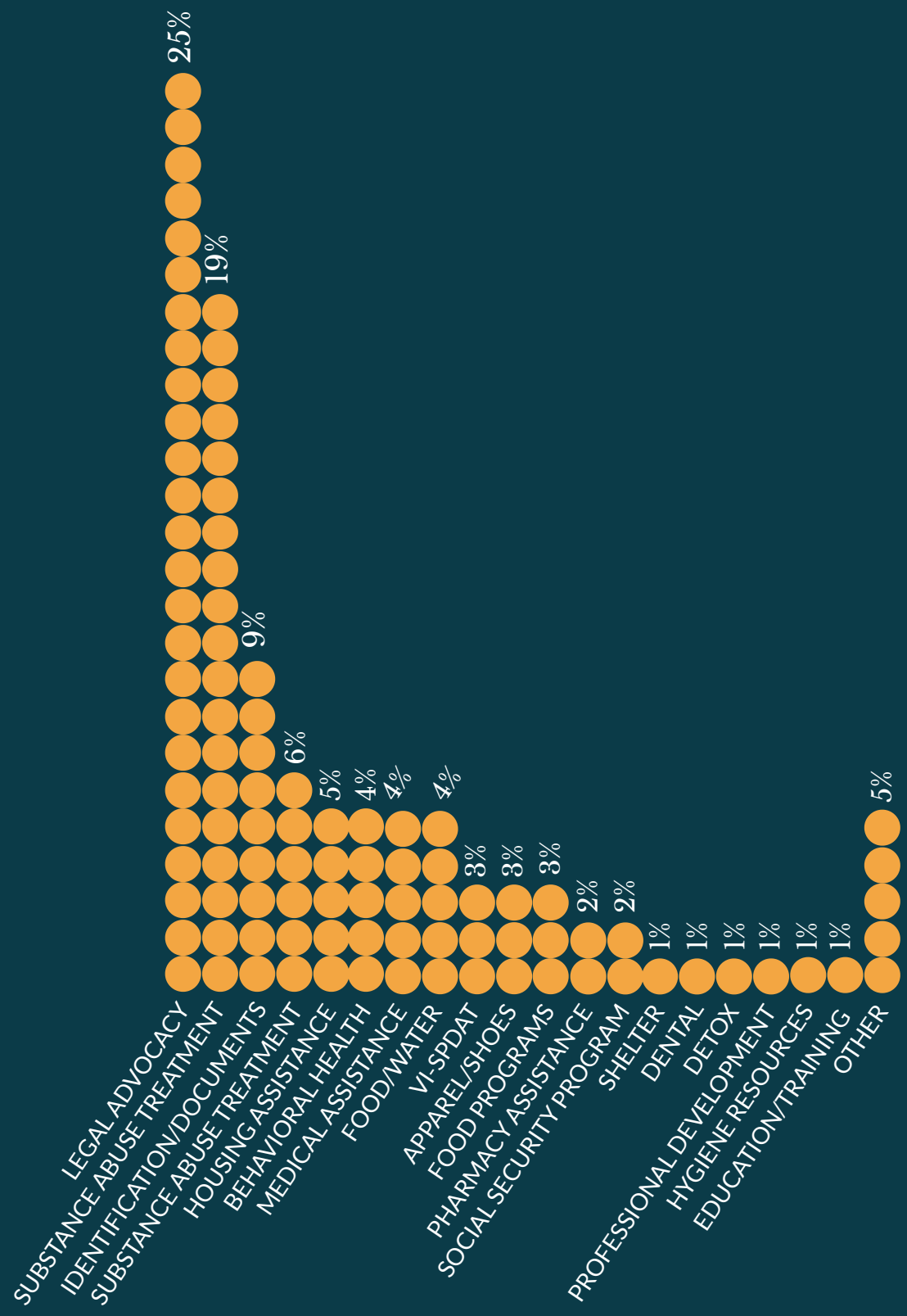








RESOURCES


LEGAL ADVOCACY 25%
SUBSTANCE ABUSE TREATMENT 19%
IDENTIFICATION/DOCUMENTS 9%
SUBSTANCE ABUSE TREATMENT 6%
HOUSING ASSISTANCE 5%
BEHAVIORAL HEALTH 4%
MEDICAL ASSISTANCE 4%
FOOD/WATER 4%
VI-SPDAT 3%
APPAREL/SHOES 3%
FOOD PROGRAMS 3%
PHARMACY ASSISTANCE 2%
SOCIAL SECURITY PROGRAM 2%
SHELTER 1%
DENTAL 1%
DETOX 1%
PROFESSIONAL DEVELOPMENT 1%
HYGIENE RESOURCES 1%
EDUCATION/TRAINING 1%
OTHER 5%

COMMUNITY RESPONSE TEAM (CRT)

The CRT program was developed to assist patients suffering from acute behavioral health crisis by employing cross-agency collaboration to integrate behavioral health services into the broader healthcare spectrum.

Using the flexibility of emergency services, but with a mindset of healthcare integration, teams identify behavioral health needs and work to connect patients to a larger collaborative healthcare team. CRT engages patients that have extensive and often complicated diagnoses, who encounter significant medical, social, and behavioral health barriers posing potential risk to themselves or others and provides a progressive alternative to a strictly law enforcement response.
Designed to respond to behavioral health crisis calls from 9-1-1 and the state crisis line, the CRT team decreases the time between a patient's call for help and their receipt of definitive services. This eliminates prolonged and often detrimental emergency room stays where little to no behavioral health intervention or treatment is performed.

CRT OVERVIEW

3,092 INCIDENTS IN 2022
946 PATIENTS TREATED IN 2022
97 M1 HOLDS IN 2022
1,882 UNITS RELEASED IN 2022

CRT1

740 TOTAL INCIDENTS
253 PATIENTS TREATED
124 MALES
129 FEMALES
19 M1 HOLDS

CRT2

692 TOTAL INCIDENTS
204 PATIENTS TREATED
98 MALES
106 FEMALES
16 M1 HOLDS

CRT3

1,073 TOTAL INCIDENTS
297 PATIENTS TREATED
156 MALES
141 FEMALES
27 M1 HOLDS

CRT4

587 TOTAL INCIDENTS
192 PATIENTS TREATED
105 MALES
87 FEMALES
35 M1 HOLDS

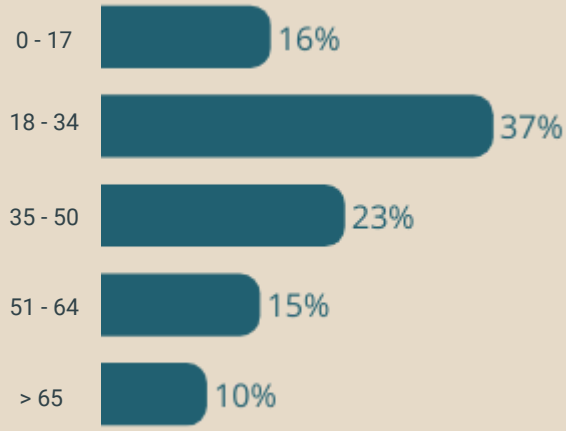
CRT DEMOGRAPHICS

GENDER

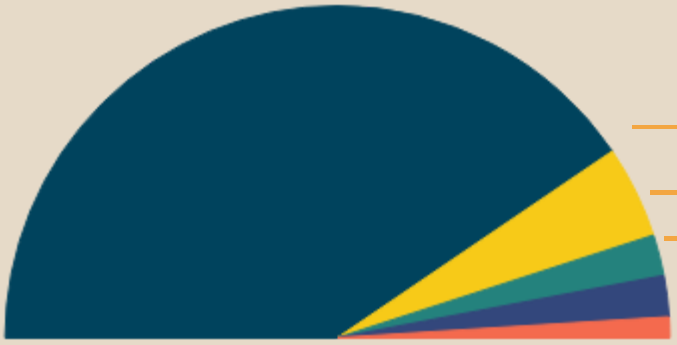
51% MALE

49% FEMALE

AGE GROUPS



DISPATCH SOURCE



9-1-1, 81%

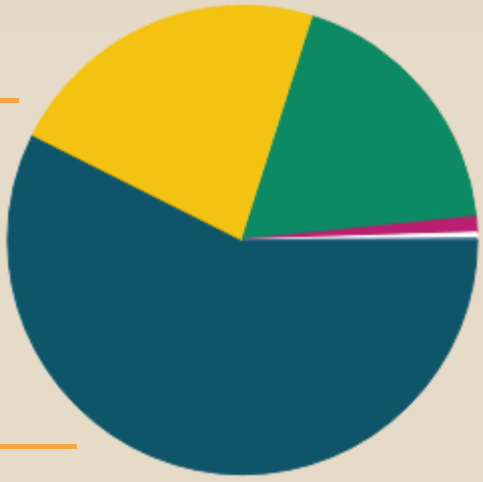
UNIT TO UNIT, 9%

CRISIS LINE, 4%

DIVERSUS HEALTH, 4%

CRT, 2%

CALL TYPE



PSYCH, 22.5%

CTW , 18.5%

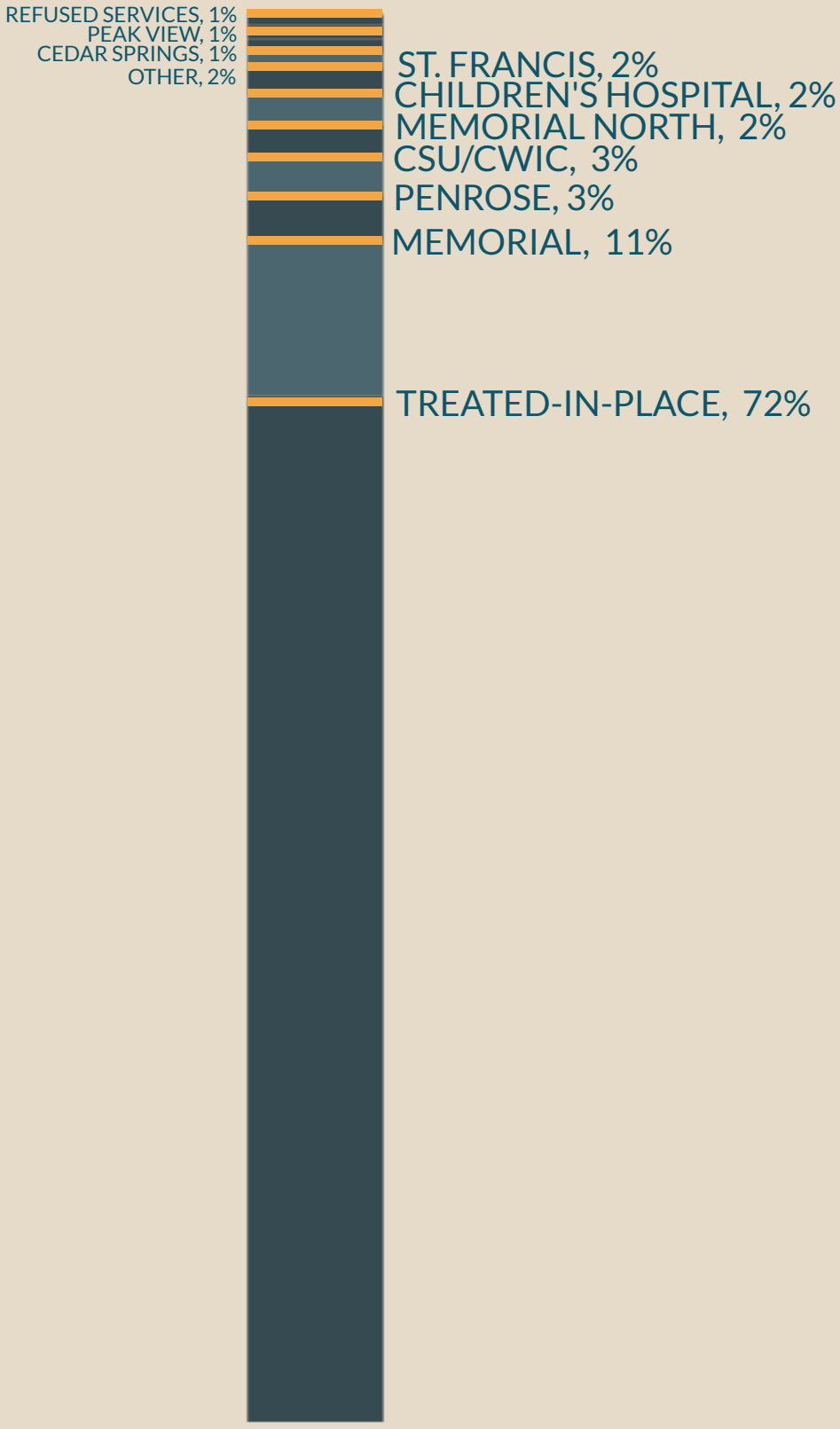
MEDICAL, 1.1%

ETOH, 0.4%

HOMICIDAL, 0.1%

SUICIDAL, 57.4%

CRT DISPOSITIONS



UNITS RELEASED

475
FD UNITS RELEASED

1,712
PD UNITS RELEASED

ALTERNATE RESPONSE TEAM (ART)

The ART team is expanding the scope of collaborative response in our community by responding to low acuity 9-1-1 calls while the CRT units are responding to higher levels of mental health crisis.

The Alternate Response Team (ART) consisting of a Crisis Navigator and an EMT is responding to appropriate low acuity call types such as: medical check the welfare, mental health check the welfare and unwanted person calls. The ART team assists and navigates the individual of concern into the correct resources and/or disposition of care.

Both ART and CRT units are able to make referrals to existing CSFD Community and Public Health navigation programs as appropriate. For individuals who are homeless, the ART team can consult with our Homeless Outreach Program who can in turn reach out to the CSPD HOT or DART teams as necessary. Thus, the addition of the ART teams expands the coordination and collaboration occurring across our city with community service providers, CSPD and CSFD.

Through the recent addition of the two Alternate Response Teams, members of our community experiencing a crisis receive appropriate access to the right care in an expedient fashion. At the same time, CSPD Patrol officers are able to respond to call types that are more appropriate for their mission and their training. As a result of this addition of ART to a continuum of crisis response in our city, our citizens in need receive definitive care in a timely manner while our CSPD patrol officers are more readily available to respond to the law enforcement concerns for which they are trained. The end result is that all citizens across our community benefit from increased 9-1-1 response availability, a healthier social environment and a healthier citizen population.

ART OVERVIEW

456 TOTAL INCIDENTS
52 PATIENTS TREATED
32 MALES
20 FEMALES

ART1

401 TOTAL INCIDENTS
46PATIENTS TREATED
30 MALES
16FEMALES

ART2

55 TOTAL INCIDENTS
6 PATIENTS TREATED
2 MALES
4 FEMALES

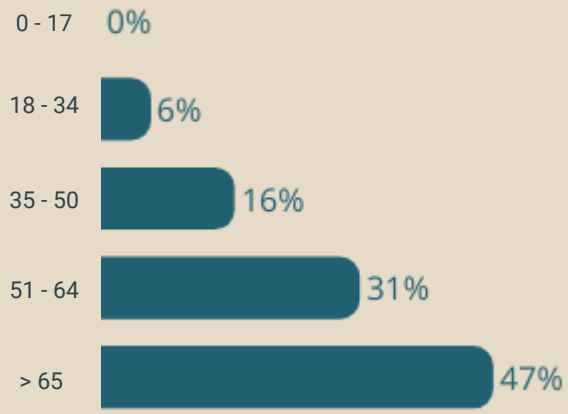
ART DEMOGRAPHICS

GENDER

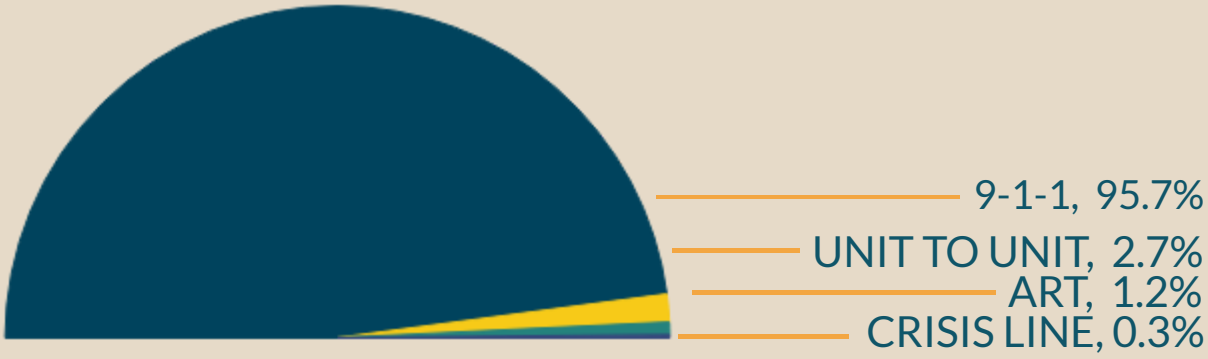
62% MALE

38% FEMALE

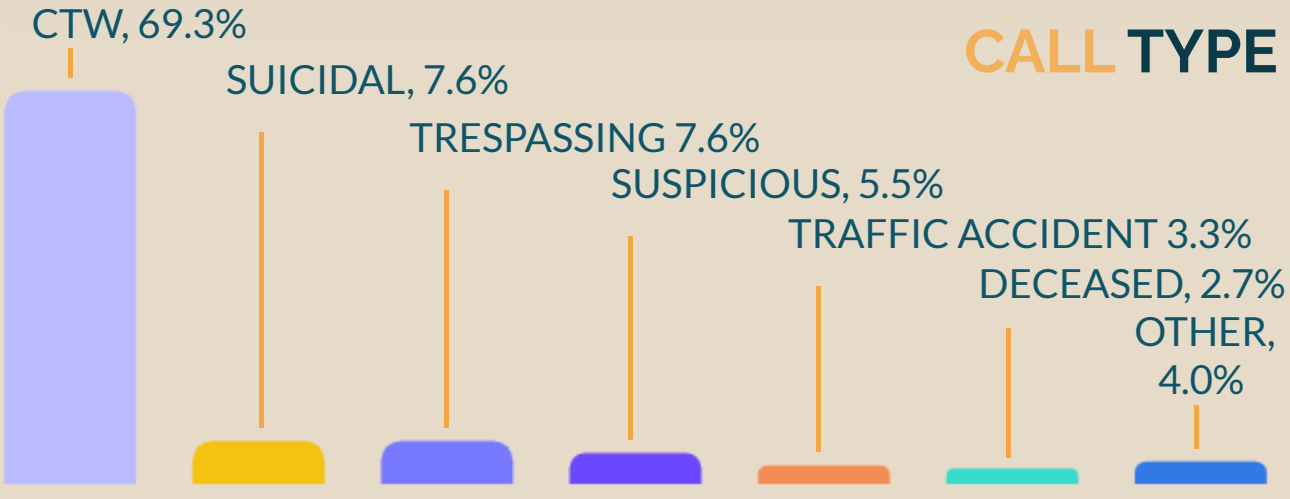
AGE GROUPS



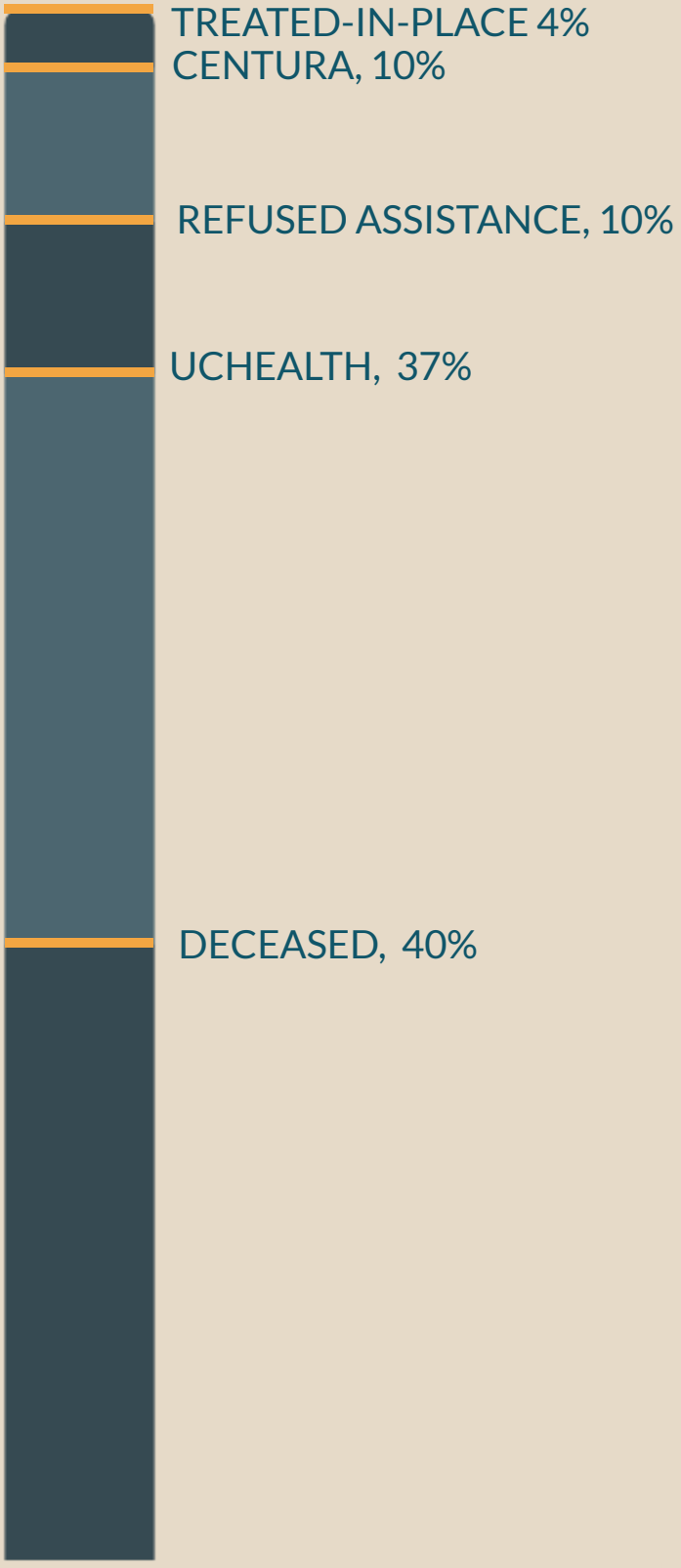
DISPATCH SOURCE



CALL TYPE



ART DISPOSITIONS



UNITS RELEASED

34
FD UNITS RELEASED

274
PD UNITS RELEASED

prepared by: Isaac D. Martinez | Sr. Analyst

p: 719.385.2273
e: csfdcares@coloradosprings.gov
Colorado Springs Fire Department, Community & Public Health
31 S. Weber, Colorado Springs, CO 80903