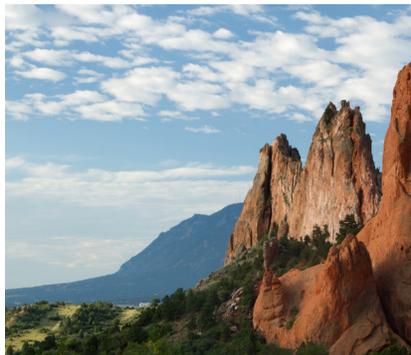


BRIDGING THE DIVIDE: ADDRESSING COLORADO'S SUBSTANCE USE DISORDER NEEDS

FEBRUARY 2017



Report produced by



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EXECUTIVE SUMMARY

Substance abuse is a key public health priority in the state of Colorado, having been identified as one of Colorado's *10 Winnable Battles*. A recently conducted analysis commissioned by the Office of Behavioral Health and led by the Western Interstate Commission for Higher Education documented unmet needs for substance use disorder (SUD) services across the state. This comprehensive behavioral health needs analysis also projected the extent of unmet need to increase significantly by 2025.¹ Senate Bill 16-202, passed by the Colorado General Assembly and signed by Governor John Hickenlooper, seeks to improve access to these services.

To determine how to most effectively allocate increased funding for SUD services with Colorado's Managed Service Organization (MSO) regions, the Keystone Policy Center (Keystone) conducted dozens of interviews, 10 statewide meetings, and hundreds of surveys with key stakeholders to solicit feedback on gaps in services. The meeting, interview, and survey participants worked in the following sectors and organizations: mental health centers; substance use prevention, intervention, treatment and recovery providers; behavioral health organizations; county departments of human services; local public health agencies; law enforcement; homeless and veteran serving organizations; probation; primary care providers; regional care coordination organizations; hospital systems; crisis system; and state agencies. Alongside this stakeholder feedback effort, the OMNI Institute reviewed and synthesized existing sources of information regarding the needs and priorities for SUD services in Colorado. These joint efforts identified what is working well and prioritized needs within each MSO region.

Stakeholders across Colorado emphasized that when it comes to SUD services, the gaps and needs are significant and varied and nearly every population is underserved. Most regions shared similar concerns about needs with respect to the workforce, residential treatment options, detoxification (detox) services, education and de-stigmatization, and supportive services, but — recognizing that needs vary greatly from community to community — stakeholders called for funding that is flexible at the regional and community levels, sustainable, and focused on the development of a continuum of care. Stakeholders recognized the importance of funding non-crisis services — including prevention, intervention, treatment, and recovery — if services are to be effective over the long term.

Across the state, stakeholders identified the financial challenges of building and sustaining a continuum of care due to disjointed and inflexible funding, inconsistent benefits, lack of consistent access to services, and the inability to appropriately scale capacity in both rural and urban areas.

Such variability in funding disincentivizes provider participation in offering these services; most providers increasingly share feedback that their services have no source of reliable funding, with all sources, including the state, competing to be the “payer of last resort.” Indeed, this problem was identified by the Governor's Office of State Planning and Budgeting in the Behavioral Health Funding Study released in November 2016:

[T]he requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to clients. One of [the Office of Behavioral Health's (OBH)] reimbursement requirements, referred to as the ‘capacity based protocol,’ provides an example of the complexity of the system ... From a provider perspective, the capacity based protocol presents challenges to plan for and provide services, as it

EXECUTIVE SUMMARY

creates uncertainty as to what level of revenue will be available to staff and to operate the program. This uncertainty is proportional to the percentage of non-OBH revenue (cash receipts from non-OBH payers) the program earns and the monthly or periodic variances in these non-OBH revenues. The protocol also does not allow programs to retain any excess earnings or offset expenses for capital expenditures, both critical considerations for expanding programs and maintaining or upgrading capital equipment or building new facilities.²

This topic has been raised during the 2017 legislative sessions — namely, the question of whether the state legislature intends funding to be restricted by the payment protocol, resulting in “reversions” (funding that had been appropriated by the legislature but that is returned or goes unused due to an inability to utilize the funding, variability in other funding sources, or other challenges). This creates the inaccurate impression that the funding is not needed. Rather, the constraints on the funding often result in these reversions. Last year alone, approximately \$1.7 million in SUD funding was reverted — funding that could have gone to support prevention, intervention, treatment, or recovery services if it had not been narrowly constrained in many cases. Allowing providers and MSOs greater flexibility in how they may use funding to support their communities with needed services was a common request from stakeholders.

Lastly, stakeholders raised specific funding challenges as they relate to the sustainability of services in rural areas. Typically, services like an outpatient clinic may be easy to sustain in a larger population center, but in a rural area demand is not met by appropriate billing support. Thus, rural and frontier residents have less availability to the entire continuum of services due to the often-mistaken belief that such services are covered — sustained — by other payers. In the example of the rural outpatient clinic, that clinic may provide services to only a handful of clients, though the clinic’s overhead costs remain fixed at a minimum level. Further, having qualified staff in rural areas is disproportionately challenging, with a given provider needing to offer better pay and benefits to compete against the staff leaving for a population center. As this example makes clear, service sustainability funding is needed to offset the gap in direct service reimbursement support from other payers.

This report summarizes stakeholder feedback on general needs and gaps, needs and gaps related to specific populations, funding priorities, and promising practices for SUD services across the state and within the seven MSO regions.

SUBSTANCE USE DISORDERS IN COLORADO

A rise in substance abuse poses serious challenges for Colorado families, community leaders and agencies, and treatment providers. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.”³ Access to SUD treatment is more important than ever: More than 255,000 Coloradans misuse prescription drugs, and deaths involving the use of opioids nearly quadrupled between 2000 and 2011.⁴ According to new data from the Colorado Department of Public Health and Environment,⁵ overdose deaths from just one kind of opioid painkiller outnumbered all homicides in Colorado in 2015. In that same year, there were 904 drug-induced deaths and 847 alcohol-induced deaths across the state.⁶ Drug- and alcohol-related deaths were most common among those aged 25-65, individuals of White, Hispanic, and American Indian/Native Alaskan descent, and those living in areas of high poverty.⁶

In response to this growing epidemic, Senate Bill 16-202 seeks to increase access to effective SUD services, beginning with a stakeholder assessment process to identify priorities. In coordination with the statewide MSOs, Keystone conducted interviews, meetings across Colorado, and surveys with key stakeholders to solicit feedback on gaps in services, identify what is working well, and prioritize needs to determine how to most effectively allocate funding for SUD services within each MSO region.

Continuum of Care for Substance Use Disorder Treatment

Senate Bill 16-202 directed an analysis of resources available to provide a continuum of SUD services, including prevention, intervention, treatment, and recovery support. Throughout this report and the feedback process, stakeholders refer to this “continuum of care,” which addresses the elements identified in the legislation as well as “enhancing health.” Individuals do not always move through the SUD continuum neatly and in one direction; due to the chronicity and the related risk of relapse with SUDs, individuals often move across and within different SUD treatment services, depending upon their needs and the services available to them. For instance, many individuals will complete detox on several occasions over the course of treatment and will also utilize other services on the continuum at different points in their recovery process.

SUBSTANCE USE DISORDERS IN COLORADO

SUBSTANCE USE CARE CONTINUUM



Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health communications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: <ul style="list-style-type: none"> • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services. 	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Figure 1: Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

The benefits of substance abuse treatment are well established. Numerous studies have demonstrated the positive effect of treatment on reducing substance use and improving health status and social functioning. In addition to recovery from addiction, people who comply with substance abuse treatment often experience gains in family functioning, mental health, and employment. Despite this significant and growing body of knowledge documenting that substance use addiction is a preventable, treatable and manageable disease, and despite the proven efficacy of prevention, intervention, and treatment techniques, our state continues to pay for the consequences of substance abuse and addiction: illness, injury, death, and crime, overwhelmed social service systems, impeded education — which are not an effective use of taxpayer dollars. The following graphic illustrates the situation statewide as well as through a specific lens of spending in Larimer County.

INVEST *in* SUCCESS

PREVENTION, INTERVENTION & TREATMENT

COLORADO
SNAPSHOT

LOSING GROUND

Substance Use Disorder is Skyrocketing in our Communities

224K
PEOPLE *in*
COLORADO
misuse prescription
medications every year

19.1%
of all TREATMENT
ADMISSIONS
are for methamphetamines

300
DEATHS/YR.
are the result of
painkiller overdoses

↑82%
UNINTENTIONAL DRUG
POISONING DEATHS
from 2004 to 2013

1 IN 7
HIGH SCHOOL
STUDENTS
has taken prescription
medications without a
doctor's prescription

12TH
in the NATION
for self-reported
nonmedical use of opioid
painkillers in 2012-13

3X MORE
in 4 YEARS
deaths due to heroin
in Colorado

Sources: Take Meds Seriously, State of Colorado, Colorado Consortium for Prescription Drug Abuse Prevention; Colorado Department of Health and Environment; National Survey on Drug Use and Health; Centers for Disease Control; Colorado Meth Project

spent on ACUTE SERVICES

SPENDING EXAMPLE
LARIMER COUNTY

spent on TREATMENT

88%
\$1.71
MILLION

Jail, emergency medical transport, hospital inpatient, emergency department, police contact and detoxification

Source: Larimer County High Utilizers Study 2015/2016, Health District of Northern Larimer County

Dollars are not being used effectively. Too many substance use disorder dollars are spent on acute services rather than treatment.

\$239
THOUSAND **12%**

Outpatient mental health and/or substance use disorder treatment, and treatment provided through Alternative Sentencing and Community Corrections

COLORADO *can do* BETTER

SUBSTANCE USE DISORDER PREVENTION, INTERVENTION & TREATMENT STRENGTHENS COMMUNITIES & SAVES DOLLARS

\$1 SPENT ON TREATMENT RETURNS AS MUCH AS **\$7**

in reduced drug-related crime, criminal justice costs, and theft

WHEN YOU ADD HEALTH-RELATED SAVINGS: fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths

TOTAL SAVINGS exceed COSTS BY **12:1**

Source: National Institute for Health

SUBSTANCE USE DISORDERS IN COLORADO

The Colorado Office of Behavioral Health contracts with regional MSOs for the provision of SUD treatment services throughout Colorado.

Colorado Managed Service Organizations



Region 1: Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties

Region 2: Denver, Adams, Arapahoe, Broomfield, Douglas, Jefferson, Clear Creek, and Gilpin Counties

Region 3: El Paso, Teller, Park, Lake, Chaffee, Fremont, and Custer Counties

Region 4: Pueblo, Crowley, Kiowa, Huerfano, Las Animas, Otero, Bent, Prowers, Baca, Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla Counties

Region 5: Archuleta, La Plata, Montezuma, Dolores, San Miguel, San Juan, Ouray, Hinsdale, Gunnison, Montrose, and Delta Counties

Region 6: Mesa, Garfield, Rio Blanco, Moffatt, Routt, Eagle, Pitkin, Summit, Grand, and Jackson Counties

Region 7: Boulder County

SUBSTANCE USE DISORDERS IN COLORADO

Assessments of availability and need for SUD services underscore a shortage of SUD services across the spectrum,⁷ with a particular need in many regions for additional availability of social detox models.¹ The Department of Health Care Policy and Financing reports that there are 18 detox facilities licensed by the Office of Behavioral Health in Colorado, with 409 beds available between them.⁷

Consumers in Colorado seeking SUD services can access LinkingCare.org, the directory for OBH licensed providers that allows consumers to search for some services on the SUD continuum, including: (1) emergency/medical detox providers; (2) residential treatment providers; (3) outpatient service providers; and (4) methadone clinic providers.⁸ Of these four service provider types, those locally (i.e., within-county) available that consumers can find through LinkingCare.org differ considerably from one region to another.

For example, there are:⁸

- Six counties with none of these four service provider types available (Region 2: Gilpin; Region 4: Kiowa, Mineral, Dolores; Region 5: Hinsdale, San Juan);
- 12 counties with all of these four service provider types available (Region 1: Larimer; Region 2: Adams, Arapahoe, Denver, Jefferson; Region 3: El Paso, Fremont; Region 4: Alamosa, Pueblo, La Plata; Region 6: Mesa; Region 7: Boulder); and,
- 15 counties with only outpatient service provider types (i.e., no emergency medical/detox providers, residential treatment providers, or methadone clinic providers; Region 2: Broomfield; Region 3: Lake, Park, Teller; Region 5: Archuleta, Delta, Gunnison, Montezuma, Ouray, San Miguel; Region 6: Eagle, Grand, Jackson, Moffat, Rio Blanco).

Funding

For SUD treatment, state and local funding are the largest payers, followed by Medicaid and other federal spending. Total private spending makes up a smaller component of funding.

A brief examination of the distribution of SUD services funding for youth (ages 12-17) and transition-age youth (ages 18-24) conducted by the Office of Behavioral Health indicated that in FY 2011-12, the majority (80 percent) of youth SUD funding came from state funds and 37 percent of combined state and federal youth SUD funding was derived from justice-involved youth dollars. Additionally, youth mental health/co-occurring services received 1.7 times as much funding as youth SUD services, and transition-age youth received more than \$1 million in SUD services than youth.

STAKEHOLDER ASSESSMENT: KEY FINDINGS AND THEMES

Key Findings/Themes

While specific priorities for funding varied across the MSO regions, Keystone observed several key findings and themes with respect to need for SUD services statewide:

Care coordination and continuity of care across phases of the continuum: SUDs seldom occur in isolation. Consequently, mental, substance-use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Improving outcomes depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients.

This disconnected care delivery system requires numerous patient interactions with different providers, organizations, and government agencies. It also requires multiple provider “handoffs” of patients for different services and transmittal of information to and joint planning by all these providers, organizations, and agencies if coordination is to occur. Overcoming these separations also is made difficult because of legal and organizational prohibitions on clinicians’ sharing information about mental and substance-use diagnoses, medications, and other features of clinical care, as well as a failure to implement effective structures and processes for linking the multiple clinicians and organizations caring for patients. Stakeholders repeatedly identified the need for better linkages among mental, substance-use, and general health care and other human service agencies caring for these patients. It is critical that individuals can access the services they need in a timely manner, particularly when in treatment or at risk for relapse. Stakeholders acknowledged that SUDs have not been treated, monitored, or managed like other chronic illnesses, nor has care for these conditions been covered by insurance to the same degree.

Additionally, stakeholders acknowledged the lack of a rational, integrated approach to SUD and the importance of using evidence-based early interventions to stop the addiction process before the disorder becomes more chronic, complex, and difficult to treat. They stressed the importance of a development of and sustainable funding for a continuum of care (Figure 1), which refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed.⁹ Sufficient capacity at each level of care is necessary for a well-functioning SUD treatment continuum.

Workforce: The field is experiencing high turnover rates, worker shortages, inadequate compensation, and insufficient training especially for trauma-informed care, Medication-Assisted Treatment (MAT), and treatment for adolescents. Workforce vacancies for master’s-level clinicians, counselors, and social workers; nurses; peer support specialists; and mobile crisis staff all contribute to many of the service gaps identified by stakeholders across the regions.

Flexibility and sustainability in funding: Many stakeholders noted the importance of creating a continuum of care — a comprehensive array of accessible health services appropriate to an individual’s needs — and a strategy for funding that continuum. They emphasized the challenge of creating a sustainable continuum with the current funding sources, in part due to the effort required for every payer or grant sought, as well as efforts to maintain, administer, and meet funders’ reporting requirements. Stakeholders overwhelmingly expressed frustration that funding is often tied to specific populations or is too restrictive in scope, which limits a community’s ability to target resources in the way that is right for their community.

STAKEHOLDER ASSESSMENT: KEY FINDINGS AND THEMES

Rural and frontier stakeholders also identified the unique barriers they face in obtaining comprehensive and convenient health care services: Services are not as readily available in rural communities and, for those that are available, their range of services may be limited; developing sustainable funds is challenging when that funding is based on a population distribution; law enforcement and prevention programs may be spread sparsely over large rural geographic areas; and patients seeking substance abuse treatment may be hesitant to do so because of privacy issues associated with smaller communities.

Residential treatment: Medicaid does not cover residential treatment except for pregnant women, via the Special Connections program, though there is limited funding for that program which limits access to providers. Stakeholders indicated the need for an expanded benefit that would include inpatient residential treatment programs (low-, medium-, and high-intensity) for periods of time that support needs of individuals as they diminish or intensify. Stakeholders talked about the importance of local transitional programs being available and a vehicle for helping people integrate back into community, following treatment at a more regionally located intensive residential program.

Detox services and detox facilities with a medical component: Two main areas of need commonly came up in stakeholder feedback with respect to detox. First, there was a general need for additional clinically managed, social model detox capacity to be added throughout the state.

Second, most detox services, when available, are for social detox; stakeholders also raised the need for a medical component, as rapid or non-medicated withdrawal from substances can produce seizures and other health complications. Stakeholders acknowledged that when there are medical complications that cannot be addressed in social detox, patients are sent to emergency departments for detox, which is neither effective nor a good avenue for connecting patients with continued care.

Overall, the mixture of static and variable payment sources challenges the sustainability of any detox, rural or otherwise. The need versus sustainability in rural areas makes such rural detoxes almost impossible to sustain. Disproportionate subsidy is required to provide local detox.

Supportive and transitional services: Stakeholders called for better availability of housing and transportation options for individuals transitioning back to their community. Individuals who struggle to access health services and stable housing that will support them through recovery may be more likely to relapse.

Agency alignment and integration: Stakeholders raised the need to enhance integration and alignment among systems of care, as well as across agencies. Stakeholders identified the lack of alignment of funding, planning, programs, and regulations among agencies as a barrier to building a continuum of care for SUD. Additionally, they called for improvements in the connections between aspects of the SUD service continuum (e.g., treatment and recovery); the integration of SUD services into primary care and mental health systems; and strengthening the continuity of care between SUD services and other social services (e.g., hospitals, police departments, emergency response, etc.). Stakeholders suggested enhancing these connections and integration through common information/data management systems and funding for care coordination or case management among the health, health care, and social services systems.

As the Department of Health Care Policy and Financing moves forward with its next iteration (Phase II) of the Accountable Care Collaborative, there should be direct inclusion of substance use services and MSOs. MSOs can help reach Medicaid members with services, like residential services, that are not currently included in their benefit so requiring the Regional Accountable Entity (RAE) to substantively coordinate with the MSOs will improve care delivery, access, and outcomes for clients.

STAKEHOLDER ASSESSMENT: KEY FINDINGS AND THEMES

Lastly, stakeholders acknowledged there is no centralized authority or group with either primary responsibility for positive outcomes and continuity of care for all clients of SUD services, or with ensuring parity (meaning they must be comparable to medical/surgical benefits) requirements are met. SUD services in Colorado will continue to be disjointed and ineffective if this role is left unfulfilled.

Stigma and lack of education: Stigma and lack of education about SUD were identified as barriers to treatment. Specifically, in rural communities, individuals dealing with SUD fear that neighbors, community members, and co-workers or employers will judge them if they seek services. Many stakeholders also identified the lack of recognition of SUD as a chronic disease within and outside the health system as a barrier to long-term care and recovery. Stakeholders highlighted the need for de-stigmatization and greater education and awareness for SUD.

The pages that follow summarize the needs, gaps, and funding priorities specific to each MSO region. The graphic summarizes the stakeholder feedback solicited by Keystone, and the text that follows supplements that feedback with secondary data gathered by the Omni Institute.

Region 1 Northeast Colorado

Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties



NEEDS/GAPS

- Workforce: Retention and training including Medication Assisted Therapy (MAT)
- Increased training in trauma-informed care
- Case or care management, system navigation
- Better information and data sharing
- Better data related to outcomes of interventions and treatment
- Crisis service alternatives and stabilization/ acute treatment unit
- Funding for transitions, including kids re-entering school setting and homeless
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Short- and long-term residential treatment
- Intensive outpatient services, including sustainable rural options
- Prevention including early intervention, especially with kids
- Detox services/facilities with a medical component
- Public education
- Creating sustainability in rural communities

PRIORITIES *for* FUNDING

Detox services/facilities with a medical component in Larimer and Logan Counties

Workforce: Retention and training including Medication Assisted Therapy (MAT)

Crisis service alternatives and stabilization/ acute treatment unit

Intensive outpatient services and transitions to these services

Continuum of housing options

Short- and long-term residential treatment (Larimer/Weld Counties)

Transportation to and from treatment and recovery-oriented programs

Creating sustainability in rural communities (Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 1

By 2025, Region 1 is expected to have the largest increase in unmet need for substance use services among children and adults in the state.¹ Substance abuse has been identified by county public health departments as a priority in Cheyenne, Kit Carson, Lincoln, and Weld counties.¹⁰ Adult binge drinking¹¹ and prescription drugs^{12,13} were identified as particular areas of concern.

Prevention

Prevention of substance abuse was identified as a key focus area,¹⁴ with a need for more early intervention for youth.¹ Better community services to support school-based services were highlighted.¹ In addition, offering greater access to preventive care for uninsured and Medicare/Medicaid patients was identified as a way to decrease the number of emergency department visits for substance abuse issues that occur for this population.¹⁵

Intervention

Evidence suggests that there is a need for more crisis stabilization services and higher capacity for detox services in Region 1.¹ From January-October 2015, one detox facility in Region 1, serving primarily Weld and Larimer counties, was unable to admit approximately 500 clients, due to the detox facility being at capacity, a lack of transportation options, or limitations around staffing requirements due to licensing regulations.¹⁶

Treatment

Many communities within Region 1 see a need for more treatment services options and providers within their county.^{1,12,17} Identified unmet treatment needs include intensive outpatient services and residential care.¹⁶

Recovery

Identified needs for recovery support in Region 1 include housing and transitional supports, peer supports, mentoring, and peer groups.^{1,16}

Workforce

There is an identified need for a greater number of qualified SUD professionals.¹² In Logan County, the number of behavioral health providers is extremely low compared to the population, and primary care physicians are being tasked with providing psychiatric care that exceeds their capacity, resulting in a lower quality of care.¹⁸ One issue that may exacerbate the lack of qualified SUD professionals is the high turnover rate in the region.¹

Continuum of Care

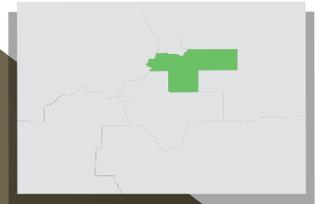
Connectedness across the continuum of SUD services was identified by many counties in Region 1 as a concern. For example, in Morgan County, the process of accessing SUD services was recognized as being disjointed and cumbersome, especially for those entering through an Emergency Department.¹² In Larimer, the lack of a continuum of care services was identified as the primary issue in SUD services.¹⁶

Cost

Hospitals in Weld and Larimer counties cite the high number of people using Emergency Departments as the primary access point for behavioral health care, including substance abuse, as indicative of the lack of access to affordable and/or covered SUD services.^{17,19} The providers who are in the community primarily treat those who have insurance or can pay cash for their services, leaving those who cannot afford services with very limited options, including the Emergency department.¹⁵

Region 2 Denver Metro

Denver, Adams, Arapahoe, Broomfield, Douglas,
Jefferson, Clear Creek, and Gilpin Counties



NEEDS/GAPS

- Workforce: Shortages of providers, training including Medication Assisted Therapy (MAT), certifications, access to telehealth and mobile services
- Increased training in trauma-informed care and adverse childhood experiences
- Case or care management, system navigation
- Prevention
- Support for community transitions including peer supports, family/community reconnection, and nutrition
- Better information and data sharing
- Continuum of housing options
- Transportation to and from treatment- and recovery-oriented programs, including for veterans
- Detox services/facilities with a medical component
- Intensive outpatient services
- Connecting and convening the different sectors to develop a system of care
- Treatment within the criminal justice system
- Residential treatment (short-, mid-, and long-term) and transitional residential services

PRIORITIES *for* FUNDING

Continuum of housing options

Workforce: Shortages of providers, training including Medication Assisted Therapy (MAT), certifications, access to telehealth and mobile services

Residential treatment (short-, mid-, and long-term) and transitional residential services

Better information and data sharing

Detox services/facilities with a medical component

Treatment within the criminal justice system

Case or care management, system navigation

SUMMARY OF EXISTING REPORTS AND DATA: REGION 2

Projections of SUD service needs in Region 2 through 2025 are not significantly different than the state.¹ Substance abuse has been identified by county public health departments as a priority in Clear Creek,¹⁰ and by hospitals serving Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Jefferson, and Weld counties.^{17,20,21,22} Hospitals identified behavioral health and substance abuse as priorities due to substance-abuse related visits to the Emergency Department and admissions.^{20,22,23,24} One hospital in Denver reported that, of substance-related visits, alcohol accounted for the most hospital admissions and Emergency Department visits, followed by marijuana, then cocaine and opioids, and finally amphetamines.²⁴

Prevention

School- and family-based prevention services, including screenings, early intervention, and counseling, are needed. School-based services were identified as overtaxed, and in need of better integration with community and inpatient services.¹

Intervention

No available information was identified in this area.

Treatment

Community members believe more substance abuse treatment services are needed.^{17,25} A need for more residential and in-patient beds was identified, particularly for children, adolescents, and long-term patients.¹

Recovery

Recovery supports were cited as a system gap in Region 2, including the need for better discharge, transitional, and follow-up services; additional family support services; and better case management.¹

Continuum of Care

A need for a greater integration of primary care and behavioral health care was identified in Arapahoe, Broomfield, Douglas, and Jefferson counties. This integration was identified as a way to combat stigma associated with behavioral health issues such as substance abuse, to increase access to and completion of treatment, and improve the quality of treatment services.^{22,23,26} More generally, increased coordination and communication between service components was identified as an area of need.¹

Workforce

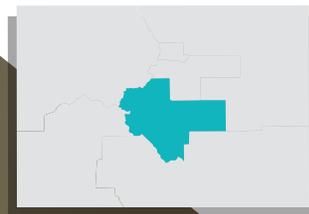
A greater number of behavioral health professionals, and substance abuse counselors in particular, was identified as a top need for Arapahoe, Adams, Douglas, Jefferson, Broomfield, and Denver counties.^{1,21,23,26} One potential identified cause for the shortage of behavioral health professionals was lower insurance reimbursement for mental health care and substance use versus physical health care, which prohibits investment in behavioral health services.²² Similarly, low funding and reimbursement for behavioral health services was identified as a major issue in Douglas county.²³

Cost

Increasing access to affordable or no-cost SUD services was identified by the community as a primary action needed to address substance abuse.^{1,25} Monetary barriers to access include coverage for those not on Medicaid and those without any insurance coverage.¹

Region 3 Central Colorado

El Paso, Teller, Park, Lake, Chaffee,
Fremont, and Custer Counties



NEEDS/GAPS

- Workforce: Access and capacity including telehealth/mobile services, retention, more training with co-occurring behavioral health issues, and certifications vary by payer
- Affordability of treatment
- Residential treatment (short-, mid-, and long-term)
- Intensive outpatient services
- Case or care management
- Better data: Cost/benefit of treatment, and cultural needs
- Public education and awareness
- Barriers related to internal regulations
- Siloed funding and administration at state and local levels
- Continuum of housing options
- Supportive transportation
- Prevention including early intervention and in schools
- Loss of mental health court (El Paso County)
- Transitional supports, especially for those transitioning from the criminal justice system
- Increased training in trauma-informed care
- More flexibility and nimbleness in state and local funds to better meet community needs
- Effective mental health services
- Detox services/facilities with a medical component

PRIORITIES *for* FUNDING

Residential treatment (short-, mid-, and long-term)

Detox services/facilities with a medical component

Continuum of housing options

Intensive outpatient services

Supportive transportation

More flexibility and nimbleness in state and local funds to better meet community needs

More affordable treatment options

Workforce: Retention and increased access, potentially through telehealth and mobile services (Teller, Park, Lake, Chaffee, Fremont, and Custer Counties)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 3

Projections of SUD service needs in Region 3 through 2025 are not significantly different than the state.¹ Substance abuse has been identified by county public health departments as a priority in Fremont, Lake, and Teller.¹⁰ Substance use among high school students was identified as a particular concern by community members in El Paso.²⁷

Prevention

There is a perceived need for more education, awareness, information about behavioral health, and resources to expand prevention services, especially for youth.^{1,28} However, in Chaffee County there is concern that the prevention services that do exist are targeted primarily to adolescents and families, and more is needed for the general population.²⁹

Intervention

There is a recognized need for more acute services, including crisis response, stabilization, and detox services in Region 3.¹

Treatment

Concerns about treatment in Region 3 primarily focus on access to existing sources. In Park and Chaffee counties, there are people who need treatment but do not ever receive it, despite the fact that treatment facilities often do not have a waiting list. This highlights that while general treatment services are available, not all take insurance, and there are not enough affordable options.²⁹

Recovery

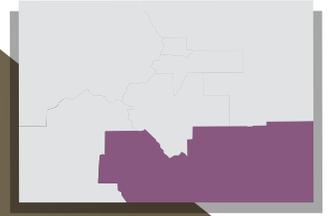
Identified recovery needs include sufficient follow-up, after-care, and transitional supports. Currently, there is inadequate transportation, supportive housing, and supports for reintegration after in-patient services.¹

Continuum of Care

Previous needs assessments have called for a systematic approach to prevention, intervention, and treatment that improves integration and coordination of services along the continuum of care to impact substance use issues in the region.^{28,29}

Region 4 Southeast Colorado

Pueblo, Crowley, Kiowa, Huerfano, Las Animas, Otero, Bent, Prowers, Baca, Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla Counties



NEEDS/GAPS

- Workforce: Access and capacity, certification requirements, retention, and training including Medication Assisted Therapy (MAT)
- Team-based care to address generational use
- Residential treatment (short-, mid-, and long-term)
- Transitional residential treatment
- Case or care management: Navigation and whole person care
- More flexibility and nimbleness in state and local funds to better meet community needs
- Better partnerships with law enforcement, including awareness of community resources
- Transitional services for those leaving the criminal justice system
- Continuum of housing options
- Supportive transportation
- Detox services/facilities with a medical component
- More coordination among state and local agencies related to funding, communication, and administration
- Lack of resources for those with co-occurring mental health and substance use disorders
- Prevention: Trauma-informed care, adverse childhood experiences, informed consumers, stigma, early intervention, addressing normalization of use
- Public education and awareness, personal motivation
- Intensive outpatient services, including sustainable rural options

PRIORITIES for FUNDING

Residential treatment (short-, mid-, and long-term)

Supportive transportation

Transitional residential treatment

Continuum of housing options

Resources for those with co-occurring mental health and substance use disorders

More flexibility and nimbleness in state and local funds to better meet community needs

Detox services/facilities with a medical component

Prevention

Workforce: Access and capacity, certification requirements, retention, and training including Medication Assisted Therapy (MAT)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 4

Currently, Region 4 has the highest penetration rates for substance use services (i.e., proportion of individuals who need a service and subsequently receive it). If service provision remains stable, the region will continue to have the highest penetration rates through 2025.¹ Substance abuse has been identified by county public health departments as a priority in Alamosa, Las Animas, and Huerfano counties¹⁰ and by a hospital in Pueblo county.³⁰ In Pueblo County, mental health hospitalizations (often including co-morbid substance abuse) are double the state rate, and limited availability of and access to services is a concern.^{1,30} Moreover, the opioid epidemic is particularly acute in this area of the state, with the southeast region leading the state on rates of opioid- and heroin-related poisoning deaths,³¹ emergency department visits,³² and treatment admissions.³³

Prevention

Evidence suggests that there are insufficient prevention services in Region 4. A higher percentage of individuals reported seeking prevention resources in Region 4 (46 percent) than statewide (32 percent), and individuals in Region 4 were less likely to be successful in finding prevention services (68 percent) compared to the rest of the state (85 percent).³⁴ Action areas for many communities in the region fall under the umbrella of prevention, including reducing rates of use across many substances, and postponing age of initiation.³⁵

Intervention

Acute services, including crisis stabilization and detox services, were identified as a key area of need by community members.¹

Treatment

Treatment services for co-occurring mental health and substance use were identified as a particular area of need.¹

Recovery

Identified areas of need for recovery included transportation, housing, and transitional and community integration supports.¹

Continuum of Care

The need for greater integration of primary and behavioral health care was identified, with the possibility that such an integration may lead to decreased stigma for behavioral health care, and thus improved treatment.³⁰

Cost

Better insurance reimbursement policies for behavioral health services are needed; low funding and low reimbursement rates for behavioral health services are considered major issues.³⁰

Workforce

Substance use service agencies are understaffed, and there is a workforce shortage in Region 4 that highlights the need for more mental and behavioral health professionals.^{1,30}

Region 5 Southwest Colorado

Archuleta, La Plata, Montezuma, Dolores, San Miguel, San Juan, Ouray, Hinsdale, Gunnison, Montrose, and Delta Counties



NEEDS/GAPS

- Workforce: Shortages of providers, high turnover rates, certification requirements, increased training in medication assistance, and access to telehealth and mobile services
- Increased training in evidence-based and trauma-informed care
- Case or care management, including to assist with transitions
- More flexibility in state and local funds to better meet community needs
- Creating sustainability in rural communities
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Residential treatment
- Intensive outpatient services
- Prevention, including early intervention
- Detox services/facilities with a medical component
- Addressing the festival culture
- Better access to care that reflects the culture of the region

PRIORITIES for FUNDING

Creating sustainability in rural communities

Detox services/facilities with a medical component

Residential treatment

Case or care management, including to assist with transitions

Continuum of housing options

Transportation to and from treatment and recovery-oriented programs

Workforce: Shortages, increased training in medication assistance, and access to telehealth and mobile services

More flexibility in state and local funds to better meet community needs

SUMMARY OF EXISTING REPORTS AND DATA: REGION 5

Currently, Region 5 has among the lowest penetration rates for substance use services; if service provision remains stable, the region will continue to have the lowest penetration rates through 2025 (along with Region 6).¹ Substance abuse has been identified by the West Central Public Health Partnership, which serves Delta, Gunnison, Montrose, Hinsdale, Ouray, and San Miguel counties,¹⁰ and by hospitals in La Plata, Archuleta, and Montrose counties.^{36,37} The high number of behavioral health patients served in Emergency Departments, and the high number of arrests/incarceration of individuals with substance abuse problems are concerns in the region.^{36,38} Illicit drug use among adults is a particular concern.³⁸ In Montezuma and Dolores counties, mental health and substance use emerged as a top priority, but the County Health Departments determined that they had limited capacity to impact these issues.³⁹ Likewise, the West Central Partnership health department not only recognized that substance use is consistently identified as a top issue in their communities, but also indicated that there was limited ability to accurately assess substance use issues in the region, and therefore limited capacity to effectively target them.³⁸

Prevention

Parent reports of youth substance use indicate a high level of need for youth prevention services.³⁴

Intervention

There is a recognized need for acute intensive services, including crisis stabilization and detox centers.^{1,38}

Treatment

The capacity for treatment services does not match the need in the Region.^{1,38} Of particular concern is the need for inpatient facilities.¹ The region has the lowest reported success rate for finding treatment services; only 53 percent who sought services could successfully find them, compared to a 65 percent success rate statewide.³⁴

Recovery

No available information was identified in this area.

Continuum of Care

The lack of integration between physical and behavioral health care is a concern.³⁶

Workforce

Workforce issues include not enough staff, high turnover rates, and the need for culturally and linguistically competent substance abuse providers.^{1,38}

Region 6 Northwest Colorado

Mesa, Garfield, Rio Blanco, Moffatt, Routt, Eagle, Pitkin,
Summit, Grand, and Jackson Counties



NEEDS/GAPS

- Workforce: Shortages, low salaries, and high turnover rates
- Increased training in trauma-informed care
- Case or care management
- Better information and data sharing
- More flexibility in state and local funds to better meet community needs
- Crisis service alternatives and stabilization
- Creating sustainability in rural communities
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Affordability of treatment
- Residential treatment
- Intensive outpatient services
- Prevention, including early intervention
- Detox services/facilities with a medical component
- Systems for high utilizers

PRIORITIES *for* FUNDING

Workforce: Shortages, low salaries, and high turnover rates

Detox services/facilities with a medical component

Crisis service alternatives and stabilization

Residential treatment

More affordable treatment

Better information and data sharing

Intensive outpatient services

Systems for high utilizers

SUMMARY OF EXISTING REPORTS AND DATA: REGION 6

Currently, Region 6 has among the lowest penetration rates for substance use services; if service provision remains stable, the region will continue to have the lowest penetration rates through 2025 (along with Region 5).¹ Substance abuse has been identified by county public health departments as a priority in Eagle, Grand, Pitkin, Routt, Mesa, Moffat, and Summit counties,^{10,40,41} and by hospitals in Garfield and Summit counties.^{42,43}

Prevention

No available information was identified in this area.

Intervention

There is a recognized need for acute intensive services, including crisis stabilization and detox centers.¹

Treatment

Greater availability of local treatment services, and in particular inpatient substance abuse treatment, is a recognized need.^{1,44}

Recovery

Not all towns have supportive recovery programs, such as Wayfinder, Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon.⁴⁴

Continuum of Care

There is need for greater integration between physical and behavioral health care.⁴³

Workforce

Workforce issues include the need for more mental and behavioral health professionals, and high turnover rates among the workforce.^{1,43} The need for an increased number of substance abuse counselors was identified as a top need in Garfield county in particular.⁴² There is also an identified need for more Spanish-speaking providers.⁴³

Cost

Low funding and low reimbursement rates for behavioral health services are considered major issues,⁴³ along with lack of access to affordable options for SUD services in the region. For example, although there are several counseling centers and multiple private practice counselors who provide outpatient therapy related to substance abuse and addiction in Eagle County, very few of them accept Medicare, Medicaid, have a sliding-scale fee structure, or provide charity care.⁴⁴ Treatment in Summit County is identified as being expensive, in part because many are underinsured.⁴⁵ In Grand County, there are a limited number of affordable substance abuse counseling services available.⁴⁶

Region 7 Boulder

Boulder County



NEEDS/GAPS

- Workforce: Shortage of providers, training in medication assistance, and certification requirements
- Treatment within the criminal justice system
- Transitional programs and services, including people leaving criminal justice system
- Focus on harm reduction
- Case or care management, system navigation
- Prevention: SBIRT, stigma, early intervention, and screening
- Detox services/facilities with a medical component
- Better information and data sharing
- Continuum of residential treatment (short-, mid-, and long- term) and transitional residential services
- More flexibility and nimbleness in state and local funds to better meet community needs
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Workforce development programs
- Crisis stabilization services available 24/7
- Public education, communication, partnerships (including faith community) to increase awareness of resources available
- Agency alignment of funding, administration, and rules

PRIORITIES for FUNDING

Detox services/facilities with a medical component

More flexibility and nimbleness in state and local funds to better meet community needs

Prevention

Transitional programs and services, including people leaving criminal justice system

Public education, communication, and partnerships (including faith community) to increase awareness of resources available

Better information and data sharing

Continuum of housing options

Focus on harm reduction

SUMMARY OF EXISTING REPORTS AND DATA: REGION 7

Projections of SUD service needs in Region 7 through 2025 are not significantly different than the state.¹ Substance abuse has been identified by the county public health department and hospitals in Boulder county as a priority.^{10,21,47} In Longmont, the emergency room often serves as the primary access point for behavioral health issues. In addition, substance abuse is the leading cause of inpatient admission in the Emergency Department for patients ages 35-49, and alcohol/substance abuse is the second highest diagnosis for patients ages 35-49 (25 percent) and ages 50-64 (19 percent).¹⁹ The need for expanded, improved, accessible, and timely SUD services is recognized.^{25,47}

Prevention

Prevention was identified as a key priority for tackling SUD issues in Region 7. Areas of concern include reducing substance use, improving early detection and health promotion by reducing the stigma of SUD/behavioral health issues, increasing counseling and prevention programs in schools, teaching coping and stress reduction skills during childhood, and increasing housing support programs to decrease homelessness.^{47,48}

Intervention

No available information was identified in this area.

Treatment

There is a recognized need for additional inpatient services.⁴⁷

Recovery

No available information was identified in this area.

Continuum of Care

There are identified challenges in Region 7 with core coordination of SUD services. Issues that have been identified include high incarceration rates when SUD treatment is more appropriate, challenges in capacity for first responders to assess for SUD issues and make appropriate referrals, and lack of systematic process to connect those with acute issues to appropriate services. A lack of integration of SUD services with primary care has also been identified as an area of concern.⁴⁷

Workforce

Workforce concerns include a lack of doctors, substance abuse counselors, and other providers to meet need for treatment.^{21,47} There is also a shortage of specialized providers in the region.⁴⁷

Cost

The costs of SUD services in Region 7 are seen as high, and there is a need for more affordable options when insurance coverage is insufficient.⁴⁷

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

Population-Specific Feedback

The legislation also directed the MSOs to assess needs for five specific populations:

- Adolescents (ages 17 and younger)
- Young adults (ages 18-25)
- Pregnant women
- Women who are postpartum and parenting
- Other adults in need of SUD services

In the stakeholder interviews, community meetings, and final stakeholder surveys, Keystone asked about needs and gaps related to these specific populations. While stakeholders in all regions agreed that some of the populations identified in the legislation and other specific populations needed targeting — and that there can be unique needs and gaps associated with these populations — they expressed frustration that funding is often targeted to certain populations. For instance, stakeholders rarely expressed concern about gaps for pregnant women, because pregnant women are often a target population for community health efforts; in contrast, it can be hard to access funding for single adult men because they do not fit within a target population, though their SUD service needs may be great. Stakeholders emphasized that when it comes to substance use services, every population is underserved.

While acknowledging the challenges that can impact certain populations, stakeholders in all regions strongly encouraged the MSOs to avoid tying funding to specific populations or restricting the scope of funding as that limits a community's ability to target its resources in the way that is right for their community. To the extent possible, stakeholders asked that funding remain flexible at the community level.

Still, stakeholders did identify needs and gaps specific to populations, and identified populations within or in addition to those specified in the legislation that should be carefully considered as MSOs determine how to use their funds. Below, Keystone has summarized the population-related feedback statewide, with outlying regional perspectives identified.

Adolescents

Stakeholders identified several specific gaps and needs for adolescent SUD services:

- ***Prevention, education, and early intervention, especially in schools:*** Stakeholders in every region discussed the importance of prevention, education, and early intervention for adolescents. They particularly called for more resources in schools, including School-Based Health Centers, case managers, school/provider linkages, and mental health teams in school districts. Stakeholders also discussed the importance of identifying high-risk youth, such as individuals in the child welfare system, the children of parents with SUDs, individuals with a history of juvenile delinquency, victims of human trafficking, adolescents who have dropped out of high school, and pregnant teens. For effective prevention, stakeholders called for better social supports and access to extracurricular activities, especially for low-income populations and in rural areas. They also discussed the importance of education to counter the normalization of substance abuse and ease of access to substances.

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

- **Access to a comprehensive system of care, with programs that are geared towards (or at least accept) adolescents:** Statewide, stakeholders called for access to treatment options across the continuum so that adolescents have access to the specific care they need. This includes access to detox; a range of inpatient treatment options; outpatient treatment; residential care; longer-term sober living and supportive housing; and in-home providers for multi-generational substance use. Stakeholders also emphasized the importance of supportive services like transportation, housing, mentoring, positive peer support, and family education and support.
- **Coordination with the criminal justice system:** Stakeholders called for better coordination between substance abuse treatment and the criminal justice system, noting that many services are only available for youth who have been in the criminal justice system, and adolescents should not have to move deeper into the system than warranted (by their risk level) to receive treatment.

Stakeholders also identified priority groups within the adolescent population:

- **Adolescents with co-occurring disorders:** In Region 3, stakeholders called for mobile mental health services for all counties, detox that accounts for co-occurring disorders, and substance abuse-informed psychiatric care. Stakeholders in Region 4 cited the importance of prevention and support for the children of addicts, who are likely to have multiple mental health diagnoses from enduring multi-level trauma, including exposure to drug use, domestic violence, and sexual abuse within the home. Regions 1 and 6 also identified adolescents with co-occurring disorders as a priority population.
- **LGBTQ adolescents:** Regions 1 and 3 called for more services for LGBTQ youth, who typically have higher rates of both substance use and mental illness and need targeted and inclusive services.

Young Adults

Stakeholders did not focus on young adults in most of the interviews and statewide meetings, but in survey responses, they were clear that the young adult population — as with all populations — is underserved and could use more funding, especially for young adults with co-occurring disorders. More services are available to the young adult population than other populations, but services are still lacking across the continuum of care, including additional supportive services such as better education, employment, housing, and peer support. Stakeholders in Region 1 noted that Colorado State University offers a comprehensive and evidence-based treatment program for students in this demographic.

Pregnant Women and Women Who Are Postpartum and Parenting

Statewide, stakeholders observed that because pregnant, postpartum, and parenting women are a target population, they receive more money and services than other populations. Still, they noted that this population — as with all populations — is underserved. In particular, stakeholders called for better screening and treatment for perinatal depression and other mental health issues. They also said the stigma and guilt surrounding pregnant women or mothers with SUD can lead to fear of seeking treatment. In Region 5, stakeholders called for more transitional housing for pregnant and parenting women. Additionally, stakeholders mentioned the importance of the provision of child care during treatment times.

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

Other Adults in Need of Substance Use Disorder Services

Stakeholders identified many additional populations in need of SUD services:

- **Individuals with Co-Occurring Disorders:** Stakeholders emphasized the importance of treating individuals with co-occurring mental illness, from mild to moderate depression to more acute diagnoses. Many stakeholders were frustrated that patients with co-occurring disorders are denied mental health treatment if they are using drugs or alcohol but cannot stop using until an underlying mental illness is addressed, leaving them with no options for treatment.
- **Individuals with Comorbidity or Other Diagnoses:** Stakeholders also called for special care to be taken for patients with chronic pain, developmental or intellectual disabilities, and HIV.
- **Seniors:** Stakeholders in Regions 1 through 6 said that older adults (65 and older) are underserved and have unique challenges to consider, including isolation, stigma, access challenges, and comorbidity (especially with conditions like mental illness, reduced motor and memory function, Alzheimer's, and dementia) that make it harder for older adults to get treatment. The workforce, especially in assisted living facilities and nursing homes, needs to be better trained to work with this population.
- **Uninsured or underinsured populations:** Across the state, stakeholders bemoaned the lack of services for the uninsured or underinsured working poor and middle class who do not qualify for assistance but cannot afford insurance or the co-pays and deductibles required by their insurance. Stakeholders also observed that with capitated services, low-income adults may lose benefits before developing the resources for long-term sobriety. In Region 6, stakeholders expressed concern that certain service providers, like home health agencies, may discharge clients with SUDs because of safety concerns.
- **Homeless population:** Stakeholders called for more services for the homeless and transient population, especially homeless individuals dealing with co-occurring disorders. They encouraged shelters to be better equipped with medications like Suboxone and Narcan, as well as recovery supports. Stakeholders in Region 7 supported a Housing First model for treatment, focusing on providing homeless individuals with housing and then addressing their SUD needs.
- **Veterans and Active Military:** Stakeholders in Regions 2, 3, 4, 5, and 7 said that the veteran and active military populations are underserved, especially when it comes to co-occurring mental health disorders. They called for trauma-informed care that recognizes veterans' brain trauma and post-traumatic stress disorder may drive substance use. These stakeholders noted that while the Department of Veterans Affairs makes some substance use treatments available to veterans, patients may not be able to access the full continuum of care or may be resistant to seeking services within the Department. Stakeholders called for better education of veterans on the options available to them, along with more flexibility so that veterans can take advantage of community services.
- **Incarcerated or criminal justice-involved population:** Stakeholders in Regions 1 through 6 emphasized the importance of offering SUD services in jails and prisons, including medication-assisted treatment, especially for inmates with co-occurring disorders. Stakeholders also called for services in the transition out of jail or prison; rates of relapse are high among recently released inmates, and

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

patients need ongoing care and supportive services that may not be available or covered due to lapses between when they are released from jail or prison and when they are eligible for Medicaid. Additionally, stakeholders in Regions 2, 3, and 6 noted challenges for patients with criminal records, especially sex offenders, who may not be allowed in many treatment programs or SUD-providing housing facilities.

- ***Non-English speaking, immigrant, and refugee populations:*** Regions 1 through 6 called for improved services for these populations, including more bilingual and bicultural providers and services, as well as funding and training for cultural competency.
- ***Minorities:*** Stakeholders in Regions 2, 3, 5, and 6 said that minority populations, including ethnic and racial minorities and the LGBTQ population, are underserved. In Regions 2 and 5, stakeholders called for culturally specific treatment, including peer support and traditional healing methods for tribal populations.
- ***Families:*** Across the state, stakeholders called for better access to services for families as a unit, such as supportive housing that allows children; treatment that addresses multi-generational use; social supports like affordable preschool and childcare; resources and social supports for family members who may be caring for children whose parents have SUD; and education, support, and services for families when an individual with SUD is reintegrating into their community.
- ***Individuals with a history of trauma:*** Stakeholders in Regions 1 and 5 called for improved trauma-informed care for victims of domestic violence (especially women) and others.
- ***Adult women:*** Stakeholders in Regions 1, 2, 4, and 6 noted that single adult women are not usually a target population and thus lack gender-specific services for addiction or mental health. Stakeholders called for more sober housing and vocational training for women (including single mothers).
- ***Adult men:*** In Regions 1, 2, and 7, stakeholders observed that adult men are not usually a target population and thus may have trouble accessing treatment and support services. In Region 1, stakeholders expressed concern for the adult male population at risk for suicide and blue collar men working in construction, oil, and mining.
- ***Tourists:*** Stakeholders in Region 5 cited challenges related to tourists and festival culture that may not share the community's values and may be focused on using substances as part of their tourist experience, not considering or caring about the impact on the community. They encouraged a tourist education program.

Effective Community Strategies

Keystone interviewed stakeholders about the SUD services that are working well both within the state and across the country. Using feedback from those interviews, as well as comments from the statewide meetings and email surveys, Keystone identified the following programs and practices that stakeholders believe are working well to address SUD.

Coordination across agencies and organizations providing SUD services: Across the state, stakeholders expressed the need for coordination of care in all forms, including fully integrated care models; collaboration among state agencies that address substance use; warm referrals between providers; and coordinated transitions among facilities and levels of treatment. In cases where care is not systematically coordinated,

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

stakeholders identified value in care coordinators or navigators, a role that can be served by a peer or a medical professional. They cited several specific examples, including: West Pines Behavioral Health, which offers a continuum of services including psychiatric services, therapy, family involvement, exercise, medication management, and peer support (Region 2); Douglas County's multi-faceted crisis stabilization teams (Region 3); Summit County's early intervention case managers (Region 6); Cherokee Health Systems' integrated care model (Tennessee); and Medicaid's Health Homes (Section 2703), which provides a comprehensive system of care coordination for individuals with chronic conditions

Partnerships with law enforcement and judicial system: Stakeholders in regions with drug courts, problem-solving courts, and/or DUI courts said these courts are valuable, as are partnerships with law enforcement. Mental Health Partners' (Region 7) Project EDGE, for instance, offers an alternative to incarceration for individuals with behavioral health conditions, an evidence-based program that works with police officers to provide crisis support and links to supportive services.

Evidence-based care: Stakeholders encouraged the use of a wide range of evidence-based treatment options, including medication-assisted treatment (especially for detox) and harm-reduction models. For example, Colorado Coalition for the Homeless' Stout Street Health Center has a culturally competent staff trained to offer Suboxone when needed. Seattle's Law Enforcement Assisted Diversion (LEAD) program uses a harm reduction model to offer community-based treatment and support services for individuals engaged in low-level drug crimes.

Hot-spotting: Stakeholders in Regions 2, 3, and 6 found hot-spotting to be a useful tool for identifying and treating frequent utilizers. In Region 6, a pilot program funding a full-time case manager to identify and follow up with frequent utilizers resulted in a 45 percent engagement rate for treatment.

Peer support: Stakeholders encouraged better use of peer support, including the use of peer specialists to encourage follow-up and assist with navigation of care options.

Family involvement in care: Stakeholders pointed to Shields for Families in California and the Recovery Village in Florida as excellent examples of comprehensive care that involve the patient's family in treatment. Boulder (Region 7) has also seen success with a program called Genesister, which works with the siblings of pregnant youth to prevent teen pregnancy, which could be adapted to focus on the siblings of individuals with SUD.

Community involvement in care: Stakeholders in Region 3, 5, and 7 found value in community involvement in education, early intervention, and treatment. In July 2016, El Paso County (Region 3) directed grant funding to using the Communities That Care model, which mobilizes a community to identify prevention priorities, and choose and implement effective programs, policies, and strategies to address those concerns. A recent study showed that youth in these communities were up to one-third less likely to have health and behavior problems than youth in communities without these services.

Telehealth or mobile services: Rural communities face challenges in accessing substance abuse treatment services given workforce shortages. Some promising advancements in the delivery of rural health care services have been made in technology. Telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination. These applications have the potential to reduce the disparities in the delivery of SUD services in rural and frontier communities as well as for under-

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

served communities, individuals with mobility issues, and in the provision of specialty care that is not widely available.

National organization resources and guidance: Several stakeholders commended best practices and resources available through the Substance Abuse and Mental Health Services Administration. Stakeholders also pointed to the Centers for Disease Control and Prevention, National Association of County and City Health Officials, and the National Institute on Drug Abuse.

CONCLUSION

It is time to change how Colorado addresses SUDs. The benefits of substance abuse treatment are well established. Numerous studies have demonstrated the positive effect of prevention, intervention, treatment, and recovery support services on reducing substance use and improving health status and social functioning. Yet most Colorado's SUD dollars are spent on acute services (ED visits, etc.) rather than on evidence-based practice.

SUD treatment is not a one-size-fits-all service or one that remains static over time for a participant. This speaks to the importance of integrating, and funding a continuum care for SUD in Colorado communities. This separation of SUD treatment from the rest of health care — both primary care and mental health care — has created challenges and barriers for those seeking care.

These identified priorities in the seven MSO regions will become the basis for action plans to address local needs in a sustainable and flexible way. Additionally, it should drive new funding allocations and inform the mechanisms by which funding should be provided. Every dollar spent on appropriate SUD treatment saves \$4 in medical costs and \$7 in criminal justice.

At the same time, it will be important for the state to continue to provide leadership, guidance, and vision on improving the health of Coloradans by improving public education and awareness of SUDs; providing incentives, funding, and assistance to promote implementation of effective prevention, treatment, and recovery practices, policies, and programs; addressing legislative and reducing regulatory barriers; and improving coordination between health care, human services, and criminal justice agencies and organizations.

The priorities and scope of this report are intended to help support the goals and vision of the State, its partnership with its community stakeholders and providers, towards the vision of healthier Colorado.

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APPENDIX A: METHODOLOGY

Data were gathered from primary and secondary sources. The methodology for each approach is outlined below.

Primary Data Gathering

Keystone gathered qualitative input from stakeholders for this SUD report through key informant interviews, statewide meetings and an email survey. The stakeholders solicited for input included, but were not limited to, representatives from community mental health providers, SUD treatment providers, primary care providers, hospital representatives, health and human services, public health, state agencies, law enforcement, probation, problem-solving courts, first responders, veteran-serving organizations, homeless population-serving organizations, non-profits, school/education representatives, and elected officials. Keystone used the feedback from the interviews to frame the statewide meetings and used the feedback from the interviews and meetings to inform the survey, but always provided space for stakeholders to offer their thoughts on needs, gaps, and priorities not previously identified.

Key Informant Interviews

Keystone performed 40 interviews with key stakeholders from each MSO region, as identified by MSO representatives from that region. Keystone conducted the 30-minute interviews by phone and used the following template to guide the discussion:

What is your perception of substance use disorder services and resources (for prevention, intervention, and/or treatment) provided in your region?

- a. What are the gaps/biggest needs in your region?
- b. What programs/resources have been working well to address substance use issues?
- c. What programs/resources could use improvement? What kind of improvement is needed?

What resources/ services do you have available to provide substance abuse services in your region for the following populations called out in Senate Bill 16-202, and where are the gaps?

- a. Adolescents (ages 17 and younger)
- b. Young adults (ages 18-25)
- c. Pregnant women
- d. Women who are postpartum and parenting
- e. Other adults in need of substance use disorder services

In your opinion, what are the biggest needs/ priorities to you in your role? With an increase in funding, where would you direct resources (prevention/intervention/treatment or specific programs/ existing efforts or specific population)?

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What do you believe are the underlying causes for substance abuse in your areas?

Are there other Substance Use Disorder programs that you turn to for examples of best practices?

Is there anything else you would like to include to ensure we consider for this assessment?

Statewide Meetings

Over a two-week period, Keystone held meetings throughout Colorado in each of the MSO regions, with multiple meetings in some of the regions, to solicit additional feedback from representatives from various fields that deal with substance abuse. During the meetings, attendees participated in round table discussions on the most pressing needs in their region related to substance use disorder treatment, including what areas needed the most improvement, where there were gaps in providing services, and what programs that are working well. Keystone also asked participants about areas of need for specific populations affected by substance abuse. At the end of each meeting, Keystone polled participants on the priority needs and gaps for their region, as well as priorities for specific populations.

Approximately 250 stakeholders attended the 10 meetings; attendance per meeting is indicated in parentheses:

Region 1: Fort Collins (18) and Sterling (9)

Region 2: Denver (32)

Region 3: Colorado Springs (27) and Woodland Park (16)

Region 4: Pueblo (22) and La Junta (19)

Region 5: Durango (34) and Montrose (14)

Region 6: Grand Junction (24)

Region 7: Boulder (36)

Email Survey

Finally, additional stakeholders were asked to provide feedback through an email survey. Keystone tailored the surveys to each MSO region based on the needs and gaps that were identified in each region through the key informant interviews and statewide meetings. Respondents identified what they believed were the biggest needs and gaps related to SUD treatment in their region, ranked their top priorities towards which to direct resources with an increase in funding, and identified populations with the biggest needs for substance abuse treatment.

Over 500 stakeholders participated in the survey; respondents per region are indicated below:

Region 1: 36

Region 2: 101

Region 3: 93

Region 4: 153

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Region 5: 28

Region 6: 96

Region 7: 18

Secondary Data Gathering

Additionally, existing sources of information regarding the needs and priorities for SUD services in Colorado were reviewed and synthesized. A search for relevant reports and databases was conducted, and 74 relevant sources were identified. Many of these sources included documentation from previous stakeholder feedback, gathered at other times prior to the beginning of SB202's community assessment. Coupling empirical data sources with previously acquired stakeholder feedback ensured a level of continuity of previous efforts.

After review, 44 sources contributed to the report. Identified resources included Community Health Needs Assessments conducted by public health departments and non-profit hospitals in Colorado, needs assessments conducted by other non-profit organizations, reports funded through or conducted by state agencies (e.g., Office of Behavioral Health, Colorado Department of Public Health and Environment), statistics collected through survey efforts (e.g., National Survey on Drug Use and Health), and a database of SUD services maintained by the Colorado Department of Human Services (www.linkincare.org). High-level themes regarding prevalence, identified areas of need, and key populations were extracted from these sources and compiled. Statewide and regional findings are reported; county-level information was compiled into MSO regions. In cases where references included information that could not be distinguished between counties in two (or more) regions, the information was captured in all relevant regional breakdowns (e.g., information from a community health needs assessment for a hospital that serves Boulder and Broomfield counties, and did not distinguish between them, was reported in the sections for Region 2 and Region 7).

Colorado’s Substance Use Disorder Services: Levels of Care Continuum

Levels of Care

The American Society of Addiction Medicine (ASAM) Criteria is the most commonly used resource nationally to help determine levels and need for consumers with addictions and co-occurring disorders.

In Colorado, providers utilizing public funds must use the ASAM criteria to make placement decisions. Based on a structured assessment of needs, clinicians can determine level of care along a continuum:



Property of the American Society of Addiction Medicine

Funding the Continuum

Colorado’s behavioral health system depends on a broad of funding to ensure every community has access to needed services. Several funding sources focus on specific sets of services and populations:

❖ Colorado General Fund Allocations & Local Funding:

Beyond the specific programs created by legislation, Colorado uses general fund allocations and local funding sources to target the gaps in the continuum which aren’t otherwise paid for including certain residential or inpatient programs. State and local funding are the largest payors for SUD services. One of the most notable areas is from legislation passed in 2016 by the Colorado legislature entitled, “Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)”

❖ **Medicaid Funding:**

Medicaid members in Colorado can use their coverage to pay for outpatient services including MAT, treatment and more under the behavioral health capitation program. The physical health Medicaid benefit covers some inpatient levels of care as well screening and referral services (SBIRT).

❖ **Federal Block Grant Funding:**

Colorado manages the federal block grant allocation from SAMHSA to cover a wide range of services in the continuum, including intervention efforts as well as inpatient and residential. Twenty percent of all federal block grant dollars must be spent on prevention across the state.

Regional Varieties

In Colorado, geographic and socioeconomic differences make access to various services differ from community to community. A recent community assessment of SUD services and needs, commissioned by previously mentioned SB16-202, allowed a deeper understanding of the regional variances within Colorado’s SUD services continuum. The survey outlined several types of modalities and service types across the continuum:

- (1) prevention and early intervention;
- (2) withdrawal management/detox;
- (3) residential treatment providers;
- (4) outpatient service providers;
- (5) medication assisted treatment; and
- (6) recovery services.

Colorado’s Managed Service Organizations managed the state funding for the SUD services continuum on a regional basis. This study was helpful in highlighting the most urgent needs, or gaps in the continuum, per region:

Region 1: Northeast Colorado

- Residential Services
- Withdrawal Management Services
- Geographically Accessible Rural Detox/Withdrawal Management
- Geographically Accessible Rural Outpatient
- Treatment transitions to Recovery
- Supportive Housing Services
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention
- Outreach
- Case or care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women’s specific care)
- SUD Integration with, and Education for, Primary Care
- Opioid and other drug/alcohol crisis management

Region 2: Denver Metro and Gilpin/Clear Creek

- Residential Services
- Withdrawal Management Services
- Treatment transitions to Recovery
- Supportive Housing Service
- Workforce Sufficiency and Capability/Competency

- MAT Expansion and Education
- Prevention
- Outreach, Case/care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)

- Integration with and Education for Primary Care
- Opioid and other drug/alcohol crisis management

Region 3: Colorado Springs Area and Central Colorado

- Withdrawal Management Services
- Residential Services
- Sustaining and Expanding Supportive Housing Services
- Transportation to and from treatment and recovery-oriented programs
- Workforce: retention and training
- Treatment transitions to recovery

- MAT Expansion and Education
- Prevention Options
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- Opioid and other drug/alcohol crisis management

Region 4: Southeast Colorado and the San Luis Valley

- Residential Services
- Withdrawal Management Services
- Geographically Accessible Rural Withdrawal Management
- Geographically Accessible Rural Outpatient
- Treatment transitions to Recovery
- Supportive housing service options
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention

- Outreach
- Case or care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- Integration with and Education for Primary Care
- Opioid and other drug/alcohol crisis management

Regions 5 & 6: Western Slope

- Sustaining and Expanding integrated withdrawal management and respite care
- Jail-Based Services

- Services to Homeless individuals
- Sustaining and Expanding Residential Treatment

Region 7: Boulder

- Residential Services
- Detox Withdrawal Management Services
- Treatment transitions to Recovery
- Supportive Housing Services
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention

- Case or care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- SUD Integration with, and Education for, Primary Care
- Opioid and other drug/alcohol crisis management

Increase Investment in Substance Use Disorder (SUD) Services

Action Taken: *House amendment to the Long Bill passed which increased the SB-202 line-item by \$6M (total \$12M) to expand access to SUD services based on regional need.*

Managed Service Organization (MSO) Community Assessment Planning

In February 2017, Colorado's MSOs released [*Bridging the Divide: Addressing Colorado's Substance Use Disorder Needs*](#), a needs assessment authorized by the Colorado legislature in 2016 with SB-202. The report includes findings from extensive stakeholder feedback in conjunction with a review of existing research. At the MSO regional level, the report aims to identify what is working well, clarify remaining needs and service gaps, and articulate how to best allocate additional funding for SUD services.

Regional Action Plans

As part of the SB-202 report, the MSOs worked with SUD providers in their networks to identify priority needs in regional action plans. Common themes emerged from every region:

- ❖ **Support and Expand Residential Treatment Services.**
 - Across every region of the state, communities identified residential services as a gap in available services. While cost structures and program design vary by region, this service is a critical gap in the continuum and requires sufficient funding to appropriately meet community need.
- ❖ **Expand Access to Detox & Withdrawal Management Services.**
 - Throughout the report, rural detox was noted as an urgent need. Individuals in need of these services may travel far, enter inappropriate settings (e.g. the criminal justice system or hospital emergency department), or find no help at all. Across the state, diverse stakeholders agree that access to the full continuum of detox services is necessary to promote best clinical outcomes and control costs.
- ❖ **Increase Access to Outpatient, School, and Cross-Systems Services.**
 - Across the state, and especially in rural and frontier communities, outpatient and early interventions are the most commonly needed SUD services. Providers need significant support to sustain clinics and programs that provide a wide continuum of treatment options which promote population health, save lives, reduce medical expenses, and return individuals to productive work and their communities.
- ❖ **Target Opioid Epidemic Interventions**
 - The report highlighted areas of Colorado where the opioid epidemic is particularly acute. Significant additional support is needed to sustain and expand life-saving services in Colorado communities.
- ❖ **Promote and Expand Access to Recovery Services**
 - To ensure that Colorado's investment in SUD services achieves potential, additional funding is needed to provide resources and supports that promote recovery and that help providers achieve the best outcomes for all Coloradans (e.g. workforce development and ensuring necessary service coordination and case management).

SB202 MSO Community Action Plan

FOR STATE YEARS 2016-2018



SIGNAL BEHAVIORAL HEALTH NETWORK

6130 GREENWOOD PLAZA BLVD, #150, GREENWOOD VILLAGE, CO 80111

About Signal Behavioral Health Network

Signal Behavioral Health Network (Signal), is one of Colorado's Managed Service Organizations. Signal is responsible for providing a continuum of substance use disorder (SUD) services in three regions on behalf of the State of Colorado. Additionally, Signal seeks to ensure a consistent level of quality and ensure compliance with State and Federal requirements relating to services offered. Signal may choose to deliver these services by subcontracting with local providers who demonstrate competency, compliance with quality standards, and positive outcomes.

The regional map for Managed Service Organizations is known as Sub-State Planning Areas (SSPAs). There are seven SSPAs in Colorado:

- SSPA 1: Northeast Colorado (Signal)
- SSPA 2: Metro Denver (Signal)
- SSPA 3: Colorado Springs Area
- SSPA 4: Southeastern Colorado including San Luis Valley (Signal)
- SSPA 5: Northern Western Slope
- SSPA 6: Southern Western Slope
- SSPA 7: Boulder

Signal is responsible for providing services in three of these seven regions (Northeast Colorado, Metro Denver, and Southeastern Colorado including San Luis Valley).

About the Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)

During the 2016 Colorado Legislative Session, the Increasing Access to Effective Substance Use Disorder Services Act was passed, directing and empowering Colorado's Substance Use Disorder Managed Service Organizations to perform several tasks:

- 1) Conduct a statewide needs assessment reviewing and identifying gaps in SUD services, including issues with capacity, access, and sustainability
- 2) Develop and refine community action plans, with intentions around addressing as many areas of priority as possible
- 3) Direct coordination, strategy, and funding towards as many of these areas as possible

The needs assessment is a previously completed reporting, outlining community feedback, gleaned from interviews, stakeholder meetings, surveys, and previous research and needs assessments. Much of this report is based on that needs assessment. It can be found by visiting:

<http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>

Readers of this action plan are encouraged to review that report in its entirety to allow for context and support for the initiatives targeted in this plan.

Community Action Plan Overview

The intent of this community action plan is to increase access to effective substance use disorder services; fulfilling this intent requires a continuum of substance use disorder services, including prevention, intervention, treatment, and recovery support services. In order for a community to increase access to effective substance use disorder services, there must be a roadmap to fill the most critical service gaps in each geographic region to create a basic continuum of care.

Substance Use Care Continuum

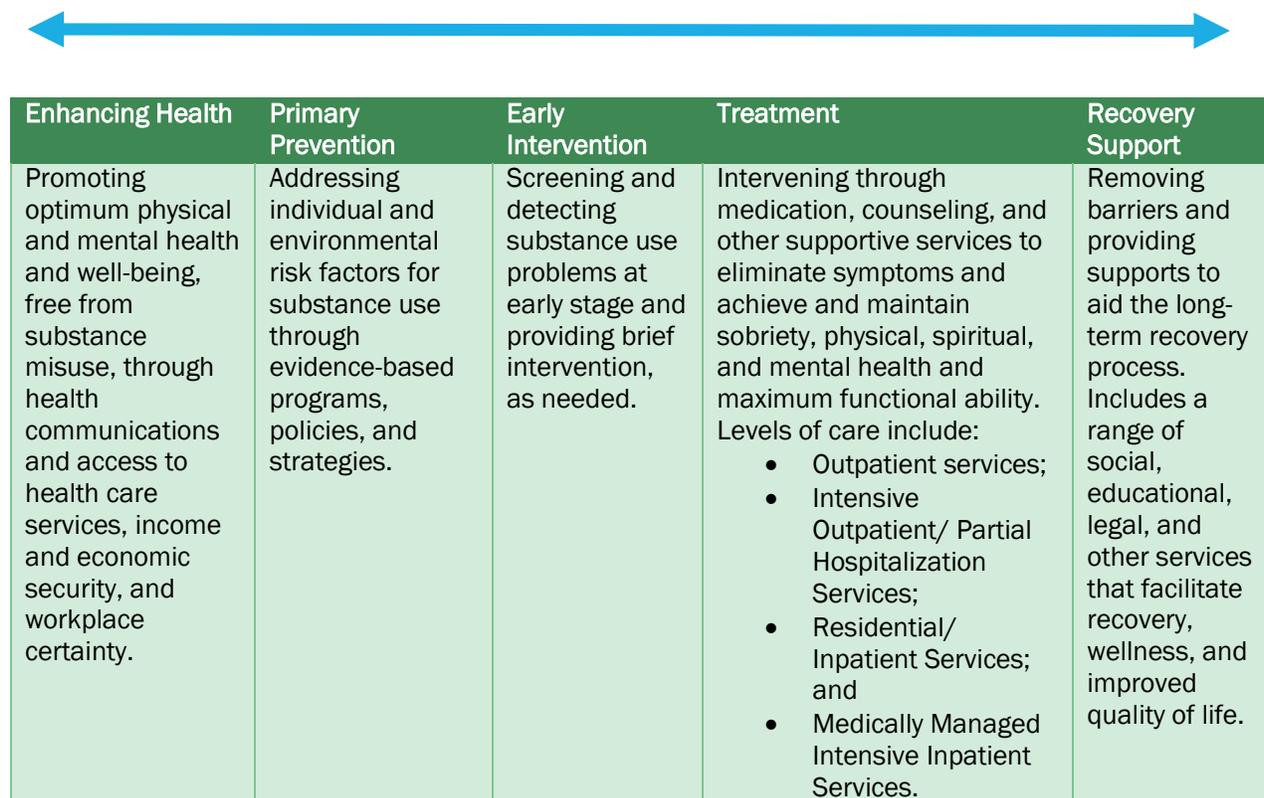


Figure 1: Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

Overall Action Plan Considerations

Access, effectiveness, and efficiency are interdependent goals. Services that are available can be highly effective, but if there is difficult or limited access to those services, the value of those services is diminished. If there is immediate access to services that are ineffective, the value of those services to communities is diminished. It is essential that services be delivered in an efficient continuum of care that allows for the correct dose, intensity, and duration of services.

Several examples can be given: detox services in rural areas need to be scaled and supported for efficient low-volume use; rural outpatient services need to be available within a reasonable distance; outpatient services, no matter where provided, need to have strong, integrated transitions to recovery support services; prevention services need to be targeted to reduce risk, as well focus on community

health. It is clear that access to effective substance use disorder services provides significant improvement to individual and community health outcomes.

While there is a universal desire for everyone to be able to access services regardless of ability to pay, it should be noted there really are no “free” services. There is a cost to all services. If there is not access to affordable or subsidized SUD services for those without ability to pay, those persons normally end up in the most expensive care settings (emergency services units). By the time those persons end up in expensive care settings, the conditions from which they are suffering tend to be more severe and more chronic.

Action Plan Approach

The following action plan is structured around areas of priority, which are regarded as critical to provide an effective and efficient continuum of care. The ultimate strategic goal is for geographic areas to each have access to a complete continuum of care.

It should be noted as well, that while it is Signal’s intention to provide as complete a continuum as possible, a major limitation is total funding available, location and accessibility of providers capable of offering services, sufficient workforce, and other challenges. As the plan begins implementation, and further need for funding, resources, and other linkages become clearer, it will be important to see continued investment towards the ultimate goal of a fully-scaled Substance Use Disorder (SUD) service system to all residents of Colorado.

Critical gaps may include the need to expand and sustain existing services, as well as initiate new services. An absolute necessity is for each geographic area to have the ability to sustain the continuum that is created despite the challenges presented by geography—this includes services supported through other funding sources. It is important as new services are initiated to ensure there is equal emphasis on continuing to sustain essential existing services.

There are many SUD needs and gaps across Colorado. The magnitude of the gaps, addressed with finite resources, requires that there be prioritization in addressing those needs. Signal Behavioral Health Network (Signal) has highlighted items of significant need and major gaps identified by stakeholders in various regions. Examining the totality of all the gaps identified in each of the regions, the objective is to prioritize items that form the basis for creating a continuum of care within each region. When there are many gaps it becomes a challenge to identify those that are critical and achievable. In Signal’s analysis, “critical” encompasses: essential, urgent, and greatest potential to enhance the regional continuum of care. A priority is achievable when available funding, capable providers, and other needed resources (such as workforce) coalesce. While all regions share many of the needs and gaps, some gaps are a greater challenge in one region than another. The stakeholder assessment highlights a number of issues key to providing access to effective substance use disorder services across geographic regions.

Areas of Priority to Create a Continuum of Care

It is Signal’s intention to sustain existing capacity and services while systematically filling gaps in services in a way that creates sustainability for the continuum of care in each geographic area. In order to fill gaps in the substance use conditions service system, it is necessary to address some key barriers to access and sustainability. There are challenges with regard to: delivering services in rural areas; overall workforce sufficiency, capability and competency; expanded comprehensive case management; and recovery supports. While there are challenges across the state, the creation and sustainability of the continuum of care is most challenging in rural areas. These challenges include maintaining a stable specialty workforce, a dispersed population, many times a lack of economies of scale, reasonable access, etc.

Addressing Gaps in the Continuum

Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes reducing rates of use across many substances, postponing age of initiation, and enhancing overall risk reduction. Prevention services also need to target minimizing harm and stopping deaths from opioids, other drugs, and alcohol. It is expected prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Detoxification services must include both intoxication management and withdrawal management, and at the minimum provide ASAM Level 3.2-WM, Clinically Managed Residential Withdrawal Management. Narcan should be available at every detoxification unit. In addition, every detoxification unit should include attached/affiliated comprehensive community-based case/care management appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment. Detoxification units are often the initial point of access for individuals with substance use conditions. It is important to view this initial access as an opportunity to begin engagement of individuals, provide motivational enhancement, and link people to case management. While “detoxification” is a lay term, and withdrawal and intoxication management are ASAM professional terms for major services provided in detoxification units, it’s important to note laypersons will be looking for services labeled detoxification.

All treatment services must be managed so there is varying intensity, dose, and duration of treatment services. “One-size-fits-all” is inappropriate. Effective transitions must be implemented between levels of care, and if needed between different providers. Comprehensive case/care management, including system navigation should be routinely provided across all treatment modalities. There need to be treatment transitions to recovery support that includes supportive housing services, and access to primary medical care that has sophistication regarding substance use conditions. Where possible it is important to have a level of integration with primary care providers, as well as ensuring a level of continuous education for primary care regarding substance use disorders, and education for behavioral health staff regarding primary care. Bi-directional linkages throughout the service continuum are essential. It is desirable to expand specialty services which provide individual and overall health improvement (e.g., women’s specific services).

As with all healthcare, it is essential care be evidence-based with utilization of best practices. In particular, the provision of substance use disorder services needs to include medication assisted treatment, trauma informed care, and technology solutions that increase access. Organizations philosophically opposed to medication assisted treatment will not be provided funds.

There are services for which there is the need for additional access. There are services for diverse populations that need to be enhanced across the entire state. For example, while in the majority, women have treatment needs that are specific and different from those of men and need to be routinely addressed. There is a need for additional women’s specific services. In addition, for pregnant and parenting women with substance use disorder, access to services with prenatal and pediatric enhancements is meager across the state. For pregnant women at or below 195% of the federal poverty level, Medicaid currently funds many of the essential substance use disorder services including comprehensive care management, various levels of treatment services, as well as necessary prenatal and postnatal medical services. “Special Connections” provides residential treatment for pregnant women, along with comprehensive case management. SB 202 resources could also be used to provide additional wraparound and care management services if needed. There is a need for startup resources to expand geographic availability and access. In addition, women above 195% of the federal poverty level require financial assistance for such services.

One key area that should be highlighted in every region is that there is clearly a significant opioid problem that includes both prescription drugs and illicit drugs. In the regional prioritization of gaps, the “opioid crisis” has been identified. It is important to note, with regard to the opioid crisis, that specific opioid funds are coming to the state of Colorado as a result of the federal 21st Century Cures Act. It is anticipated that these funds will be used to address issues related to the opioid epidemic.

Crises around specific drugs arise from time to time; they are symptomatic of the insufficiencies and gaps in prevention and treatment of substance use conditions. While the resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis, the impact of SB 202 resources should be seen as creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis. As stated at the outset of this plan, the goal in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise.

Signal Priority Areas

Signal has used the following categories as the high-level template for areas of focus within geographic regions. The section below, entitled “Implementation Elements to Create a Continuum” provides additional detail. It’s important to note that any implementation will be incremental and targeted at a limited number of areas for which there are sufficient funds to create an adequate response. Not every priority will be met in every geographic area, due to finite funding, shortage of capable providers, and constraints in workforce and other resources.

Signal has selected core services for the first round of improvements. This means focusing on those services from a regional view that are needed to create the foundation for a continuum of care and create a firm basis for the short-term and long-term enhancement of the continuum care in a specific region. These areas are

- Sustaining and Expanding Residential Services
- Sustaining and Expanding Detox Services
- Sustainable and Geographically Accessible Rural Detox
- Sustainable and Geographically Accessible Rural Outpatient
- Treatment Transitions to Recovery
- Supportive Housing Services
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention - Primary and Secondary
- Outreach, Case/Care Management, System Navigation
- Specialty services which provide individual and overall health improvement (e.g., women’s specific care)
- Integration with and Education for Primary Care
- Opioid and other drug/alcohol crisis management

Implementation Elements to Create a Continuum

Sustaining and Expanding Residential Services

Residential substance use disorder (SUD) treatment can be viewed as the equivalent of inpatient rehabilitation services for other severe illnesses. “Residential” in this use should not be thought of as “housing.” It is a 24/7 treatment environment that can vary in duration, intensity, and dose of treatment. There are levels of SUD residential treatment that range from: acute stabilization to intensive rehabilitation to transitional care.

“Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.”

NIDA 2012 Principles of Drug Addiction Treatment: A Research Based Guide

Items of note to integrate into the continuum:

- residential treatment services of varying intensity, dose, and duration
- effective transitions from one level of care to another
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Ensuring existing programs are sustainable and can be expanded as needed

Sustaining and Expanding Detoxification Services

American Society of Addiction Medicine (ASAM) Level 3-WM is Residential/Inpatient Withdrawal Management. What has commonly been called “social detoxification” in Colorado, is actually ASAM Level 3.2-WM [Clinically Managed Residential Withdrawal Management]. ASAM Level 3.7-WM [Medically Monitored Inpatient Withdrawal Management] has a higher involvement of medical professionals, and most frequently would be found in a freestanding withdrawal management center. Detoxification units are “urgent care” settings that provide: intoxication management; withdrawal management; assessment; brief intervention; Naloxone/Narcan for opioid overdose reversal; comprehensive case management (including outreach) attached to and integrated with the detoxification unit; coordination and collaboration with other health care providers including primary care and crisis/emergency services.

Items of note to integrate into the continuum:

- Detoxification services must include both intoxication management and withdrawal management
- attached comprehensive community-based case/care management and outreach appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment.
- effective transitions from one level of care to another
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- initiation of, and linkage to, MAT as a priority

Sustainable and Geographically Accessible Rural Detox

Rural detoxification units have the same challenges as urban units, coupled with challenges around economies of scale, geographic distance, professional workforce shortages that tend to be greater than urban areas. Additionally, service billing is insufficient to sustain a rural or frontier clinic, therefore offsetting support funds must exist to target these areas and ensure outpatient services are available to all Coloradoans.

Sustainable and Geographically Accessible Rural Outpatient

Outpatient treatment settings are familiar to many folks. Primary medical care occurs in clinics, as do outpatient SUD treatment services. Just like residential treatment services, outpatient treatment services can vary in intensity, dose, and duration. Treatment may occur in individual sessions (1 to 1), or in small groups. Treatment can range from 20 hours a week, to three times a week, to once a week, to once a month. Treatment which is 20 or more hours a week may be referred to as “day treatment.” Treatment occurring three hours a day for three days a week may be referred to as “intensive outpatient.” Follow-up appointments, often referred to as continuing care, may occur monthly or less frequently.

Items of note to integrate into the continuum:

- outpatient treatment services of varying intensity, dose, and duration
- recovery support, including safe and supportive housing services, and access to primary care with sophistication regarding substance use conditions
- service billing is insufficient to sustain a rural or frontier clinic, therefore off-setting support funds must exist to target these areas and ensure outpatient services are available to all Coloradoans

Treatment Transitions to Recovery

Recovery can be thought of as self-management of a long-term and chronic illness. All chronic illnesses require an individual to manage those illnesses on an ongoing basis to prevent the return of symptoms and enhance wellness. Examples include individuals with severe diabetes, severe hypertension, severe asthma. Persons with chronic illnesses, including SUD, actively manage those illnesses to enhance the quality of their life. They often do this in relationship to health professionals, with engagement in a support group, and within a supportive environment.

Items of note to integrate into the continuum:

- recovery support, including safe and supportive housing services
- access to primary care with sophistication regarding substance use conditions
- support of others with lived experience, often in a way that provides mutual assistance
- employment of recovery coaches attached to treatment facilities

Workforce Sufficiency and Capability/Competency

There is a significant shortage of behavioral health professionals in Colorado, and across the nation. This is particularly challenging in rural and frontier areas. Many health training programs have limited education regarding substance use conditions, which means those with substance use disorder sophistication are relatively rare. There are multiple approaches to increase the numbers of professionals. Organizations within Colorado compete collaboratively at a national level for qualified professionals.

Items of note to integrate into the continuum:

- consider the array of incentives used in other health shortage areas (e.g., loan forgiveness, sign-on incentives, enhance salaries and benefits, etc.)
- restructure treatment teams in such a way as to leverage professional time
- use peer coaches and recovery mentors

- use technology (e.g., telehealth, smart phone capability, etc.)

Medication Assisted Treatment (MAT) Expansion and Education

The number of medications that are FDA approved for treatment of substance use disorders has grown over the past few decades. The broad use of these medications by practitioners has developed slowly. Reasons for this slow development include: inability to pay for the medications, practitioner discomfort with the regulations regarding use of certain medications for SUD, and lack of information about the efficacy and administration of such medications.

Items of note to integrate into the continuum:

- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone
- Review and expansion of payment methodology for FDA approved medications for treatment of substance use disorder
- assistance to providers and provider organizations regarding buprenorphine certification and applications for physician waivers, as well as certification of nurse practitioners (NPs) and physician assistants (PAs) to prescribe buprenorphine
- expansion of the use in primary care clinics of oral and injectable extended-release naltrexone for persons in treatment for opioid and alcohol disorders

Prevention

Prevention may emphasize services that are both primary prevention and early intervention. An objective of primary prevention is to prevent or reduce the risk of developing substance use problems. It may target prescription drug misuse, underage alcohol or marijuana use, illicit drug use, postponing age of initiation, and reducing rates of use across many substances; all prior to the development of a substance use disorder. Strategies may be focused on reducing individual risk, or community level risk reduction. Community level strategies may include impacting policies, attitudes, and community norms. Early intervention focuses upon identifying and assisting individuals early in the development of substance use conditions to prevent development of more severe disorders.

Items of note to integrate into the continuum:

- Implementation of multiple prevention approaches is essential
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan

Outreach, Case and/or Care Management

Outreach to individuals takes several forms, including comprehensive case management, and system navigation. The function of this in the general health system has been performed by community health workers.

Items of note to integrate into the continuum:

- System navigation
- Population campaigns
- comprehensive case management includes active outreach into the community, as well as one-to-one work with affected individuals in the community itself
- assertive community treatment

Specialty Services to Provide Individual and Overall Health Improvement

There are a variety of specialty services available to address the needs of segments of the population (e.g., persons so severely ill they require some involuntary treatment, individuals using inhalants, persons with multiple complex clinical needs). Those individuals may require enhanced case management, coordination of care with multiple health providers, unique interventions, etc.

Treatment sensitive and tailored to that diversity is important to increase positive health outcomes. Some of that diversity is present in a large portion of our population. For example, women experience a variety of complications from substance use disorders that require extra attention in treatment. For example, “Women are more likely to have chronic pain, then prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men. Women may become dependent on prescription pain relievers more quickly than men.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”]. Women also are more likely than men to be single parents of households where there are dependent children. When women experience substance use disorders, they require specially services that address their unique needs. It is important for women with dependent children, to have access ability to treatment to her and her children as a family unit.

Items of note to integrate into the continuum:

- utilization of evidence-based and best practices
- collaborative services with primary care and/or specialty medical providers
- case management and system navigation in order to assist individuals access to services and support they need
- alcohol and drug-free housing

Primary Care SUD Integration and Education

Medical, nursing, and other health and behavioral health professionals have had limited education and training with regard to substance use disorder. Integration of behavioral health, SUD, and primary services necessitates bidirectional workforces. Education needs to be made available to enhance the specific workforce. Primary care is in a position to identify developing substance use conditions, as well as provide continuing care to individuals who are in recovery from substance use disorders. “Integration” refers to having substance use specialty behavioral health providers available in primary care practices, as well as having primary care services delivered in specialty SUD treatment settings.

Items of note to integrate into the continuum:

- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Training and CME events regarding substance use conditions for primary care, and training regarding primary care for SUD providers

Opioid and Other Drug/Alcohol Crisis Management

Opioids are a group of drugs that include illicit drugs, such as heroin, and prescription drugs used for pain relief, such as Vicodin, codeine, morphine, OxyContin, fentanyl, and others. In the last few years, overdose deaths from prescription and illicit opioids have more than quadrupled. Fatal overdoses exceed deaths from shootings and fatal traffic accidents. “Drug overdose is the leading cause of accidental death in the US, with 52,404 lethal drug overdoses in 2015. Opioid addiction is driving this epidemic, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”] This in essence is the opioid crisis.

The resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis; the impact of SB 202 resources should be seen as creating a better foundation for the substance use

disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis.

- The objective in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise
- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone.
- Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes reducing rates of use across many substances, postponing age of initiation, and overall risk reduction.
- Prevention services also need to target minimizing harm and stopping deaths from opioid, other drugs, and alcohol.
- Prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Regional Needs

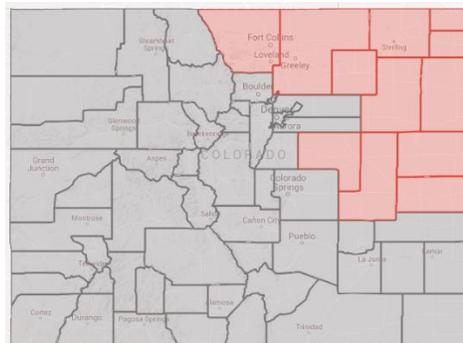
With regard to specific regional needs and gaps, the “summary of existing reports and data” for each region as defined in “Bridging the Divide: Addressing Colorado’s Substance Use Disorder Needs” has been partially reproduced to give context to the priorities for gap reduction.

Region 1: Northeast Colorado (SSPA 1)

Summary of Existing Reports and Data for Region 1

By 2025, Region 1 is expected to have the largest increase in unmet need for substance use services among children and adults in the state.¹ Substance abuse has been identified by county public health departments as a priority in Cheyenne, Kit Carson, Lincoln, and Weld counties.¹⁰ Adult binge drinking¹¹ and prescription drugs^{12,13} were identified as particular areas of concern. (Referenced citations can be found in endnotes of the SB202 Community Needs Assessment located at:

<http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>).



Stakeholder Priorities for Funding

- Detox withdrawal management services/facilities with possible medical monitoring
- Continuum of supportive housing service options
- Transportation to and from treatment and recovery-oriented programs
- Workforce: retention and training including Medication Assisted Therapy (MAT)
- Intensive outpatient services and transitions to the services
- Short- and long-term residential treatment (Larimer/Weld Counties)
- Creating sustainability in rural communities (Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties)

Region 1 Signal Behavioral Health Network Targeted Priorities

Signal will be targeting sustainable detox services as a priority, including small, geographically remote facilities. As noted by stakeholders in SSPA 1, Detox facilities located in Larimer and Logan, as well as other rural counties, are needed. Additionally, stakeholders noted the need for medically monitored detox services (ASAM 3.7-WM) to be co-located with the primarily needed ASAM 3.2-WM: clinically managed residential withdrawal management. Medical detox facilities would be a secondary to locating sufficient capacity of clinically managed residential detox.

Additional priorities at this time include having a continuum of supportive housing service options, increasing and sustaining short-and long-term residential treatment in Larimer and Weld Counties.

There is particular interest in beginning to create sustainability of services in rural communities (Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties). It is also a priority in SSPA 1 to address workforce issues. This includes enhancing retention of providers, increasing provider medication assisted treatment knowledge and skills, and increasing use of medication assisted treatment. The objective is to ensure that there is sufficient workforce, that there are the needed capabilities and competencies necessary to provide quality substance use disorder services.

Some workforce issues, and thus population access to services, may be addressed through telehealth and mobile services.

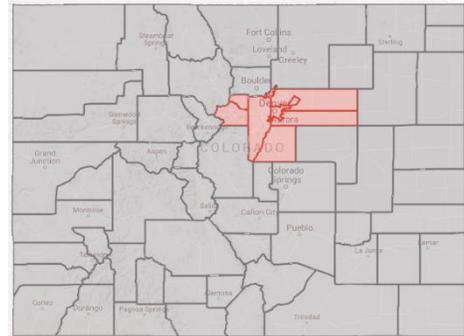
In list form, the areas of priority are, with key or core regional services highlighted:

- **Sustaining and Expanding Residential Services**
- **Sustaining and Expanding Detox Withdrawal Management Services**
- **Sustainable and Geographically Accessible Rural Detox/Withdrawal Management**
- **Sustainable and Geographically Accessible Rural Outpatient**
- Treatment transitions to Recovery
- Supportive Housing Services
- **Workforce Sufficiency and Capability/Competency**
- **MAT Expansion and Education**
- Prevention - Primary and Secondary
- Outreach
- Case or care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- SUD Integration with, and Education for, Primary Care
- Opioid and other drug/alcohol crisis management

Region 2: Metro Denver (SSPA 2)

Summary of Existing Reports and Data for Region 2

Projections of SUD service needs in Region 2 through 2025 are not significantly different than the state.¹ Substance abuse has been identified by county public health departments as a priority in Clear Creek,¹⁰ and by hospitals serving Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Jefferson, and Weld counties.^{17,20,21,22} Hospitals identified behavioral health and substance abuse as priorities due to substance-abuse related visits to the Emergency Department and admissions.^{20,22,23,24} One hospital in Denver reported that, of substance-related visits, alcohol accounted for the most hospital admissions and Emergency Department visits, followed by marijuana, then cocaine and opioids, and finally amphetamines.²⁴ (Referenced citations can be found in endnotes of the SB202 Community Needs Assessment located at: <http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>).



Stakeholder Priorities for Funding

- Continuum of supportive housing service options
- Residential treatment (short-, mid-, and long-term) and transitional residential services
- Detox services/facilities with a medical component
- Case or care management, system navigation
- Workforce: Shortages of providers, training including Medication Assisted Therapy (MAT), certifications, access to telehealth and mobile services
- Better information and data sharing
- Treatment within the criminal justice system

Region 2 Signal Behavioral Health Network Targeted Priorities

Signal will be targeting residential treatment levels which need enhancement, as well as detoxification services to ensure there is adequate access and capacity. In addition, integration with, and bidirectional education, for primary care and allied health professionals will be a priority to enhance community services to individuals. Signal also will be targeting increased case/care management and system navigation within SSPA 2. The objective of this is to enhance transitions between a variety of providers, including transitions to recovery support. Community linkages are an essential piece of this enhancement. The intent is to assist individuals receiving services in accomplishing smooth transitions between levels of care. Integration with education for primary care regarding substance use conditions is important as is education for substance use disorder providers to be educated with regard to primary care. Transitions to recovery support would include recovery support and collaboration with primary care.

In list form, these areas of priority are, with key or core regional services highlighted:

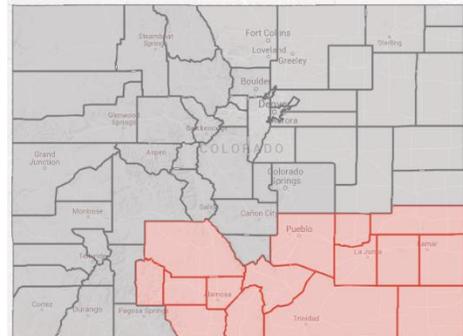
- **Sustaining and Expanding Residential Services**
- **Sustaining and Expanding Withdrawal Management Services**
- Treatment transitions to Recovery
- Supportive Housing Service
- Workforce Sufficiency and Capability/Competency
- **MAT Expansion and Education**
- Prevention - Primary and Secondary

- **Outreach, Case/care management, system navigation**
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- **Integration with and Education for Primary Care**
- Opioid and other drug/alcohol crisis management

Region 4: Southeast Colorado and San Luis Valley (SSPA 4)

Summary of Existing Reports and Data: Region 4

Currently, Region 4 has the highest penetration rates (i.e., proportion of individuals who need a service and subsequently receive it) for substance use services; if service provision remains stable, the region will continue to have the highest penetration rates through 2025.¹ Substance abuse has been identified by county public health departments as a priority in Alamosa, Las Animas, and Huerfano counties¹⁰ and by hospitals in Pueblo county.³⁰ In Pueblo County, mental health hospitalizations (often including co-morbid substance abuse) are double the state rate, and limited availability of and access to services is a concern.^{1,30} Moreover, the opioid epidemic is particularly acute in this area of the state, with the southeast region leading the state on rates of opioid- and heroin-related poisoning deaths³¹, emergency department visits,³² and treatment admissions.³³ (Referenced citations can be found in endnotes of the SB202 Community Needs Assessment located at: <http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>).



Stakeholder Priorities for Funding

- Residential treatment (short-, mid-, and long-term)
- Transitional residential treatment
- Resources for those with co-occurring mental health and substance use disorders
- Detox services/facilities with a medical component
- Workforce: Access and capacity, certification requirements, retention, and training including Medication Assisted Therapy (MAT)
- Support of transportation
- Continuum of supportive housing service options
- More flexibility in nimbleness in state and local funds to better meet community needs
- Prevention

Region 4 Signal Behavioral Health Network Targeted Priorities

Signal will be targeting residential treatment levels which need enhancement, as well as detoxification services to ensure there is adequate access and capacity. It is a priority in SSPA 4 to address workforce issues. Clearly, the level of opiate challenges in Region 4 necessitate intervention around opiates to be a significant priority. It is essential to have prevention services targeted at minimizing harm and stopping deaths from opiates, as well as other substances. This needs to focus upon not only opiate overdose reduction but also upon reversal strategies in communities. Ensuring the widespread community availability of Narcan is essential. Detoxification services which include the capability of addressing opiate overdose and withdrawal management are essential, and may require additional medical support to provide the appropriate withdrawal management and intoxication management services. Connected to the services need to be comprehensive case management, access to medication assisted treatment, linkages and system navigation to assist persons served become engaged in intervention and appropriate treatment services. This includes reducing shortages of providers, increasing provider medication assisted treatment knowledge and skills, licensure and certification. The objective is to ensure that there is sufficient workforce, that there are the needed capabilities and competencies necessary to provide quality substance use disorder services. Some workforce issues may be able to be addressed through access to telehealth and mobile services.

In list form, these areas of priority are, with key or core regional services highlighted:

- Sustaining and Expanding Residential Services
- **Sustaining and Expanding Detox/Withdrawal Management Services**
- Sustainable and Geographically Accessible Rural Detox
- **Sustainable and Geographically Accessible Rural Outpatient**
- Treatment transitions to Recovery
- Supportive housing service options
- **Workforce Sufficiency and Capability/Competency**
- **MAT Expansion and Education**
- Prevention - Primary and Secondary
- Outreach
- Case or care management, system navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- Integration with and Education for Primary Care
- **Opioid and other drug/alcohol crisis management**

Implementation Timeline

Implementation framework for initial enhancement of services includes:

Step	Timeline Item
1	Signal will design an action plan in each region with the input provided through the assessment and survey process. Signal will define priorities and the ranking of priorities in terms of implementation by March 2017 (this document)
2	Signal will target the most attainable priorities in this action plan starting March 2017 and continuing through June 2018 upon which time Signal will reassess and update the plan as needed. These targeted areas may include services already funded during the initial period of SB202 funding that began August 2017.
3	For more complex services, modified RFA (Request for Application) will begin being issued April 15 and continue to be issued as additional funding becomes available for essential services in each region by April 30, 2017.
4	Signal will begin select services to be funded no later than May 15, 2017, and will continue as funding is available beyond that date.
5	Signal will work with selected providers to develop implementation plans and begin execution of those plans no later than June 1, 2017 and continuing thereafter.
6	Future gap reduction will be blended with the immediate sustaining and expansion of detoxification and residential treatment, enhancements of outpatient services, case management, MAT, and workforce starting in March 2017
7	Signal will design a communication plan for each geographic area to ensure key stakeholders are informed about what's happening in addition to the entire Signal provider network in July 2017
8	Detoxification/Withdrawal Management, residential, outpatient, and other enhancement service pilots will be designed as a means to create iterative innovation and implementation starting in May 2017.

The SB202 Community Action Plan is intended to be an iterative process, where community needs are continually reviewed and prioritized.

Signal will continue to reevaluate and update of the action plan action plan based on continuing community assessments of needs for SSPAs 1, 2, and 4. An updated plan will be released no later than July 2018.

SB202 MSO Community Action Plan - SSPA Region 3

FOR STATE YEARS 2016-2018



AspenPointe Health Networks

6208 Lehman Drive, Suite 317, Colorado Springs, CO 80918

About AspenPointe Health Network

AspenPointe Health Network (AspenPointe), is one of Colorado's Managed Service Organizations. AspenPointe is responsible for providing a continuum of substance use disorder (SUD) services in the central part of Colorado. AspenPointe seeks to ensure a consistent level of quality and guarantee compliance with State and Federal requirements relating to SUD services offered. AspenPointe may choose to deliver these services by subcontracting with local providers who demonstrate competency, compliance with quality standards, and positive outcomes.

SSPA Region 3 (Region 3) consists of El Paso, Teller, Custer, Chaffee, Fremont, Park and Lake Counties. While the geographical area is large, the overwhelming percentage of residents reside in the El Paso County service area.

The regional map for Managed Service Organizations is known as Sub-State Planning Areas (SSPAs). There are seven SSPAs in Colorado:

- SSPA 1: Northeast Colorado (Signal)
- SSPA 2: Metro Denver (Signal)
- SSPA 3: Colorado Springs Area
- SSPA 4: Southeastern Colorado including San Luis Valley (Signal)
- SSPA 5: Northern Western Slope
- SSPA 6: Southern Western Slope
- SSPA 7: Boulder

About the Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)

During the 2016 Colorado Legislative Session, the Increasing Access to Effective Substance Use Disorder Services Act was passed, directing and empowering Colorado's Substance Use Disorder Managed Service Organizations to perform several tasks:

- 1) Conduct a statewide needs assessment reviewing and identifying gaps in SUD services, including issues with capacity, access, and sustainability
- 2) Develop and refine community action plans, with intentions around addressing as many areas of priority as possible
- 3) Direct coordination, strategy, and funding towards as many of these areas as possible

The needs assessment is a previously completed reporting, outlining community feedback, gleaned from interviews, stakeholder meetings, surveys, and previous

research and needs assessments. Much of this report is based on that needs assessment. It can be found by visiting:

Community Action Plan Overview

The intent of this community action plan is to increase access to effective substance use disorder services; fulfilling this intent requires a continuum of substance use disorder services, including prevention, intervention, treatment, and recovery support services. For a community to increase access to effective substance use disorder services, there must be a roadmap to fill the most critical service gaps in each geographic region to create a basic continuum of care.

Substance Use Care Continuum



Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health communications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: <ul style="list-style-type: none"> • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services. 	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Figure 1: Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

Overall Action Plan Considerations

Action Plan Approach

The following action plan is structured around areas of priority, which are regarded as critical to provide an effective and efficient continuum of care. The ultimate strategic goal is for geographic areas to each have access to a complete continuum of care.

It should be noted as well, that while it is AspenPointe's intention to provide as complete a continuum as possible, a major limitation is total funding available, location and accessibility of providers capable of offering services, sufficient workforce, and other challenges. As the plan begins implementation, and further need for funding, resources, and other linkages become clearer, it will be important to see continued investment towards the goal of a fully-scaled Substance Use Disorder (SUD) service system to all residents of Colorado.

Critical gaps may include the need to expand and sustain existing services, as well as initiate new services. An absolute necessity is for each geographic area to have the ability to sustain the continuum that is created despite the challenges presented by geography—this includes services supported through other funding sources. It is important as new services are initiated to ensure there is equal emphasis on continuing to sustain essential existing services.

There are many SUD needs and gaps across Colorado. The magnitude of the gaps, addressed with finite resources, requires that there be prioritization in addressing those needs. AspenPointe has highlighted items of significant need and major gaps identified by stakeholders in various regions. Examining the totality of all the gaps identified in each of the regions, the objective is to prioritize items that form the basis for creating a continuum of care within each region. When there are many gaps it becomes a challenge to identify those that are critical and achievable. In AspenPointe's analysis, "critical" encompasses: essential, urgent, and greatest potential to enhance the regional continuum of care. A priority is achievable when available funding, capable providers, and other needed resources (such as workforce) coalesce. While all regions share many of the needs and gaps, some gaps are a greater challenge in one region than another. The stakeholder assessment highlights several issues key to providing access to effective substance use disorder services across geographic regions.

Areas of Priority to Create a Continuum of Care

It is AspenPointe's intention to sustain existing capacity and services while systematically filling gaps in services in a way that creates sustainability for the continuum of care in each geographic area. To fill gaps in the substance use conditions service system, it is necessary to address some key barriers to access and sustainability. There are challenges regarding: delivering services in rural areas; overall workforce sufficiency, capability and competency; expanded comprehensive case

management; and recovery supports. While there are challenges across the state, the creation and sustainability of the continuum of care is most challenging in rural areas. These challenges include maintaining a stable specialty workforce, a dispersed population, many times a lack of economies of scale, reasonable access, etc.

Addressing Gaps in the Continuum

Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes reducing rates of use across many substances, postponing age of initiation, and enhancing overall risk reduction. Prevention services also need to target minimizing harm and stopping deaths from opioids, other drugs, and alcohol. It is expected prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Detoxification services must include both intoxication management and Withdrawal Management, and at the minimum provide ASAM Level 3.2-WM, Clinically Managed Residential Withdrawal Management. Narcan should be available at every detoxification unit. In addition, every detoxification unit should include attached/affiliated comprehensive community-based case/care management appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment. Detoxification units are often the initial point of access for individuals with substance use conditions. It is important to view this initial access as an opportunity to begin engagement of individuals, provide motivational enhancement, and link people to case management. While “detoxification” is a lay term, and withdrawal and intoxication management are ASAM professional terms for major services provided in detoxification units, it’s important to note laypersons will be looking for services labeled detoxification.

All treatment services must be managed so there is varying intensity, dose, and duration of treatment services. “One-size-fits-all” is inappropriate. Effective transitions must be implemented between levels of care, and if needed between different providers. Comprehensive case/care management, including system navigation should be routinely provided across all treatment modalities. There need to be treatment transitions to recovery support that includes supportive housing services, and access to primary medical care that has sophistication regarding substance use conditions. Where possible it is important to have a level of integration with primary care providers, as well as ensuring a level of continuous education for primary care regarding substance use disorders, and education for behavioral health staff regarding primary care. Bi-directional linkages throughout the service continuum are essential. It is desirable to expand specialty services which provide individual and overall health improvement (e.g., women’s specific services).

As with all healthcare, it is essential care be evidence-based with utilization of best practices. The provision of substance use disorder services needs to include medication assisted treatment, trauma informed care, and technology solutions that increase access. Organizations philosophically opposed to medication assisted treatment will not be provided funds.

There are services for which there is the need for additional access. There are services for diverse populations that need to be enhanced across the entire state. For example, while in the majority, women have treatment needs that are specific and different from those of men and need to be routinely addressed. There is a need for additional women's specific services. In addition, for pregnant and parenting women with substance use disorder, access to services with prenatal and pediatric enhancements is meager across the state. For pregnant women at or below 195% of the federal poverty level, Medicaid currently funds many of the essential substance use disorder services including comprehensive care management, various levels of treatment services, as well as necessary prenatal and postnatal medical services. "Special Connections" provides residential treatment for pregnant women, along with comprehensive case management. The reimbursement rate for Special Connections is inadequate to meet the costs of providing the services; an appropriate rate should be provided by Medicaid. SB 202 resources could be used to provide additional wraparound and care management services if needed. There is a need for startup resources to expand geographic availability and access. In addition, women above 195% of the federal poverty level require financial assistance for such services.

One key area that should be highlighted in every region is that there is clearly a significant opioid problem that includes both prescription drugs and illicit drugs. In the regional prioritization of gaps, the "opioid crisis" has been identified. It is important to note, regarding the opioid crisis, that specific opioid funds are coming to the state of Colorado because of the federal 21st Century Cures Act. It is anticipated that these funds will be used to address issues related to the opioid epidemic.

Crises around specific drugs arise from time to time; they are symptomatic of the insufficiencies and gaps in prevention and treatment of substance use conditions. While the resources from the 21st Century Cures Act are specifically addressing the opioid crisis, the impact of SB 202 resources should be creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis. As stated at the outset of this plan, the goal in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise.

AspenPointe Priority Areas

AspenPointe has used the following categories as the high-level template for areas of focus within geographic regions. The section below, entitled "Implementation Elements to Create a Continuum" provides additional detail. It's important to note that any implementation will be incremental and targeted at a limited number of areas for which

there are sufficient funds to create an adequate response. Not every priority will be met in every geographic area, due to finite funding, shortage of capable providers, and constraints in workforce and other resources.

AspenPointe has selected core services for the first round of improvements. This means focusing on those services from a regional view that are needed to create the foundation for a continuum of care and create a firm basis for the short-term and long-term enhancement of the continuum care in a specific region. These areas are

- Sustaining and Expanding Residential Services
- Sustaining and Expanding Detox Services
- Sustainable and Geographically Accessible Rural Detox
- Sustainable and Geographically Accessible Rural Outpatient
- Treatment Transitions to Recovery
- Supportive Housing Services
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention - Primary and Secondary
- Outreach, Case/Care Management, System Navigation
- Specialty services which provide individual and overall health improvement (e.g., women's specific care)
- Integration with and Education for Primary Care
- Opioid and other drug/alcohol crisis management

Implementation Elements to Create a Continuum

Sustaining and Expanding Residential Services

Residential substance use disorder (SUD) treatment can be viewed as the equivalent of inpatient rehabilitation services for other severe illnesses. "Residential" in this use should not be thought of as "housing." It is a 24/7 treatment environment that can vary in duration, intensity, and dose of treatment. There are levels of SUD residential treatment that range from: acute stabilization to intensive rehabilitation to transitional care.

"Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture."

NIDA 2012 Principles of Drug Addiction Treatment: A Research Based Guide

Items of note to integrate into the continuum:

- residential treatment services of varying intensity, dose, and duration
- effective transitions from one level of care to another
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Ensuring existing programs are sustainable and can be expanded as needed

Sustaining and Expanding Detoxification Services

American Society of Addiction Medicine (ASAM) Level 3-WM is Residential/Inpatient Withdrawal Management. What has commonly been called “social detoxification” in Colorado, is ASAM Level 3.2-WM, Clinically Managed Residential Withdrawal Management. ASAM Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management has a higher involvement of medical professionals, and most frequently would be found in a freestanding Withdrawal Management center. Detoxification units are “urgent care” settings that provide: intoxication management; Withdrawal Management; assessment; brief intervention; Naloxone/Narcan for opioid overdose reversal; comprehensive case management (including outreach) attached to and integrated with the detoxification unit; coordination and collaboration with other health care providers including primary care and crisis/emergency services.

Items of note to integrate into the continuum:

- Detoxification services must include both intoxication management and Withdrawal Management
- attached comprehensive community-based case/care management and outreach appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment.
- effective transitions from one level of care to another
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- initiation of, and linkage to, MAT as a priority

Sustainable and Geographically Accessible Rural Detox

Rural detoxification units have the same challenges as urban units, coupled with challenges around economies of scale, geographic distance, professional workforce shortages that tend to be greater than urban areas. Additionally, service billing is insufficient to sustain a rural or frontier clinic, therefore offsetting support funds must

exist to target these areas and ensure outpatient services are available to all Coloradoans.

Sustainable and Geographically Accessible Rural Outpatient

Outpatient treatment settings are familiar to many folks. Primary medical care occurs in clinics, as do outpatient SUD treatment services. Just like residential treatment services, outpatient treatment services can vary in intensity, dose, and duration. Treatment may occur in individual sessions (1 to 1), or in small groups. Treatment can range from 20 hours a week, to three times a week, to once a week, to once a month. Treatment which is 20 or more hours a week may be referred to as “day treatment.” Treatment occurring three hours a day for three days a week may be referred to as “intensive outpatient.” Follow-up appointments, often referred to as continuing care, may occur monthly or less frequently.

Items of note to integrate into the continuum:

- outpatient treatment services of varying intensity, dose, and duration
- recovery support, including safe and supportive housing services, and access to primary care with sophistication regarding substance use conditions
- service billing is insufficient to sustain a rural or frontier clinic, therefore off-setting support funds must exist to target these areas and ensure outpatient services are available to all Coloradoans

Treatment Transitions to Recovery

Recovery can be thought of as self-management of a long-term and chronic illness. All chronic illnesses require an individual to manage those illnesses on an ongoing basis to prevent the return of symptoms and enhance wellness. Examples include individuals with diabetes, hypertension, asthma. Persons with chronic illnesses, including SUD, actively manage those illnesses to enhance the quality of their life. They often do this in partnership with health professionals, with engagement in a support group, and within a supportive environment.

Items of note to integrate into the continuum:

- recovery support, including safe and supportive housing services
- access to primary care with knowledge and expertise regarding substance use conditions
- support of others with lived experience, often in a way that provides mutual assistance
- employment of recovery coaches attached to treatment facilities

Workforce Sufficiency and Capability/Competency

There is a significant shortage of behavioral health professionals in Colorado, and across the nation. This is particularly challenging in rural and frontier areas. Many health training programs have limited education regarding substance use conditions, which means those with substance use disorder sophistication are relatively rare. There are

multiple approaches to increase the numbers of professionals. Organizations within Colorado compete collaboratively at a national level for qualified professionals.

Items of note to integrate into the continuum:

- consider the array of incentives used in other health shortage areas (e.g., loan forgiveness, sign-on incentives, enhance salaries and benefits, etc.)
- restructure treatment teams in such a way as to leverage professional time
- use peer coaches and recovery mentors
- use technology (e.g., telehealth, smart phone capability, etc.)

Medication Assisted Treatment (MAT) Expansion and Education

The number of medications that are FDA approved for treatment of substance use disorders has grown over the past few decades. The broad use of these medications by practitioners has developed slowly. Reasons for this slow development include: inability to pay for the medications, practitioner discomfort with the regulations regarding use of certain medications for SUD, and lack of information about the efficacy and administration of such medications.

Items of note to integrate into the continuum:

- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone
- Review and expansion of payment methodology for FDA approved medications for treatment of substance use disorder
- assistance to providers and provider organizations regarding buprenorphine certification and applications for physician waivers, as well as certification of nurse practitioners (NPs) and physician assistants (PAs) to prescribe buprenorphine
- expansion of the use in primary care clinics of oral and injectable extended-release naltrexone for persons in treatment for opioid and alcohol disorders

Prevention

Prevention may emphasize services that are both primary prevention and early intervention. An objective of primary prevention is to prevent or reduce the risk of developing substance use problems. It may target prescription drug misuse, underage alcohol or marijuana use, illicit drug use, postponing age of initiation, and reducing rates of use across many substances; all prior to the development of a substance use disorder. Strategies may be focused on reducing individual risk, or community level risk reduction. Community level strategies may include impacting policies, attitudes, and community norms. Early intervention focuses upon identifying and assisting individuals early in the development of substance use conditions to prevent development of more severe disorders.

Items of note to integrate into the continuum:

- Implementation of multiple prevention approaches is essential
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan

Outreach, Case and/or Care Management

Outreach to individuals takes several forms, including comprehensive case management, and system navigation. The function of this in the general health system has been performed by community health workers.

Items of note to integrate into the continuum:

- System navigation
- Population campaigns
- comprehensive case management includes active outreach into the community, as well as one-to-one work with affected individuals in the community itself
- assertive community treatment

Specialty Services to Provide Individual and Overall Health Improvement

There are a variety of specialty services available to address the needs of segments of the population (e.g., persons so severely ill they require some involuntarily treatment, individuals using inhalants, persons with multiple complex clinical needs). Those individuals may require enhanced case management, coordination of care with multiple health providers, unique interventions, etc.

Treatment sensitive and tailored to that diversity is important to increase positive health outcomes. Some of that diversity is present in a large portion of our population. For example, women experience a variety of complications from substance use disorders that require extra attention in treatment. For example, “Women are more likely to have chronic pain, then prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men. Women may become dependent on prescription pain relievers more quickly than men.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”]. Women also are more likely than men to be single parents of households where there are dependent children. When women experience substance use disorders, they require specially services that address their unique needs. It is important for women with dependent children, to have access ability to treatment to her and her children as a family unit.

Items of note to integrate into the continuum:

- utilization of evidence-based and best practices
- collaborative services with primary care and/or specialty medical providers

- case management and system navigation to assist individuals access to services and support they need
- alcohol and drug-free housing

Primary Care SUD Integration and Education

Medical, nursing, and other health and behavioral health professionals have had limited education and training with regard to substance use disorder. Integration of behavioral health, SUD, and primary services necessitates bidirectional workforces. Education needs to be made available to enhance the specific workforce. Primary care is in a position to identify developing substance use conditions, as well as provide continuing care to individuals who are in recovery from substance use disorders. “Integration” refers to having substance use specialty behavioral health providers available in primary care practices, as well as having primary care services delivered in specialty SUD treatment settings.

Items of note to integrate into the continuum:

- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Training and CME events regarding substance use conditions for primary care, and training regarding primary care for SUD providers

Opioid and Other Drug/Alcohol Crisis Management

Opioids are a group of drugs that include illicit drugs, such as heroin, and prescription drugs used for pain relief, such as Vicodin, codeine, morphine, OxyContin, fentanyl, and others. In the last few years, overdose deaths from prescription and illicit opioids have more than quadrupled. Fatal overdoses exceed deaths from shootings and fatal traffic accidents. “Drug overdose is the leading cause of accidental death in the US, with 52,404 lethal drug overdoses in 2015. Opioid addiction is driving this epidemic, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”] This in essence is the opioid crisis.

The resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis; the impact of SB 202 resources should be seen as creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis.

- The objective in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise
- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone.
- Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes

reducing rates of use across many substances, postponing age of initiation, and overall risk reduction.

- Prevention services also need to target minimizing harm and stopping deaths from opioid, other drugs, and alcohol.
- Prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Regional Needs & Priorities

Region 3 Targeted Priorities

Region 3's SUD stakeholders identified Withdrawal Management, Residential Services and Supportive Housing as primary areas of concern. It is those services which AspenPointe intends to more proactively target during this 24-month timeframe. These categories have been historically underfunded, leading to severe capacity issues and subsequently, substandard client outcomes. What follows are AspenPointe's planned efforts to implement sustainable improvements to those programs.

- **Sustaining and Expanding Detox Services**

SSPA 3 continues to be faced with challenges in providing a comprehensive Withdrawal Management level of care for a seven-county region. To improve the care to those who access Withdrawal Management services, two areas are key. The two main areas include Withdrawal Management services themselves and linkages to and availability for ongoing services following discharge.

Utilizing SB 202 funds, during Fiscal Year 2018 AspenPointe will begin exploring the possibilities of adding a medical component to the current Withdrawal Management facility. This would lessen the burden of providing medical screening through hospital emergency rooms. AspenPointe will also explore the possibility of adding a limited Withdrawal Management facility in a rural location elsewhere in the region. Finally, AspenPointe will examine other methodologies to improve transportation from rural locations to the Colorado Springs facility. Measurable gains will be possible only with cooperation from AspenPointe's Withdrawal Management partners and stakeholders.

- **Sustaining and Expanding Residential Services**

Effective residential treatment includes individual and group therapy, transportation, transitional housing, vocational assistance, and daily living skills training. A shortage of residential beds plagues Region 3. AspenPointe, as a Managed Service Organization, is forced to contract with providers in other regions for this service.

The scarcity of alternative funding sources is perhaps the largest barrier to those seeking services. Poor reimbursement rates from existing funders exacerbates the problem. Over the next 2 years, AspenPointe will utilize SB 202 funds to incrementally

expand Region 3 residential service capacity and the quality of services delivered within the region.

- **Sustaining and Expanding Supportive Housing Services**

AspenPointe will target supportive sober housing with the goal of increasing housing resources for those with substance use disorders. In-house recovery support services, can aid individuals in their long-term recovery, providing potential for cost savings and decreased risk of relapse. AspenPointe's experience working in the supportive housing realm, as part of participation in the 7-year Access to Recovery (ATR) grant will benefit the process.

Region 3 sorely lacks outpatient follow-up, after-care, and sober living beds and other transitional support services. There are inadequate transportation, supportive housing, and reintegration options. Working with existing supportive housing providers, and leveraging community relationships will be imperative. Many providers complement housing options with other recovery supports, such as life skills, employment coaching, and other transitional supports within the residence. AspenPointe hopes to use SB 202 funds to incrementally increase supportive housing beds and improve the quantity and quality of other wraparound supports.

With respect to AspenPointe's top three priority areas, the ability to expand and continually finance that growth is vital. Inadequate funding could equate to an ostensible threat to sustainability, and thus may impact the prioritization of SB 202 fund usage during these early years. Expanding service capacity in each of these arenas typically requires substantial resources and varied degrees of upfront/fixed investment. Without some guarantee of judicious and continuous revenue flows, be they from SB 202 origin or alternative sources, the risks associated with large infrastructure investments may rise exponentially.

Other Region 3 SUD Stakeholder Focus Areas

The remaining, if not all-inclusive list of crucial funding objectives are:

- **Transportation to and from treatment and recovery-oriented programs**
Sparsely populated areas inherently create care-continuum challenges. Making transportation readily available and bringing clients to their services is often the easiest and most affordable alternative. Region 3 stakeholders also posed mobile clinical treatment as a plausible choice.
- **Workforce: retention and training**
Hiring incentives, affordable clinical education, motivational training, and retention bonuses are a few strategic methods of locating and sustaining a viable labor force.
- **Treatment transitions to recovery**
Making the full continuum of services available under a single roof, in as much as possible, is the surest way of maintaining strong client engagement.

- **MAT Expansion and Education**
Improve access to prescribing physicians.
- **Prevention Options**
Making the generational transition from treatment and recovery to more preventative, cost-effective strategies are vital. AspenPointe visualizes in-school SUD awareness programs as mandatory in adolescent curriculums.
- **Specialty services which provide individual and overall health improvement (e.g., women’s specific care)**
- Expand the access of specialty services which address the unique needs of women. Improve the continuum to focus treating women with dependent children as a family unit.
- **Opioid and other drug/alcohol crisis management**
Emphasis on “opioid” here, as Region 3’s catchment area covers a part of Colorado where abuse is widespread.

Implementation Timeline

Implementation framework for initial enhancement of services includes:

- I. As informed by the Statewide Community Assessment Plan, assessment surveys and meetings, and staged request-for-proposals to community stakeholders (for FY 17 SB 202 funds), AspenPointe has made preliminary needs determinations in this report.
- II. AspenPointe will target the most attainable priorities in this action plan starting March 2017 and continuing through June 2018 upon which time AspenPointe will reassess and update the plan intermittently, or as needed. These targeted areas may include services already funded during the initial period of SB202 funding that began August 2016.
- III. AspenPointe will continue to work collaboratively with selected providers to develop robust proposals targeted towards gaps identified in this document, and to develop implementation plans and monitor performance.
- IV. AspenPointe will design a communication plan to ensure key stakeholders are informed as to the progress of this initiative, by July 2017.

The SB202 Community Action Plan is intended to be an iterative process, where community needs are continually reviewed and reprioritized. AspenPointe will continue to reevaluate and update the action plan based on ongoing community assessments of needs. An updated plan will be released no later than September 2018.

West Slope Casa

SB 202

Community Action Plan

March 1, 2017

West Slope Casa (WSC) is the Managed Service Organization (MSO) for SSPA 5 & SSPA 6. Our providers cover Colorado from Frisco west to Utah and from New Mexico in the south to Wyoming in the north. While there are urban centers within this vast area, most of the region is rural and frontier. This combination of a vast area and greatly differing population densities creates significant challenges in serving the Substance Use Disorder population

Community Assessment – Summary and Comments

As required by SB 202, West Slope Casa (in conjunction with the other MSOs) contracted with Keystone Policy Center to complete a Community Assessment to determine the service gaps and needs along with the funding priorities around Substance Use Disorder (SUD) services. The assessment may be found at <http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>.

Keystone Policy Center undertook numerous key stakeholder interviews (more than two dozen in our area), held community stakeholder meetings and reached out to still others via Survey Monkey (more than two hundred in WSC’s region). The results specific to the WSC area SSPA 5 (covering from Montrose south) are on pages 20-21 of the assessment and WSC area SSPA 6 (covering the northern half of the Western Slope) are on pages 22-23 and are summarized below. It is interesting to note that the priorities listed in the Needs/Gaps section are significantly different from the Priorities for Funding. The Priorities in Funding list was generated in community meetings which were smaller groups and less broad than the stakeholders involved in the Needs/Gaps data gathering which was the result of the key informant interviews and the Survey Monkey surveys.

Need, Gaps and Funding Priorities

Needs, gaps and funding priorities identified by the Community assessment:

West Slope Casa
 SB 202 Community Assessment
 Gaps, Needs and funding priorities

Item	Gap/Need Ranking SSPA 5	Gap/Need Ranking SSPA 6	Funding Priority SSPA 5	Funding Priority SSPA 6
Workforce shortage	1	1	4*	1
Increased training in Evidenced based and trauma informed care	2	2	4*	
Case or care management - including assist with transitions	3	3	6	

Sustainable funding in rural areas	4	7	1	
Continuum of housing options	5	8	3	
Transportation to and from treatment and recovery-oriented programs	6	9	7	
Residential Treatment	7		2	6
Intensive Outpatient Services	8	11		4
Prevention including early intervention	9	12		
Detox services/facilities with a medical component	10	13	5	5
Addressing the festival culture	11			
Better access to care that reflects the cultural of the region	12			
More flexibility in state and local funds to better meet community needs		5	8	
Better information and data sharing between those serving individuals with SUD		4		7
Crisis service alternatives and stabilization		6		2
Affordability of treatment		10		3
Systems for high utilizers		14		8

* These two items were combined in the funding ranking exercise

With fourteen different need/gaps and funding priorities identified, it is clearly impossible to address all of them with the available funding of \$745,155 (through June 2018). Some of the needs, such as detox and residential care, are very expensive projects to undertake (ranging from hundreds of thousands to a million dollars). Detox (withdrawal management) services range from ambulatory care, through the popular Clinically Managed, Medium Intensity Residential Treatment (social detox), up to Medical Detox with 24/7 doctor and nursing staff. While every county would like a detox facility in their area, there simply is not enough funding to do so. Given the very expensive real estate prices in many of our locales, a continuum of housing options is another example of a need that is beyond the capacity of this funding.

While workforce shortage is identified as a very high priority, this is a complex, state wide (and national) challenge that is both expensive and beyond the funding scope of SB 202. While there are multiple organizations (including the Behavioral Health transformation Council and the Office of Behavioral Health) addressing this issue, next steps are not clear. One of the reasons workforce is so important is that it directly effects the ability to implement most programs. Recruiting, and retaining, the numbers of staff required for programs like detox, residential treatment and housing is almost impossible given the work force shortage that exists nationally. There are some great examples of western slope leaders partnering with schools such as Denver University to start extension sites (one in Durango and one in Glenwood Springs) to help provide local educational opportunities.

Sustainability in the long term is also a challenge. While specific services are needed in a community, there may not consistently be the sufficient ongoing flow of referrals needed to sustain a program over time. This is particularly true for bringing expanded services to our rural and frontier communities. Additionally, funding sustainability is also a question as currently funds are available through June 2018.

Calling on our providers for their local expertise, West Slope Casa sought program proposals to meet the local needs. With approximately \$745,000 available through June 2018, we received proposals for almost \$2,000,000. Following a lengthy discussion, the WSC Board decided to focus on funding sustainability and expansion programs in the areas of detox, residential care, serving the homeless population and expanding jail based services. Pending approval from the state Office of Behavioral Health, following are the plans:

- The Center for Mental Health is developing an integrated program that will include detox and crisis respite.
- Mind Springs Health is working with the Vail community to restart a detox facility there. A number of options including ambulatory detox, social detox and limited medical care are all being considered. While WSC is willing to contribute a specified amount, the decision on the program will rest on the ability of the community to contribute.
- Should detox development efforts not succeed, Mind Springs Health will focus on expanding jail based services.
- WSC is also providing some funding to the Aspen detox (open less than a year) to help provide sustainability.
- Axis Health System is being funded to sustain their homeless population programs. These programs were included in the initial program funding under SB 202.
- A pool of money is set aside to provide residential treatment for those who cannot afford it otherwise. Specific allocations are made to the programs in both the southern (Peaceful Spirit program) and northern areas (Women's Recovery Center and Summit View).

Going forward, West Slope Casa will be monitoring these funded programs. We will be developing proposals to meet addition gaps and needs with future years' funding as well as using the Community Assessment data to help make decisions on the use of other funding streams that may come available.



**Mental Health
PARTNERS**

Healthy minds, healthy lives, healthy communities

SB202 Boulder County MSO Community Action Plan

FOR STATE YEARS 2016-2018



About SSPA Region 7, Boulder County

The Managed Service Organization (MSO) for Boulder County, is administered through Mental Health Partners (MHP). MHP is responsible for providing a continuum of substance use disorder (SUD) services for Boulder County. Additionally, MHP seeks to ensure a consistent level of quality and ensure compliance with State and Federal requirements relating to services offered. MHP may choose to deliver these services by subcontracting with local providers who demonstrate competency providers who demonstrate competency, compliance with quality standards, and positive outcomes.

The regional map for Managed Service Organizations is known as Sub-State Planning Areas (SSPAs). There are seven SSPAs in Colorado:

- SSPA 1: Northeast Colorado (Signal)
- SSPA 2: Metro Denver (Signal)
- SSPA 3: Colorado Springs Area
- SSPA 4: Southeastern Colorado including San Luis Valley (Signal)
- SSPA 5: Northern Western Slope
- SSPA 6: Southern Western Slope
- SSPA 7: Boulder County

About the Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)

During the 2016 Colorado Legislative Session, the Increasing Access to Effective Substance Use Disorder Services Act was passed, directing and empowering Colorado's Substance Use Disorder Managed Service Organizations to perform several tasks:

- 1) Conduct a statewide needs assessment reviewing and identifying gaps in SUD services, including issues with capacity, access, and sustainability
- 2) Develop and refine community action plans, with intentions around addressing as many areas of priority as possible
- 3) Direct coordination, strategy, and funding towards as many of these areas as possible

The needs assessment is a previously completed reporting, outlining community feedback, gleaned from interviews, stakeholder meetings, surveys, and previous research and needs assessments. Much of this report is based on that needs assessment. It can be found by visiting:

<http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf>

Readers of this action plan are encouraged to review that report in its entirety to allow for context and support for the initiatives targeted in this plan.

Community Action Plan Overview

The intent of this community action plan is to increase access to effective substance use disorder services; fulfilling this intent requires a continuum of substance use disorder services, including prevention, intervention, treatment, and recovery support services. In order for a community to increase access to effective substance use disorder services, there must be a roadmap to fill the most critical service gaps in each geographic region to create a basic continuum of care.

Substance Use Care Continuum



Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health communications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: <ul style="list-style-type: none"> • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services. 	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Figure 1: Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

Overall Action Plan Considerations

Access, effectiveness, and efficiency are interdependent goals. Services that are available can be highly effective, but if there is difficult or limited access to those services, the value of those services is diminished. If there is immediate access to services that are ineffective, the value of those services to communities is diminished. It is essential that services be delivered in an efficient continuum of care that allows for the correct dose, intensity, and duration of services.

Several examples can be given: detox services in rural areas need to be scaled and supported for efficient low-volume use; rural outpatient services need to be available within a reasonable distance; outpatient services, no matter where provided, need to have strong, integrated transitions to recovery support services; prevention services need to be targeted to reduce risk, as well focus on community

health. It is clear that access to effective substance use disorder services provides significant improvement to individual and community health outcomes.

While there is a universal desire for everyone to be able to access services regardless of ability to pay, it should be noted there really are no “free” services. There is a cost to all services. If there is not access to affordable or subsidized SUD services for those without ability to pay, those persons normally end up in the most expensive care settings (emergency services units). By the time those persons end up in expensive care settings, the conditions from which they are suffering tend to be more severe and more chronic.

Action Plan Approach

The following action plan is structured around areas of priority which are regarded as critical to provide an effective and efficient continuum of care. The ultimate strategic goal is for geographic areas to each have access to a complete continuum of care.

It should be noted as well, that while it is the Boulder County MSO’s intention to provide as complete a continuum as possible, a major limitation is total funding available, location and accessibility of providers capable of offering services, sufficient workforce, and other challenges. As the plan begins implementation, and further need for funding, resources, and other linkages become clearer, it will be important to see continued investment towards the ultimate goal of a fully-scaled Substance Use Disorder (SUD) service system to all residents of Colorado.

Critical gaps may include the need to expand and sustain existing services, as well as initiate new services. An absolute necessity is for each geographic area to have the ability to sustain the continuum that is created despite the challenges presented by geography—this includes services supported through other funding sources. It is important as new services are initiated to ensure there is equal emphasis on continuing to sustain essential existing services.

There are many SUD needs and gaps across Colorado. The magnitude of the gaps, addressed with finite resources, requires that there be prioritization in addressing those needs. Boulder County’s MSO has highlighted items of significant need and major gaps identified by stakeholders in various regions. Examining the totality of all the gaps identified in each of the regions, the objective is to prioritize items that form the basis for creating a continuum of care within each region. When there are many gaps it becomes a challenge to identify those that are critical and achievable. In our analysis, “critical” encompasses: essential, urgent, and greatest potential to enhance the regional continuum of care. A priority is achievable when available funding, capable providers, and other needed resources (such as workforce) coalesce. While all regions share many of the needs and gaps, some gaps are a greater challenge in one region than another. The stakeholder assessment highlights a number of issues key to providing access to effective substance use disorder services across geographic regions.

Areas of Priority to Create a Continuum of Care

It is MHP’s intention to sustain existing capacity and services while systematically filling gaps in services in a way that creates sustainability for the continuum of care in each geographic area. Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes reducing rates of use across many substances, postponing age of initiation, and enhancing overall risk reduction. Prevention services also need to target minimizing harm and stopping deaths from opioids, other drugs, and alcohol. It is expected prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Detoxification services must include both intoxication management and withdrawal management, and at the minimum provide ASAM Level 3.2-WM, Clinically Managed Residential Withdrawal Management. Narcan should be available at every detoxification unit. In addition, every detoxification unit should include attached/affiliated comprehensive community-based case/care management appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment. Detoxification units are often the initial point of access for individuals with substance use conditions. It is important to view this initial access as an opportunity to begin engagement of individuals, provide motivational enhancement, and link people to case management. While “detoxification” is a lay term, and withdrawal and intoxication management are ASAM professional terms for major services provided in detoxification units, it’s important to note laypersons will be looking for services labeled detoxification.

All treatment services must be managed so there is varying intensity, dose, and duration of treatment services. “One-size-fits-all” is inappropriate. Effective transitions must be implemented between levels of care, and if needed between different providers. Comprehensive case/care management, including system navigation should be routinely provided across all treatment modalities. There need to be treatment transitions to recovery support that includes supportive housing services, and access to primary medical care that has sophistication regarding substance use conditions. Where possible it is important to have a level of integration with primary care providers, as well as ensuring a level of continuous education for primary care regarding substance use disorders, and education for behavioral health staff regarding primary care. Bi-directional linkages throughout the service continuum are essential. It is desirable to expand specialty services which provide individual and overall health improvement (e.g., women’s specific services).

As with all healthcare, it is essential care be evidence-based with utilization of best practices. In particular, the provision of substance use disorder services needs to include medication assisted treatment, trauma informed care, and technology solutions that increase access. Organizations philosophically opposed to medication assisted treatment will not be provided funds.

In order to fill gaps in the substance use conditions service system, it is necessary to address some key barriers to access and sustainability. There are challenges with regard to: delivering services in rural areas; overall workforce sufficiency, capability and competency; expanded comprehensive case management; and recovery supports.

There are services for which there is the need for additional access. There are services for diverse populations that need to be enhanced across the entire state. For example, while in the majority, women have treatment needs that are specific and different from those of men and need to be routinely addressed. There is a need for additional women’s specific services. In addition, for pregnant and parenting women with substance use disorder, access to services with prenatal and pediatric enhancements is meager across the state. For pregnant women at or below 195% of the federal poverty level, Medicaid currently funds many of the essential substance use disorder services including comprehensive care management, various levels of treatment services, as well as necessary prenatal and postnatal medical services. “Special Connections” provides residential treatment for pregnant women, along with comprehensive case management. The reimbursement rate for Special Connections is inadequate to meet the costs of providing the services; an appropriate rate should be provided by Medicaid. SB 202 resources could be used to provide additional wraparound and care management services if needed. There is a need for startup resources to expand geographic availability and access. In addition, women above 195% of the federal poverty level require financial assistance for such services.

One key area that should be highlighted in every region is that there is clearly a significant opioid problem that includes both prescription drugs and illicit drugs. In the regional prioritization of gaps, the “opioid crisis” has been identified. It is important to note, with regard to the opioid crisis, that specific opioid

funds are coming to the state of Colorado as a result of the federal 21st Century Cures Act. It is anticipated that these funds will be used to address issues related to the opioid epidemic. In generating solutions to be funded via SB 202 funds, there has been the assumption that the Cures Act funds will be available to address gaps related specifically to the opioid crisis. SB 202 funds could be used supportively to address other areas of need relating to the opioid crisis.

Crises around specific drugs arise from time to time; they are symptomatic of the insufficiencies and gaps in prevention and treatment of substance use conditions. While the resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis, the impact of SB 202 resources should be seen as creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis. The goal in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise.

Boulder County MSO Priority Areas

The Boulder County MSO has used the following categories as a “shorthand template” for areas of focus within geographic regions. The “implementation elements to create a continuum” provides additional detail. It’s important to note that any implementation will be incremental and targeted at a limited number of areas for which there are sufficient funds to create an adequate response. Not every priority will be met in every geographic area, due to finite funding, shortage of capable providers, and constraints in workforce and other resources.

The Boulder County MSO has selected core services for the first round of improvements. This means focusing on those services from a regional view that are needed to create the foundation for a continuum of care and create a firm basis for the short-term and long-term enhancement of the continuum care in a specific region. These areas are:

- Sustaining and Expanding Residential Services
- Sustaining and Expanding Detox Services
- Treatment Transitions to Recovery
- Supportive Housing Services
- Workforce Sufficiency and Capability/Competency
- MAT Expansion and Education
- Prevention - Primary and Secondary
- Outreach, Case/Care Management, System Navigation
- Specialty services which provide individual and overall health improvement (e.g., women’s specific care)
- Integration with and Education for Primary Care
- Opioid and other drug/alcohol crisis management

Implementation Elements to Create a Continuum

Sustaining and Expanding Residential Services

Residential substance use disorder (SUD) treatment can be viewed as the equivalent of inpatient rehabilitation services for other severe illnesses. “Residential” in this use should not be thought of as “housing.” It is a 24/7 treatment environment that can vary in duration, intensity, and dose of treatment. There are levels of SUD residential treatment that range from: acute stabilization to intensive rehabilitation to transitional care.

“Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.”

NIDA 2012 Principles of Drug Addiction Treatment: A Research Based Guide

- residential treatment services of varying intensity, dose, and duration
- effective transitions from one level of care to another
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Ensuring existing programs are sustainable and can be expanded as needed

Sustaining and Expanding Detoxification Services

American Society of Addiction Medicine (ASAM) Level 3-WM is Residential/Inpatient Withdrawal Management. What has commonly been called “social detoxification” in Colorado, is actually ASAM Level 3.2-WM [Clinically Managed Residential Withdrawal Management]. ASAM Level 3.7-WM [Medically Monitored Inpatient Withdrawal Management] has a higher involvement of medical professionals, and most frequently would be found freestanding or in a hospital-based inpatient unit. Detoxification units are “urgent care” settings that provide: intoxication management; withdrawal management; assessment; brief intervention; Naloxone/Narcan for opioid overdose reversal; comprehensive case management (including outreach) attached to and integrated with the detoxification unit; coordination and collaboration with other health care providers including primary care and crisis/emergency services

- Detoxification services must include both intoxication management and withdrawal management
- attached comprehensive community-based case/care management and outreach appropriate for high utilizers of detoxification units, as well as for persons under emergency and involuntary civil commitment.
- effective transitions from one level of care to another
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- effective linkages with other community resources
- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- initiation of, and linkage to, MAT as a priority

Treatment Transitions to Recovery

Recovery can be thought of as self-management of a long-term and chronic illness. All chronic illnesses require an individual to manage those illnesses on an ongoing basis to prevent the return of symptoms and enhance wellness. Examples include individuals with severe diabetes, severe hypertension, severe asthma. Persons with chronic illnesses, including SUD, actively manage those illnesses to enhance the quality of their life. They often do this in relationship to health professionals, with engagement in a support group, and within a supportive environment.

- recovery support, including safe and supportive housing services
- access to primary care with sophistication regarding substance use conditions
- support of others with lived experience, often in a way that provides mutual assistance
- employment of recovery coaches attached to treatment facilities

Workforce Sufficiency and Capability/Competency

There is a significant shortage of behavioral health professionals in Colorado, and across the nation. Many health training programs have limited education regarding substance use conditions, which means those with substance use disorder sophistication are relatively rare. There are multiple efforts to increase the numbers of professionals. Organizations within Colorado compete collaboratively at a national level for qualified professionals

- consider the array of incentives used in other health shortage areas (e.g., loan forgiveness, sign-on incentives, enhance salaries and benefits, etc.)
- restructure treatment teams in such a way as to leverage professional time
- use peer coaches and recovery mentors
- use technology (e.g., telehealth, smart phone capability, etc.)

Medication Assisted Treatment (MAT) Expansion and Education

The number of medications that are FDA approved for treatment of substance use disorders has grown over the past few decades. The broad use of these medications by practitioners has developed slowly. Reasons for this slow development include: inability to pay for the medications, practitioner discomfort with the regulations regarding use of certain medications for SUD, and lack of information about the efficacy and administration of such medications.

- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone
- Review and expansion of payment methodology for FDA approved medications for treatment of substance use disorder
- assistance to providers and provider organizations regarding buprenorphine certification and applications for physician waivers, as well as certification of nurse practitioners (NPs) and physician assistants (PAs) to prescribe buprenorphine
- expansion of the use of oral naltrexone and Vivitrol for persons in treatment for opioid and alcohol disorders

Prevention

Prevention may emphasize services that are both primary prevention and early intervention. An objective of primary prevention is to prevent or reduce the risk of developing substance use problems. It may target prescription drug misuse, underage alcohol or marijuana use, illicit drug use, postponing age of initiation, and reducing rates of use across many substances; all prior to the development of a substance use disorder. Strategies may be focused on reducing individual risk, or community level risk reduction. Community level strategies may include impacting policies, attitudes, and community norms. Early

intervention focuses upon identifying and assisting individuals early in the development of substance use conditions to prevent development of more severe disorders.

- Implementation of multiple prevention approaches is essential
- prevention services targeted at minimizing harm and stopping deaths from opiates, and other substances
- focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan

Outreach, Case and/or Care Management

Outreach to individuals takes several forms, including comprehensive case management, and system navigation. The function of this in the general health system has been performed by community health workers.

- System navigation
- Population campaigns
- comprehensive case management includes active outreach into the community, as well as one-to-one work with affected individuals in the community itself
- assertive community treatment

Specialty Services to Provide Individual and Overall Health Improvement

There are a variety of specialty services available to address the needs of segments of the population (e.g., persons so severely ill they require some involuntarily treatment, individuals using inhalants, persons with multiple complex clinical needs). Those individuals may require enhanced case management, coordination of care with multiple health providers, unique interventions, etc.

Treatment sensitive and tailored to that diversity is important to increase positive health outcomes. Some of that diversity is present in a large portion of our population. For example, women experience a variety of complications from substance use disorders that require extra attention in treatment. For example, “Women are more likely to have chronic pain, then prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men. Women may become dependent on prescription pain relievers more quickly than men.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”]. Women also are more likely than men to be single parents of households where there are dependent children. When women experience substance use disorders, they require specially services that address their unique needs. It is important for women with dependent children, to have access ability to treatment to her and her children as a family unit.

Items of note to integrate into the continuum:

- utilization of evidence-based and best practices
- collaborative services with primary care and/or specialty medical providers
- case management and system navigation in order to assist individuals access to services and support they need
- alcohol and drug-free housing

Primary Care SUD Integration and Education

Medical, nursing, and other health and behavioral health professionals have had limited education and training with regard to substance use disorder. Bidirectional integration of behavioral health SUD and primary care services necessitates bidirectional of both workforces. Primary care is in a position to identify developing substance use conditions, as well as provide continuing care to individuals who are in recovery from substance use disorders. “Integration” refers to having substance use specialty behavioral

health providers available in primary care practices, as well as having primary care services delivered in specialty SUD treatment settings.

- utilization of evidence-based and best practices, including use of medication assisted treatment for those with substance use conditions, as well as technology solutions that increase access.
- Training and CME events regarding substance use conditions for primary care, and training regarding primary care for SUD providers

Opioid and Other Drug/Alcohol Crisis Management

Opioids are a group of drugs that include illicit drugs, such as heroin, and prescription drugs used for pain relief, such as Vicodin, codeine, morphine, OxyContin, fentanyl, and others. In the last few years, overdose deaths from prescription and illicit opioids have more than quadrupled. Fatal overdoses exceed deaths from shootings and fatal traffic accidents. “Drug overdose is the leading cause of accidental death in the US, with 52,404 lethal drug overdoses in 2015. Opioid addiction is driving this epidemic, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015.” [American Society of Addiction Medicine, “Opioid Addiction 2016 Facts & Figures”] This in essence is the opioid crisis.

The resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis; the impact of SB 202 resources should be seen as creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds and holistically address the impact of the crisis.

- The objective in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug crises as they arise
- Medication assisted treatment needs to be expanded, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone.
- Community-based prevention services need to be both primary and secondary prevention in nature. They need to have an emphasis upon youth, which includes reducing rates of use across many substances, postponing age of initiation, and overall risk reduction.
- Prevention services also need to target minimizing harm and stopping deaths from opioid, other drugs, and alcohol.
- Prevention would focus upon not only overdose reduction but also upon reversal strategies in communities. This would include the widespread community availability of Narcan.

Region 7 Boulder

Boulder County



NEEDS/GAPS

- Workforce: Shortages of providers, training in medication assistance, certifications
- Treatment within the criminal justice system
- Transitional programs and services, including people leaving criminal justice system
- Focus on harm reduction
- Case/care management, system navigation
- Prevention: SBIRT, stigma, early intervention, screening
- Detox services/facilities with a medical component
- Better information and data sharing
- Continuum of residential treatment (short-, mid-, and long-term) and transitional residential services
- More flexibility and nimbleness in state and local funds to better meet community needs
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Workforce development programs
- Crisis stabilization services available 24/7
- Public education, communication, partnerships (including faith community) to increase awareness of resources available
- Agency alignment of funding, administration, rules

PRIORITIES for FUNDING

Detox services/facilities with a medical component

More flexibility and nimbleness in state and local funds to better meet community needs

Prevention

Transitional programs and services, including people leaving criminal justice system

Public education, communication, partnerships (including faith community) to increase awareness of resources available

Better information and data sharing

Continuum of housing options

Focus on harm reduction

REGION 7

Projections of substance use disorder service needs in Region 7 through 2025 are not significantly different than the state. Substance abuse has been identified by the county public health department and hospitals in Boulder county as a priority. In Longmont, the emergency room often serves as the primary access point for behavioral health issues. In addition, substance abuse is the leading cause of inpatient admission in the Emergency Department for patients ages 35-49, and alcohol/substance abuse is the second highest diagnosis for patients ages 35-49 (25%) and ages 50-64 (19%). The need for expanded, improved, accessible, and timely substance use disorder services is recognized.

Prevention

Prevention was identified as a key priority for tackling substance use disorder issues in Region 7. Areas of concern include reducing substance use, improving early detection and health promotion by reducing the stigma of substance use disorder/behavioral health issues, increasing counseling and prevention programs in schools, teaching coping and stress reduction skills during childhood, and increasing housing support programs to decrease homelessness.

Treatment

There is a recognized need for additional inpatient services. There are no Intensive Residential Treatment programs and only 6 beds in a Transitional Residential Treatment program for Region 7. All other IRT services are contracted out with other MSO's.

Continuum of Care

There are identified challenges in Region 7 with core coordination with substance use disorder services. Issues that have been identified include high incarceration rates when substance use disorder treatment is more appropriate, challenges in capacity for first responders to assess for substance use disorder issues and make appropriate referrals, and lack of systematic process to connect those with acute issues to appropriate services. A lack of integration of substance use disorder services with primary care has also been identified as an area of concern.

Workforce

Workforce concerns include a lack of doctors, substance abuse counselors, and other providers to meet need for treatment. There is also a shortage of specialized providers in the region.

Cost

The costs of substance use disorder services in Region 7 are seen as high, and there is a need for more affordable options when insurance coverage is insufficient.

In list form, the areas of priority are, with key or core regional services highlighted:

1. Sustaining and Expanding Residential Services
2. **Sustaining and Expanding Detox Withdrawal Management Services**
3. **Treatment transitions to Recovery**
4. **Supportive Housing Services**
5. **Workforce Sufficiency and Capability/Competency**
6. **MAT Expansion and Education**
7. Prevention - Primary and Secondary

- 8. Case or care management, system navigation**
9. Specialty services which provide individual and overall health improvement (e.g., women's specific care)
10. SUD Integration with, and Education for, Primary Care
- 11. Opioid and other drug/alcohol crisis management**

Implementation Timeline

Implementation framework for initial enhancement of services includes:

Step	Timeline Item
1	The Boulder County MSO will design an action plan with the input provided through the assessment and survey process. MHP will define priorities and the ranking of priorities in terms of implementation March 2017 (this document).
2	The Boulder County MSO will target the priorities in this action plan starting March 2017 and continuing through June 2018 upon which time the Boulder County MSO will reassess and update the plan as needed.
3	Modified RFA (Request for Application) for any external providers will begin being issued April 15 and continue to be issued as additional funding becomes available for essential services in each region by April 30, 2017. Internal MHP program enhancements will be described via Statements of Work with associated budgets.
4	The Boulder County MSO will begin select services to be funded no later than May 15, 2017, and will continue as funding is available beyond that date.
5	The Boulder County MSO will work with selected providers to develop implementation plans and begin execution of those plans no later than June 1, 2017 and thereafter.
6	Future gap reduction will be blended with the immediate sustaining and expansion of detoxification, residential treatment, enhancements of outpatient services, case management, MAT, workforce starting in March 2017.
7	The Boulder County MSO will design a communication plan to ensure key stakeholders are informed about what's happening in terms of expanded services being funded through SB 202 dollars
8	Detoxification/Withdrawal Management, residential, outpatient, and other enhancement service pilots will be designed as a means to create iterative innovation and implementation starting in May 2017.

The SB202 Community Action Plan is intended to be an iterative process, where community needs are continually reviewed and prioritized.

The Boulder County MSO will continue to reevaluate and update of the action plan action plan based on continuing community assessments of needs for SSPA 7. An updated plan will be released no later than July 2018.