HMA

HEALTH MANAGEMENT ASSOCIATES

Substance Use Treatment Feasibility Study and Implementation Plan

PREPARED FOR
SOUTHWEST COLORADO OPIOID RESPONSE DISTRICT

DATE
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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Purpose and Background

Southwest Colorado, like many rural and frontier areas of the country, is experiencing a growing trend in the number of people with substance use issues. At the same time, the region lacks local inpatient treatment, transitional residential treatment, methadone treatment, flexible and supportive recovery housing, and adequate step-down programs to address opioid and substance use disorder (SUD) and support recovery. The Southwest Colorado Opioid Response District (SWORD), through the Region 9 Economic Development District of Southwest Colorado, seeks to assess gaps in care across the opioid use disorder (OUD) and SUD treatment continuum and to identify services and facilities the region can develop and sustain. SWORD initiated this effort on behalf of the region's five counties (Archuleta, Dolores, Montezuma, La Plata, San Juan), 10 cities and towns, the Southern Ute Indian Tribe, and the Ute Mountain Ute Tribe.

Though substance misuse is far from unique to Region 9, its geographic isolation from services often leaves people in the community, especially low-income populations, unable to access care, recover, and return to health and their families. Region 9 has a historic opportunity to support individuals with OUD/SUD through wider availability of new resources.

SWORD contracted with Health Management Associates (HMA) to conduct a regional feasibility study provides a better understanding of what types, size, location, and programming treatment options are fiscally and culturally viable. With this study, Region 9 and SWORD intend to accomplish the following:

- Determine the types of treatment services most needed in the region and the viability of providing these options
- Determine how to make treatment resources financially feasible over the long-term and have a measurable positive impact on Region 9's OUD/SUD-related outcomes

This report includes a description of these focus areas in the context of treatment for OUD/SUD:

- An overview of the identified needs and gaps in Southwest Colorado
- The highest acuity service programming the region can support by looking at surrounding populations, demand for services, partnerships and facility needs
- Alternative strategies for hub and spoke programs and telehealth providers that can make additional treatment, rehabilitation, and recovery programs feasible
- Successful programs in similar communities as relevant
- Infrastructure and specific facility development recommendations and a rough order of magnitude cost estimate for each program
- Funding source mix to support the recommendations

The report concludes with recommended next steps and an estimated timeline to implement practicable options.

Desired State for a SUD/OUD Continuum of Services

The 2016 Surgeon General's Report on Alcohol, Drugs, and Health defines SUD treatment as "a service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability."[1] The *Diagnostic and Statistical Manual of Mental Disorders (DSM) V* classifies SUD into three categories: mild, moderate, and severe. Mild SUDs often respond to brief motivational interventions and supportive monitoring, but more severe and chronic SUDs often require specialty treatment and ongoing support.[2]

In 2018, The Office of the Surgeon General and the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a *Spotlight on Opioids from the Surgeon General's Report* to provide opioid-related information.[3] This statement stipulates that to address the spectrum of SUDs, including OUD, an adequate continuum of care offers an array of service options, including prevention, early intervention, treatment, and recovery support. Additionally, the vision for a robust and modern mental health and addiction system is grounded in a public health model that addresses the social determinants of health, ensures system and service coordination, and promotes health and well-being.[4]

As individuals move through the continuum of treatment and support in their recovery from SUD/OUD, they may need to transition to levels of care of greater or lesser intensity, depending on their clinical needs and circumstances.

Following are examples of patient flow throughout the SUD/OUD care continuum, which illustrate how important coverage of the full range of care is to the appropriate treatment of SUD/OUD :[5]

- Scenario 1: An individual with SUD/OUD may be admitted to a medically managed withdrawal management or inpatient facility with acute physical healthcare needs requiring medical and nursing care. Once stabilized, the individual may need admittance to a clinically managed adult residential program for treatment services or an intensive inpatient or outpatient program that offers medication assisted treatment (MAT).
- Scenario 2: An individual with SUD/OUD may begin treatment by receiving outpatient treatment services only to find that a more intensive level of care, such as intensive outpatient treatment, is more appropriate.

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[1] US Substance Abuse and Mental Health Services Administration, Office of the US Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Published November 2016. Available at: https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf. Last accessed July 25, 2023.

[2] US Department of Health and Human Services, Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Spotlight on Opioids*. Published September 2018. Available at: https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf. Published September 2018. Last accessed July 25, 2023.

[3] Ibid

[4] Substance Abuse and Mental Health Services Administration. *Description of a Good and Modern Addictions and Mental Health Service System*. (2011). Published April 18, 2011. Available at: https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf. Last accessed July 25, 2023.

[5] Medicaid Innovation Accelerator Program. *Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms*. Published 2017. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf. Last accessed July 25, 2023.

Individuals with SUD/OUD face higher risk of relapse and worse behavioral and physical health outcomes, including increased inpatient hospital utilization, when they are unable to transition between varying levels of care throughout treatment as their clinical needs and treatment goals evolve.

Methodology

The feasibility study used a mixed method research design that included:

- Review of past assessments of SUD/OUD continuum of care and needs in Region 9
- Cross-sector community leader interviews and focus groups
- A provider and community survey
- Secondary data analysis on SUD/OUD prevalence, drug and alcohol overdose and death rates, emergency department (ED) and hospitalization rates for SUD/OUD and co-occurring mental health conditions, and social and community drivers of health

The research questions and primary data sources for the feasibility study are described in Table 1. See Appendix A for a detailed methodology of the data collection effort.

Table 1. Research Questions and Data Sources

Research Question	Data Sources
What is needed/required for SUD treatment and recovery services, including inpatient treatment, in Region 9?	■ Colorado Department of Public Health and Environment Overdose Dashboard ■ County Health Rankings 2023 ■ Centura Mercy ED substance use-related utilization ■ Cross-sector community leader interviews and focus groups (see Appendix B for discussion guide) ■ Provider and community survey (see Appendix C for discussion guide)
What specific services exist and where do service gaps exist?	■ Cross-sector community leader interviews and focus groups ■ Provider and community survey ■ Drug and Alcohol Coordinated Data System ■ Colorado Medicaid behavioral health services utilization
What are initial estimates of feasibility (per above), including cost estimates to build, operate, equity, and contract?	■ Market demographic data ■ Cost reports ■ Colorado Medicaid rates ■ Industry benchmarks
What are initial funding recommendations and source mix?	■ Landscape scan

Region 9 Representation in the Assessment

An important limitation to acknowledge is the degree to which key informant interviews and the provider and community survey data that informed the assessment adequately represent stakeholders from throughout the region.

- Most community survey respondents reported sharing a perspective from Montezuma County; however, the key informant interviews sought to balance this viewpoint with representation from other counties within Region 9. For example, 12 key informants represented La Plata County, six were from Montezuma County, one represented Archuleta County, one was from Dolores County, and one represented San Juan County. In addition, two key informants represented the Native American communities, and four provided regional representation. Geographic representation was not mutually exclusive, meaning some key informants provided perspectives from multiple counties/locations.
- Available hospital data from Centura Mercy were incorporated into this assessment and relied on for the feasibility assessment. Cortez's Southwest Health System and Pagosa Springs' Medical Center were not included; however, two key informants did represent Southwest Health System primary care.

An Overview of the Identified Needs and Gaps in Southwest Colorado

Community Context and Population Demographics

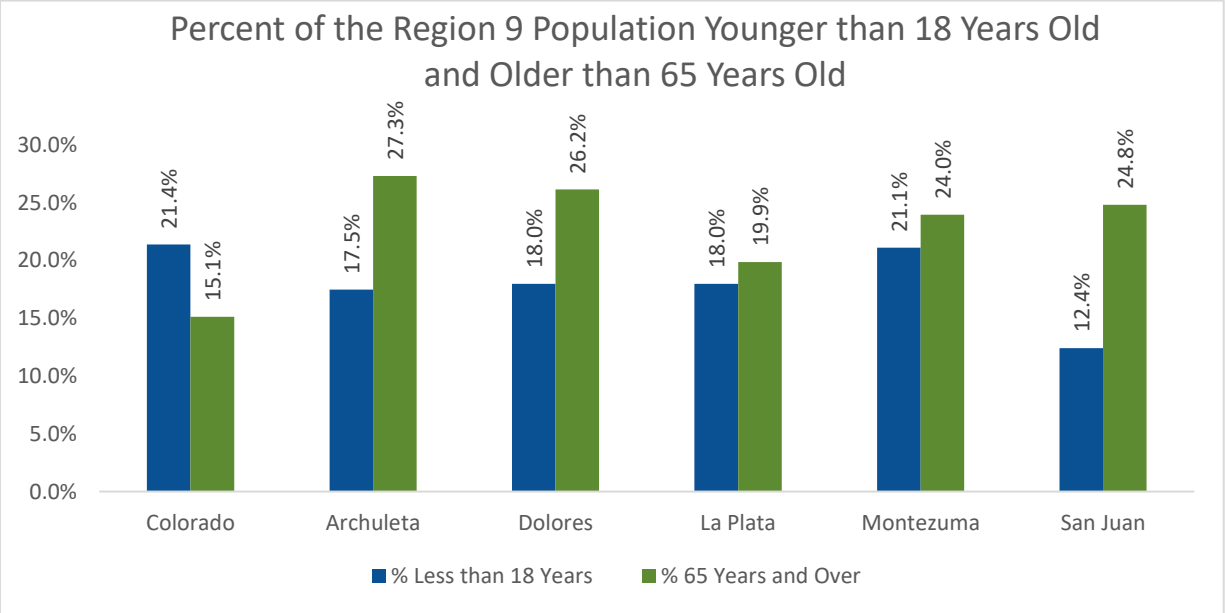
Colorado's Health Services Region 9, which encompasses Dolores, San Juan, Archuleta, Montezuma, and La Plata Counties, is in southwest Colorado and is situated on the border of Arizona, Utah, and New Mexico. This section describes the demographic and socioeconomic factors in Region 9 that are influential in driving healthcare and health outcomes.

- Demographics include age, rurality, and race/ethnicity
- Socioeconomic factors include insured status and type, economic hardship (e.g., income, employment, education level), and social connectedness

Age Group

The adequacy of the continuum of SUD/OUD care looks different for adolescents, young adults, and older adults. The SUD continuum of care for each should be designed and built with their unique needs in mind. Region 9 has an older population compared to overall state demographics. Approximately 15% of Colorado's population is age 65 and older, whereas the percentages for the counties in Region 9 range from 19.9% to 27.3%. Meanwhile, the child and youth population in Region 9 is lower compared to Colorado.

Figure 1. Percent of Population Younger than Age 18 and Older than Age 65



Source: As reported by the County Health Rankings 2023. Census, 2021.

Rurality

A larger percentage of the population in Region 9 live in rural/frontier areas (59.4%–100%) compared with Colorado as a whole (13.8%). On average, rural/fronter residents are older and generally have more complex health conditions than their urban counterparts. Furthermore, people in rural and frontier areas experience greater difficulty accessing care. The Colorado Rural Health Center reported in its *2023 Snapshot of Rural Health* that two counties in Region 9—San Juan and Dolores—did not have a

psychologist, licensed social worker, or licensed addiction counselor and, thus, the care and services these professionals offer residents.[6]

Though rural hospitals have been able to stay open in Colorado over the past decade,[7] 22 are operating in the red, according to the *2023 Snapshot of Rural Health*. Nationally, the US Government Accountability Office reports that more than 100 (4%) of rural hospitals closed in 2013−2020 across the nation, resulting in residents traveling approximately 20 miles farther for common services like inpatient care and 40 miles farther for less common services, such as alcohol or SUD/OUD treatment.[8] The average distance to obtain alcohol or SUD/OUD treatment increased to 44.6 miles in 2018 (after closures) from 5.5 miles in 2012 (before closures). The financial stress on rural hospitals may result in a reduction in the continuum of services that could have a similar impact on the proximity of services. For now, Region 9 has been able to avoid closures but very well could be next in line. The financial stressors that rural hospitals experience can limit access to specialty services like SUD treatment.

Native American Population

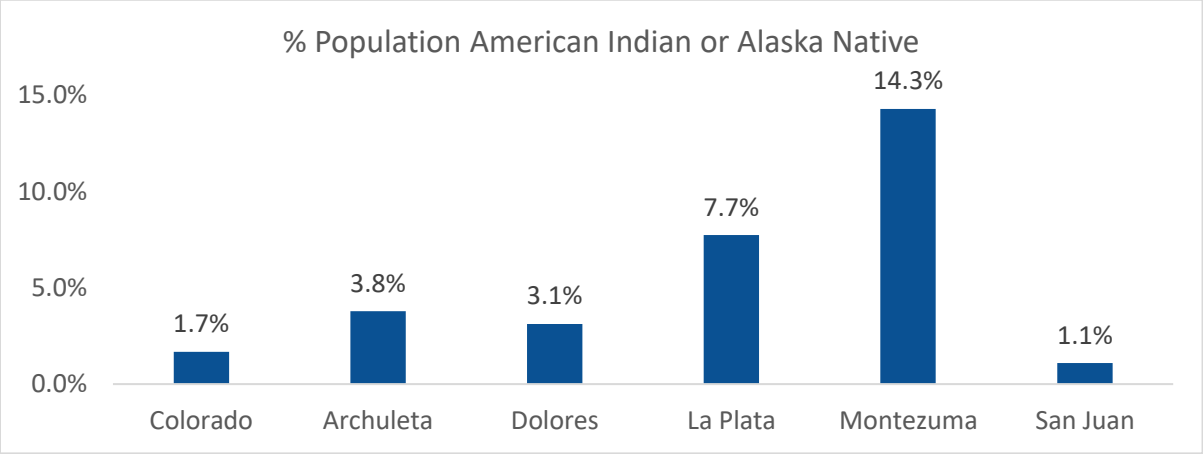
Two federally recognized Native American tribes, the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe, have tribal land boundaries within the state of Colorado (both located in the southwestern corner of the state, with the Ute Mountain Ute Tribe extending into Utah and New Mexico). Both tribal healthcare systems also serve other Native Americans living in Colorado. Native Americans also live across the state and many have tribal membership outside of Colorado. Although Indigenous groups include Native Americans, Alaskan Natives, Native Hawaiians, and people native to Mexico and the southern states that are not classified as "Native American," for this study, the focus is on the people who are members of federally and state-recognized tribes as well as descendants and people who report being of two or more races, with one being Native American or Alaska Native. This population is often cited as having high behavioral health needs and significant barriers to care.

The US Census Bureau's latest estimate of the Native American and Alaska Native population in Colorado was 1.7 percent of the total state population in 2021. Most of these individuals live in urban areas and are descendants of the Cheyenne, Lakota, Kiowa, Navajo Indians, and members of at least 200 tribal nations live in the Denver metropolitan area. The largest tribal group by origin in Colorado is the Lakota, and the fastest growing tribal group is Navajo.

Though the overall Native American population in Colorado is less than 2 percent, the Native American/Alaska Native population in Region 9 was higher for all counties except San Juan, with the largest percentage in Montezuma County. Fort Lewis College, located in La Plata County, reports 41 percent of the student body is Native American.

[6] Colorado Rural Health Center. *Snapshot of Rural Health in Colorado, 2023*. Published 2023. Available at: https://coruralhealth.org/snapshot-of-rural-health. Last accessed July 25, 2023.
[7] Hawryluk M, Kaiser Health News. Rural Hospitals that Were Struggling Financially Even Before the Pandemic Are Running Out of COVID Aid. *Fortune.* Published March 6, 2023. Available at: https://fortune.com/2023/03/06/rural-hospitals-financial-struggles-covid-aid-run-out-st-vincent-leadville-colorado/. Last accessed July 25, 2023.
[8] US Government Accountability Office. Published May 16, 2023. Available at: https://www.gao.gov/blog/why-health-care-harder-access-rural-america. Last accessed July 25, 2023.

Figure 2. Percentage of Colorado Population that Is Native American or Alaska Native, by County



Source: As reported in the County Health Rankings 2023. Census, 2021.

Uninsured Rates

Across the region, significantly higher percentages of uninsured adults reside in Archuleta (17.4%), Montezuma (17.6%), and San Juan (18.0%) counties, compared with Colorado as a whole (11.5%).[9] The uninsured rate in Dolores was 11.5 percent and was 13.7 percent in La Plata.

Insurance Coverage Type

Percent of residents with public insurance, such as Medicare, Medicaid, VA Health Care, or means-tested public health insurance, was 40.1 percent in 2017–2021 and was significantly higher than Colorado at 32.1 percent.[10] The percentage of residents with private health insurance (63.5%), such as employer-provided health insurance, direct-purchase (Affordable Care Act exchanges), or TriCare in Region 9 was significantly lower than for the entirety of the state (70.7%).

Hardship Index

The hardship index is a composite score reflecting scarcity of resources in the community, with higher values indicate harsher living conditions.[11] It incorporates unemployment, age dependency, education, per capita income, overcrowding, and poverty into a single score that allows comparison between geographies. Region 9's hardship score (37.1) was higher than Colorado's (34.8). Montezuma had the highest hardship score (56.6), followed by Archuleta (45.0), San Juan (41.9), Dolores (39.9), and La Plata (26.0).

Income Inequities

The median household income for all Region 9 counties was significantly lower than for all of Colorado, with Montezuma County at the lowest—approximately $53,337 annually. With Indigenous populations

[9] As reported by the County Health Rankings 2023. Census, 2021.
[10] American Community Survey, Tables S2704, S2701, and B27010, 2017-2021.
[11] The Hardship Index is a composite score reflecting hardship in the community (higher values indicate greater hardship). It is highly correlated with other measures of economic hardship, such as labor force statistics, and with poor health outcomes.

already experiencing significantly lower incomes ($55,122) across Colorado than White households ($86,765), in Montezuma County, Native American household incomes were considerably lower ($38,559) than that of other Native Americans across the state.[12]

Social Connectedness

The Southwestern Colorado Opioid Overdose Planning (SCOOP) Consortium assessment conducted a community survey in La Plata County in 2021.[13] Among residents in La Plata County, only 15 percent of respondents described their sense of belonging to the local community as "very strong." Additionally, culture/traditions are often not reflected in the community, with only 17 percent stating responding with "very strong." While similar data on social connectedness are unavailable in other Region 9 counties, these estimates likely can be extrapolated to the other counties and may be even higher given the increased rurality of the area outside of La Plata County.

The US Surgeon General recently released an advisory describing loneliness as a new public health epidemic. The statement cited a new report that tracks a decline in social connections—especially among young people—and shows that half of adults feel lonely, linking it to billions of dollars in healthcare costs.[14]

OUD and SUD Needs Assessment and Document Review

Health Management Associates (HMA) reviewed needs assessments and corresponding documents that highlighted work previously conducted in the region and the state to assess SUD and OUD trends by demographics and substance type. Key findings from these analyses, described in Appendix A, include:

- An increasing trend in drug overdose deaths in Region 9 similar to trajectories seen statewide.
- Opioid overdose related deaths were higher in Region 9 than alcohol related deaths.
- The death rate from alcohol overdose was significantly higher in Region 9 than in the state.
- Males had significantly higher drug overdose death rates than females.
- Native Americans residents in Region 9 had a higher rate of overdose deaths compared with that of other Region 9 residents, driven in part by methamphetamines (or other psychostimulants) and alcohol.

[12] As reported in County Health Rankings and Roadmaps, 2023 Measures, available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-measures. Last accessed July 25, 2023.

[13] Southwestern Colorado Opioid Overdose Planning (SCOOP) Consortium, Durango. Community Needs Assessment and Gap Analysis. Released March 1, 2021.

[14] US Public Health Service. *Our Epidemic of Loneliness and Isolation: U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community*. Published 2023. Available at: https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf. Last accessed July 25, 2023.

Regional Strengths	Regional Gaps	Regional Challenges
✓ Peer support models ✓ Street medicine team ✓ Committed organizations ✓ LQBTQ+ and tribal resources exist	❑ Affordable housing ❑ Living wage jobs ❑ Social/community connection ❑ Access to treatment and recovery services for priority populations, including LGBTQ+ and Native American communities ❑ Distance to services	❑ Stigma continues to be a challenge throughout the region *In SCOOP's assessment, when asked about stigma about 10% suggested strong blame for individuals with SUD.* ❑ Difficulty coordinating shared measurements for success.

The Colorado Department of Law released an Opioid Crisis Response Plan that included the following priorities, many of which overlap with Region 9's agenda to expand access to services, including telehealth, mobile, outpatient, and residential services:

- Prevention and education
- Treatment
- Criminal justice
- Harm reduction
- Recovery
- Opioid abatement in rural Colorado

Prescribing Patterns

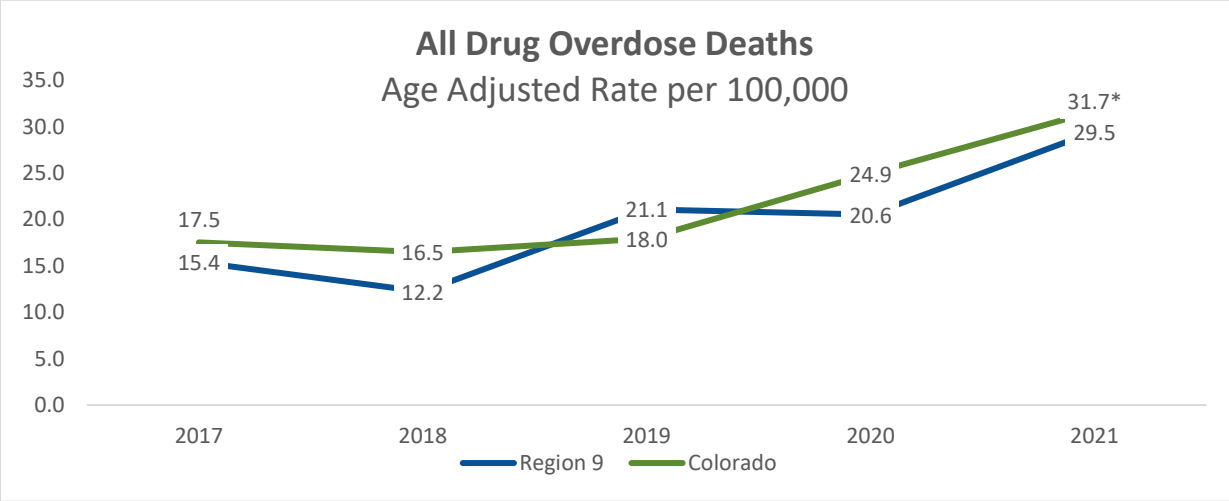
The document review highlighted work accomplished in Region 9 and statewide related to provider education and unsafe prescribing of opioids.

Prescribing data can help indicate relationships between prescribing and overdose. This region has witnessed decreases in prescriptions and increases in overdoses. For example, in 2018, Centura Mercy (formerly Mercy Regional Medical Center) implemented the alternative to opioids (ALTO) program to limit the number of opioid prescriptions. Though ALTO succeeded in decreasing opioid use by 11 percent in Centura Mercy facilities, opioid overdose rates in the community increased by 33.3 percent during the same period. This imbalance suggests that perhaps overdoses are related to nonprescription opioids such as heroin and illicitly manufactured fentanyl (IMF) or illicitly obtained opioid medications. Methamphetamine and other substances are increasingly contaminated with fentanyl, and the Drug Enforcement Administration (DEA) has seen a rise nationally in counterfeit drugs containing IMF, including in the stimulant and benzodiazepine supply.

All Drug Overdose Deaths

Region 9's age-adjusted overdose death rate per 100,000 (29.5) is still somewhat lower than Colorado's (31.7). In Region 9, overdose deaths rose slightly in 2020–2021, from 20.6 per 100,000 to 29.5 per 100,000 (see Figure 3).

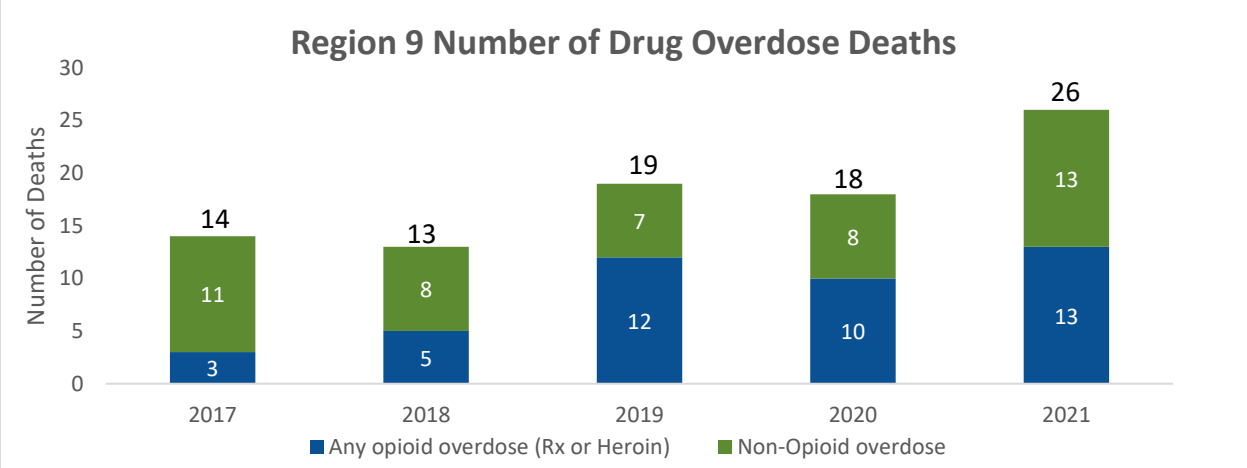
Figure 3. Drug Overdose Deaths Adjusted for Age, per 100,000



**The rate in 2021 in Colorado was significantly higher than in 2017. Source: Colorado Department of Public Health and Environment (CDPHE) Drug Overdose Dashboard.*

The Region 9 rate translates to 26 drug overdose deaths in 2021, an increase from a five-year low of 13 in 2018. In 2021, 13 deaths (50%) were opioid related (prescription or heroin), of which 10 deaths were because of synthetic opioids containing fentanyl (see Figure 4).

Figure 4. Drug Overdose Deaths in Region 9, 2017–2021



Source: CDPHE Drug Overdose Dashboard.

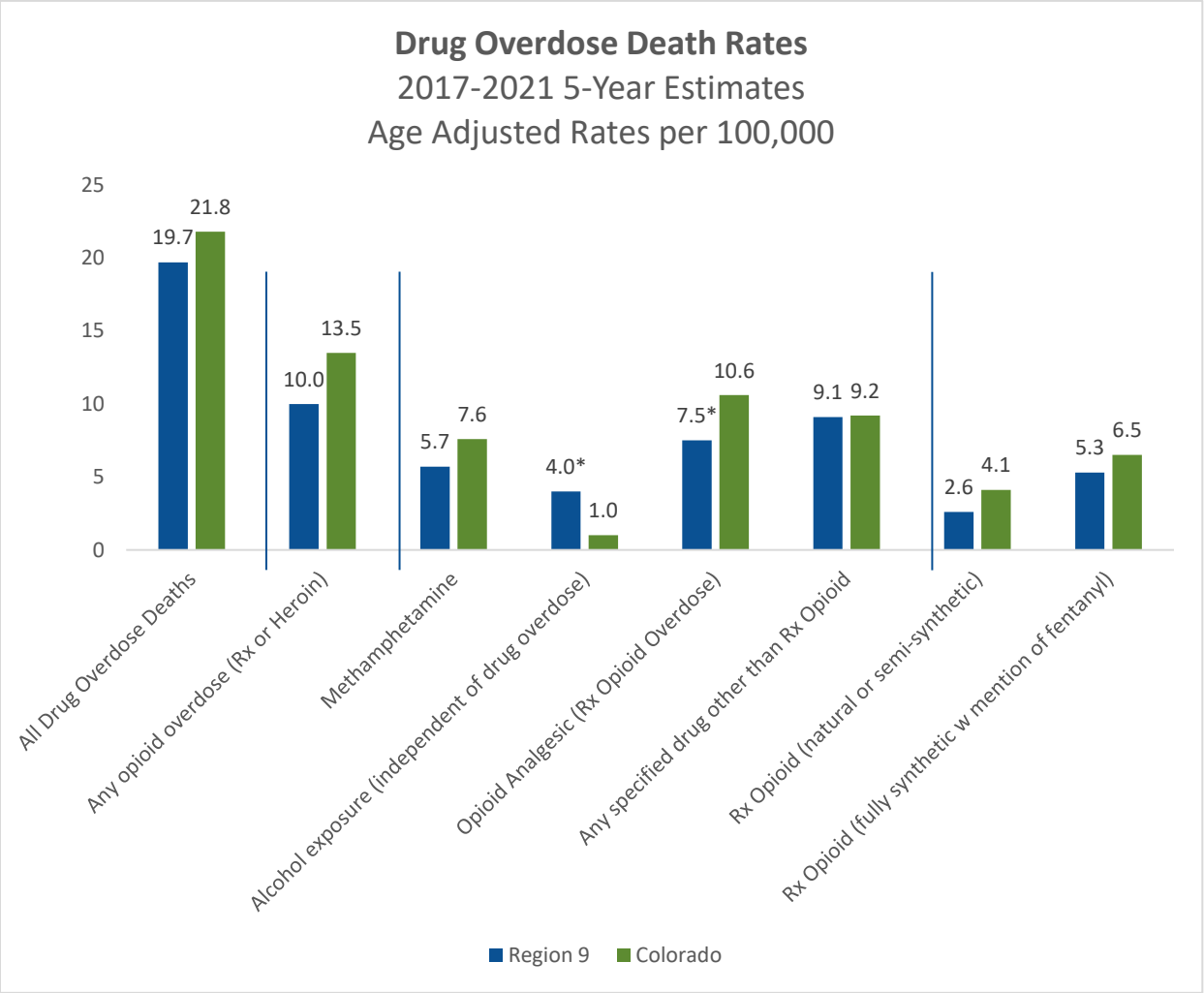
The 2017–2021 five-year estimate of drug overdose deaths of 19.7 per 100,000 in Region 9, was slightly lower than Colorado's at 21.81 per 100,000. Methamphetamine and non-prescription opioid overdose were marginally lower in Region 9 than statewide; however, alcohol and prescription opioid related overdose was significantly higher in Region 9.

- The rate of alcohol related deaths, while lower compared with other drugs, was significantly higher in Region 9 at 4.0 per 100,000 versus 1.0 per 100,000 statewide.

- The rate of prescription opioid overdose was significantly lower in Region 9 at 7.5 per 100,000 compared to 10.6 per 100,000 in Colorado.

Deaths involving natural or semi-synthetic opioids were lower (2.6 per 100,000) compared with deaths involving fully synthetic opioids containing fentanyl (5.3 per 100,000).

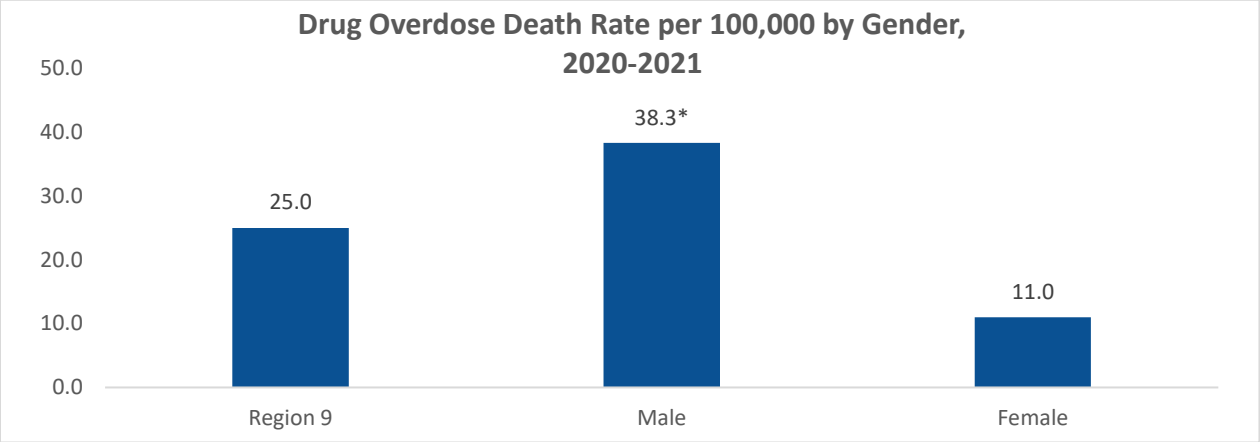
Figure 5. Drug Overdose Deaths, Five-Year Estimates Adjusted for Age per 100,000



*Note: The rate in Region 9 was significantly different than statewide. Source: CDPHE Drug Overdose Dashboard.

Gender disparities in Region 9's rate of drug overdose deaths are evident. Males were significantly more likely to experience a drug overdose death (38.3 per 100,000) than females (11.0 per 100,000) in 2020–2021 (see Figure 6).

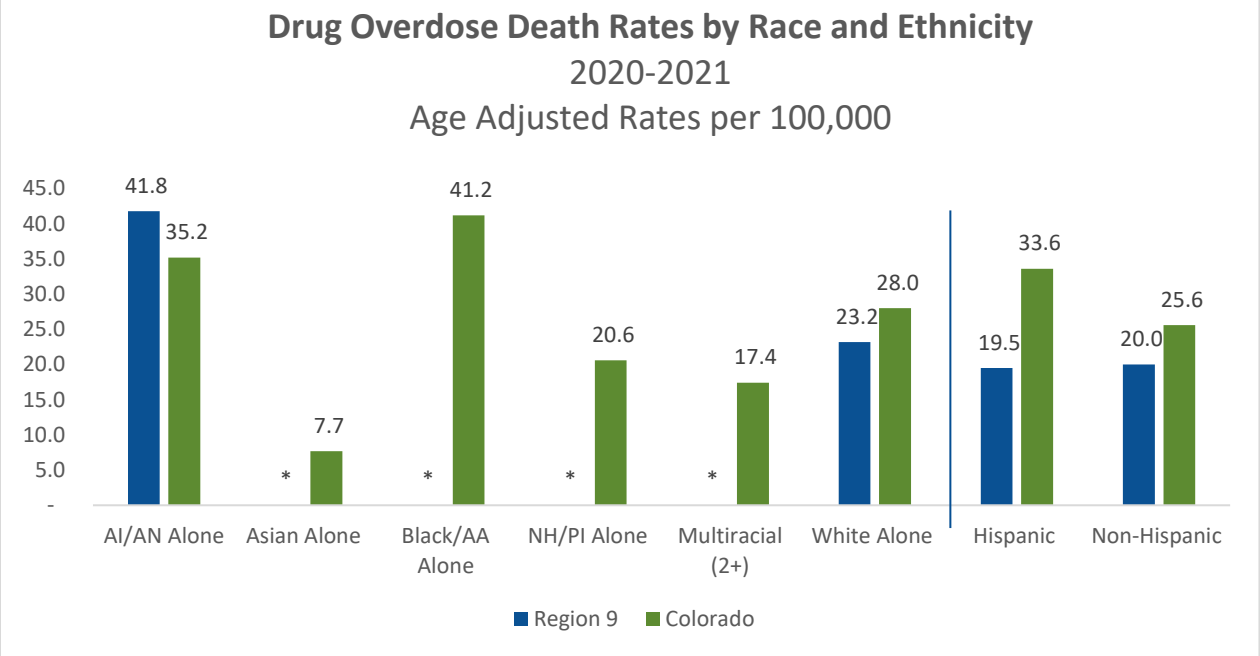
Figure 6. Drug Overdose Deaths per 100,000 by Gender, 2020–2021



*The rate for males in Region 9 was significantly higher than for females in Region 9. Source: CDPHE Drug Overdose Dashboard.

Although not statistically significant (overlapping confidence intervals), in 2020–2021, Indigenous people living in Region 9 had a higher rate of overdose deaths (41.8 per 100,000) than White residents of the region (23.2 per 100,000). No difference in death rates was between Hispanic and non-Hispanic residents (see Figure 7).

Figure 7. Age-Adjusted Drug Overdose Deaths by Race and Ethnicity per 100,000, 2020–2021



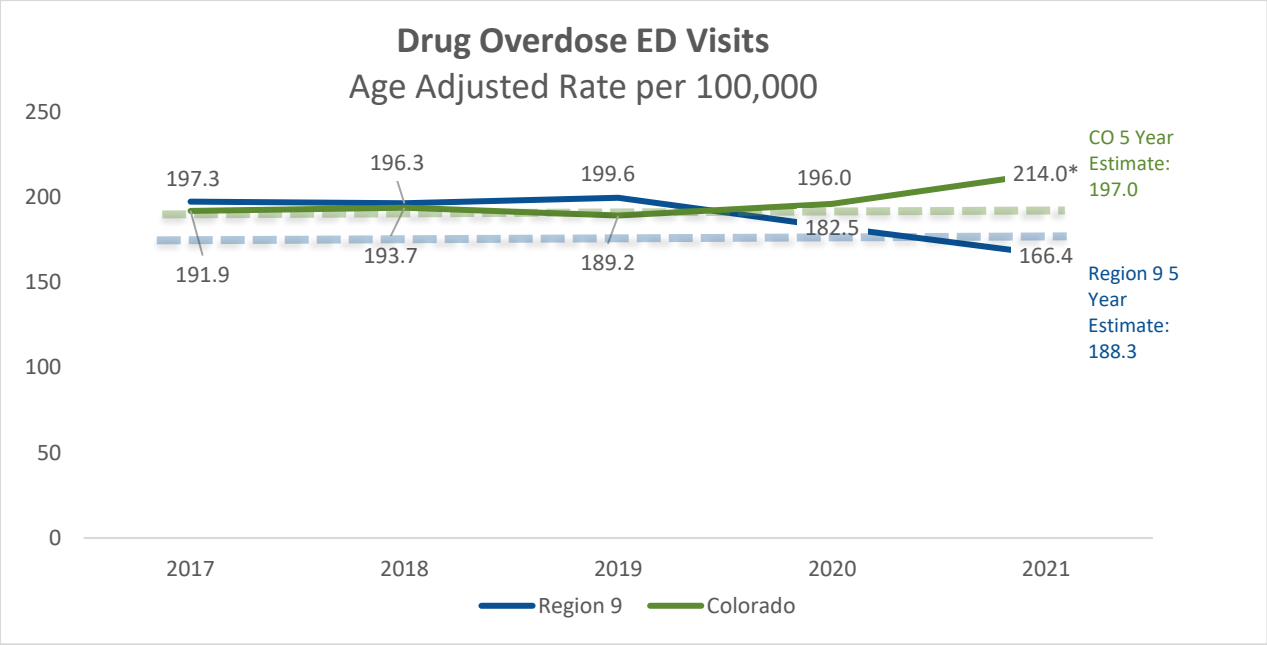
Note: African American (AA), Native Hawaiian/Pacific Islander (NH/PI)
*Zero to three deaths, suppressed for confidentiality. Source: CDPHE Drug Overdose Dashboard.

Substance Use Related ED Utilization

According to a needs assessment that the Catholic Health Initiatives (CHI) Foundation conducted in 2021, Centura Mercy treats patients from the five-county region in addition to the Southern Ute Indian Tribe, Ute Mountain Ute Tribe Reservation, Navajo Nation, and Jicarilla Apache Reservation. In 2020, Centura Mercy reported 53 patients had an opioid-related diagnosis, approximately 73 percent of whom had public insurance. That same year, Centura Mercy reported 816 patients had an alcohol-related diagnosis, and approximately 67 percent were publicly insured. Of those individuals, approximately 32.5% (266) identified as Native American/Alaska Native, which is disproportionately higher than the population of Indigenous people in La Plata County (7.7%).

Drug overdose-related ED visits were lower in Region 9 (166.5 per 100,000) than the statewide rate (214.0 per 100,000) and trending downward, whereas the statewide trajectory was moving upward (see Figure 8).

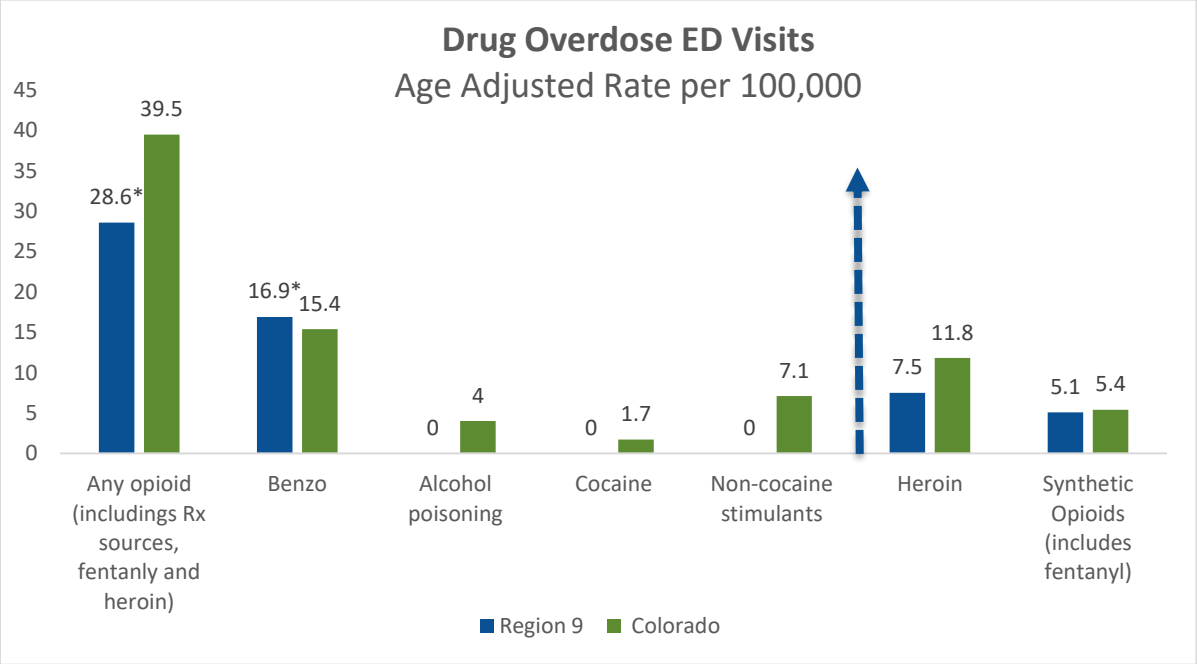
Figure 8. Drug Overdose-Related ED Use



*Colorado trend significantly different in 2021 compared with 2017. Source: CDPHE Drug Overdose Dashboard.

Figure 9 shows the drug overdose ED visits by type of drug. ED use related to overdoses from benzodiazepines (benzos) and synthetic opioids in Region 9 is comparable to the statewide rate. However, most other drug types have lower overdose ED visit rates.

Figure 9. Drug Overdose-Related ED Use



*Region 9 rate is significantly different than the statewide rate. Source: CDPHE Drug Overdose Dashboard.

Based on HMA's review of the data, the following are key takeaways:

- The drug overdose death rate in Region 9 is still slightly lower than statewide; however, overdose deaths increased somewhat in 2020–2021, which translates to 26 drug overdose deaths in 2021, an increase from a five-year low of 13 deaths in 2018. In 2021, half of the deaths (13) were opioid related (prescription or heroin), 10 of which were tied to a synthetic opioid containing fentanyl.
- Alcohol-related overdose was significantly more common in Region 9 than Colorado as a whole.
- Males were significantly more likely to experience a drug overdose death than females in Region 9.
- Drug overdose-related ED visits were lower in Region 9 compared with the statewide rate and trending downward, unlike the statewide trajectory.

Gap Analysis: SUD/OUD Services

For this assessment, HMA established a set of principles and defined a core continuum of SUD/OUD services, making it possible to compare "what is" in Region 9 to "what should be." The framework is

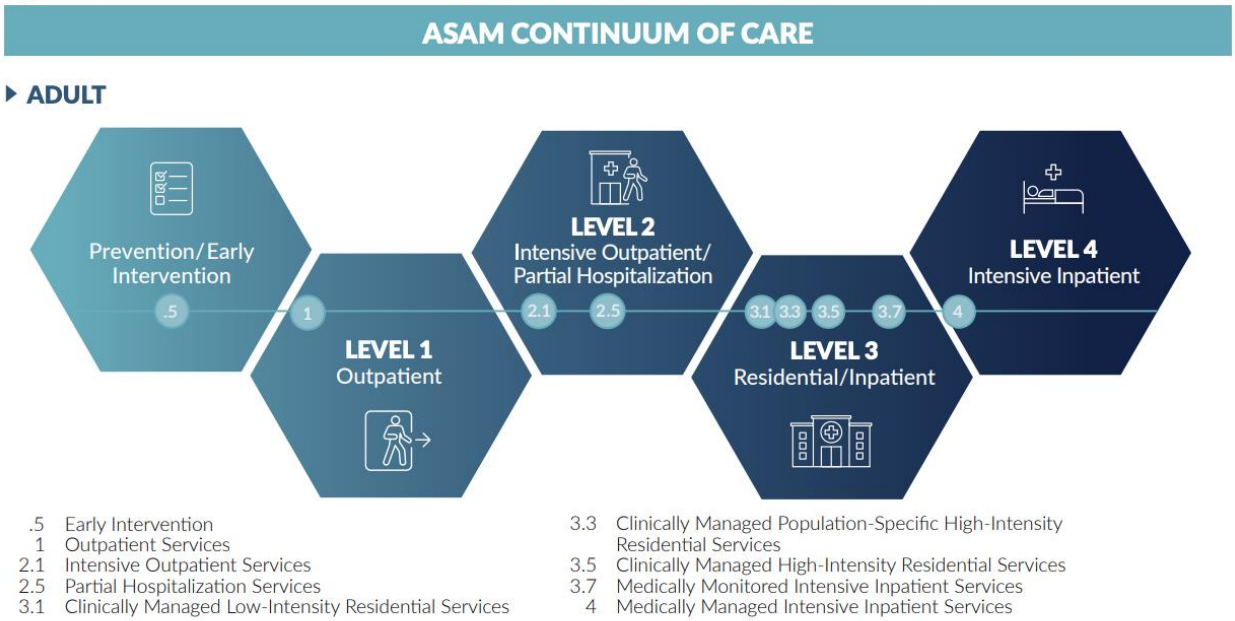
based in part on national models, including as SAMHSA's description of a good and modern addictions and mental health system.[15] The continuum should:

- **Be person-centered.** It is important that people who misuse substances are at the center of the behavioral health system. Hence, their personal experiences and priorities should be paramount when defining an optimal continuum of care, and they should play a key role in shaping behavioral health policies and practices.
- **Offer an array of services with an emphasis on upstream prevention and a range of community-based services.** The core continuum of care should include a range of services and provider types for both children and adults, reflecting that many people may require only preventive or outpatient services, whereas some people may need short-term residential or hospital-based care to keep them safe or address physical health issues. It also requires looking beyond medical care alone to consider community supports and the important role of housing, food, employment, connection, and community.
- **Focus on achieving equity.** All care provided across the continuum should be designed and delivered in a way that actively addresses disparities by race, ethnicity, ability, sexual orientation, and gender identity. Achieving this goal entails examining where providers are located, investing in a diverse behavioral health workforce, and addressing racism and discrimination with a focus on individuals who are experiencing homelessness, justice-involved, and other populations who disproportionately experience systemic racism and discrimination.
- **Reflect evidence-based and community-defined best practices.** Services should be provided in the least restrictive setting possible for the care and supports each individual need. Though some people require inpatient or residential services, the unnecessary use of inpatient or residential beds is a powerful signal that more community-based and support services are needed.

For SUD/OUD specifically, the American Society of Addiction Medicine (ASAM) provides a continuum of care and tools for clinicians to assess which services are needed along the continuum. Services range in intensity from prevention/early intervention to intensive inpatient care (see Figure 10).

[15] Substance Abuse and Mental Health Services Administration. *Description of a Good and Modern Addictions and Mental Health Service System.* Available at: https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

Figure 10. ASAM Coninuum of Care



Source: American Society of Addiction Medicine. About the ASAM Criteria. Available at: https://www.asam.org/asam-criteria/about-the-asam-criteria. Last accessed July 25, 2023.

Though the continuum describes five different major categories of services, they sometimes are indistinct from one another. In practice, a person might require and receive services from more than one category of provider at any given time. For example, an individual enrolled in an intensive outpatient program might also receive support from a peer recovery specialist. Moreover, people routinely move in and out of care, requiring services from different categories, sometimes in a matter of hours or days.

The Continuum of Services in Region 9

According to the provider survey, more than half (53%, n=8) of the respondents reported that an incomplete system or continuum of care was a barrier to the delivery of SUD/OUD treatment services and supports. Meeting the demand for services was another barrier (47%, n=7). Together, an incomplete continuum and an inability to meet the high demand for services may lead to inequitable access to timely SUD/OUD care.

Community Member Perceived Gaps in the Continuum

Key informants identified several gaps in substance use prevention, treatment, and recovery, most notably:

- **Recovery housing:** The most frequently described gap was housing for people transitioning back into the community after inpatient treatment or for people in ongoing recovery, referred to as sober, recovery, and transitional housing. Interviewees across all across all categories and disciplines—law enforcement and judicial, tribal, behavioral health, public health, primary care, and human services—all identified this gap, speaking to the ubiquity of need. Key informants stressed that housing must be flexible to meet people's different needs and stages of recovery, low barrier, follow a "housing first" model, and offer ancillary support services.
- **Access to methadone and buprenorphine:** At present, Region 9 has no methadone clinic (also known as an opioid treatment program, or OTP). The closest one is in Farmington, NM, and it operates with limited hours. Various interviewees estimated that 50−100 patients would be needed to financially sustain a program, and the demand is more than sufficient to meet this threshold. Multiple interviewees suggested that establishing such a facility could serve as a potential area of collaboration between local tribes, the Indian Health Services, and counties. Given the rural/frontier nature of the region, a traditional OTP model may not be inadequate to meet needs, and the region should focus on transportation supports and take-home doses. Innovations such as a mobile MAT clinic is another potential solution.
- **Medically managed withdrawal:** Key informants noted the only local detoxification options are social detox, a model in which individuals are not provided any medication to ease withdrawal symptoms or to initiate MAT. According to key informants, no facility in the region offers medically managed withdrawal, and facilities that provide social detox refuse services for individuals with a higher level of need (e.g., medical complications, psychiatric crisis). Interviewees who pointed to deficiency said that social detox should be eliminated or offered alongside medical detox, with supports to transition patients to community-based outpatient treatment, specifically, MAT.
- **Non-hospital inpatient or residential treatment facilities**: The closest inpatient facilities are in Grand Junction or Denver and they often have long waitlists. In addition, patient transportation is both logistically challenging and expensive. Importantly, five interviewees expressed a need for inpatient or residential SUD/OUD treatment, but the same number of participants expressed reservations about the need for and sustainability of such a facility. Concerns included workforce, funding, and insurance reimbursement, and whether the demand is large enough to fill and sustain an inpatient facility.

Multiple stakeholders identified other challenges, including:

- Care coordination, to increase awareness and use of existing services and support for individuals with complex behavioral health, medical, and social needs
- Behavioral health crisis stabilization services
- Syringe exchange
- Dual diagnosis treatment for patients with both mental health and substance use needs
- Expanded peer recovery services

ASAM Levels of Care

The State of Colorado requires that providers use ASAM criteria to determine medical necessity for residential and inpatient hospital levels of care. Medicaid-covered services include:

- Outpatient SUD services: ASAM 1.0, 2.1 (intensive outpatient [IOP] therapy)
- Clinically managed low intensity residential services (not including bed costs): ASAM 3.1, clinically managed population-specific high intensity residential services 3.3, clinically managed high intensity residential services 3.5, medically monitored intensive inpatient services 3.7
- Medically managed intensive services 4.0

Providers responding to the survey (n=15) indicated that services offered along the ASAM continuum are primarily in three domains: SUD/early intervention services (ASAM 0.5) (38%, n=5), SUD outpatient (OP) therapy (ASAM 1.0) (69%, n=9), and SUD IOP therapy (ASAM 2.1) (23%, n=3). One provider indicated offering Medically Managed Inpatient Care (ASAM 4.0). Based on the reported ASAM levels of care provider respondents reported offering, the acuity of need currently served is primarily low to medium withdrawal risk, with no to limited biomedical conditions and complications, and none to mild emotional, behavioral, or cognitive conditions and complications (see Table 2).

Table 2. Provider Survey Responses to Question Regarding Levels of Care Provided

	What ASAM levels of care do you provide? Select all that apply.			
Level of Care and Definition	**Acuity of Need Served[16]**	**Services/Treatment Approaches**	**Number of Survey Respondents**	**Percent of Survey Respondents (n=15)**
SUD Prevention/Early Intervention Services (ASAM 0.5): Assessment and education services specific to individuals who are at risk for developing a SUD	**Withdrawal risk:** None **Biomedical conditions and complications:** None or very stable **Emotional, behavioral, or cognitive conditions and complications**: None or very stable	Includes services such as screening, brief intervention, and referral to treatment (SBIRT) or driving under the influence (DUI) programs	**5**	**38%**

[16] Montana Primary Care Associates. The ASAM Criteria Crosswalk: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions. Available at: http://www.mtpca.org/wp-content/uploads/ASAM-Adult_Criteria_Crosswalk.pdf. Last accessed July 25, 2023.

What ASAM levels of care do you provide? Select all that apply.				
Level of Care and Definition	**Acuity of Need Served[16]**	**Services/Treatment Approaches**	**Number of Survey Respondents**	**Percent of Survey Respondents (n=15)**
SUD OP Therapy (ASAM 1.0): <9 hours/weekly for adults, <6 hours/ weekly for adolescents for recovery or motivational enhancement therapies	**Withdrawal risk:** Not experiencing significant withdrawal or at minimal risk of severe withdrawal **Biomedical conditions and complications:** None or very stable or is receiving concurrent medical monitoring **Emotional, behavioral, or cognitive conditions and complications**: None or very stable, or is receiving concurrent mental health monitoring	Includes several therapies and service components, including individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, MAT, or other skilled treatment services	**9**	**69%**
SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1): >9 hours/weekly for adults, >6 hours weekly for adolescents	**Withdrawal risk:** Minimal risk of severe withdrawal, manageable at Level 2-WM **Biomedical conditions and complications:** None or not a distraction from treatment **Emotional, behavioral, or cognitive conditions and complications**: Mild severity, with potential to distract from recovery; needs monitoring		**3**	**23%**
Medically Managed Inpatient (Hospital) (ASAM 4.0): 24-hour nursing care and daily physician care, with counseling available for engaging both adult and adolescent patients	**Withdrawal risk:** At high risk of withdrawal and requires full resources of a licensed hospital **Biomedical conditions and complications:** Requires 24-hour medical and nursing care and the full resources of a licensed hospital **Emotional, behavioral, or cognitive conditions and complications**: Severe acuity requires 24-hour psychiatric care with concomitant addiction treatment	Cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis; physical health interventions; health education services; planned clinical interventions; and services for the patient's family, guardian, or significant others	**1**	**8%**

The levels of care and service offerings that survey respondents said were missing include ASAM 2.5, ASAM 3.1, ASAM 3.3, and ASAM 3.5. HMA's proximity analysis, described in more detail below, indicates a provider location that offered ASAM 3.2 withdrawal management (WM) was the only SUD residential provider within the network adequacy standards. Based on missing levels of care, the following levels of acuity are being inadequately served:

- **Withdrawal risk:** People with moderate risk of severe withdrawal

- **Biomedical conditions and complications:** People needing for concurrent medical monitoring
- **Emotional, behavioral, or cognitive conditions and complications:** Mild to moderate severity, including needing 24-hour care in a structured setting and/or stabilization

Table 3 provides a description of the services and treatment definitions by acuity for each of the identified missing ASAM levels of care based on survey responses.

Table 1: Definition of ASAM Levels of Care Missing from Region 9

Level of Care	Acuity of Need Served	Services/Treatment Approaches	Definition
SUD Partial Hospitalization (ASAM 2.5)	**Withdrawal risk:** Moderate risk of severe withdrawal **Biomedical conditions and complications:** None or not sufficient to distract from treatment **Emotional, behavioral, or cognitive conditions and complications**: Mild to moderate severity, with potential to distract from recovery; needs stabilization	Includes several therapies and service components, including individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, MAT, or other skilled treatment services	Greater than 20 hours/weekly, but not requiring 24-hour care
SUD Clinically Managed Low-Intensity Residential (ASAM 3.1)	**Withdrawal risk:** None, or minimal or stable withdrawal **Biomedical conditions and complications:** None or stable, or receiving concurrent medical monitoring **Emotional, behavioral, or cognitive conditions and complications**: None or minimal; not distracting to recovery; if stable, a co-occurring enhanced program is required	Skilled treatment services include individual, group, and family therapy; medication management and medication education; mental health evaluation and treatment; motivational enhancement and engagement strategies; recovery support services; counseling and clinical monitoring; MAT; and intensive case management, medication management and/or psychotherapy for individuals with co-occurring mental illness	24-hour environment, such as a group home; both clinic-based services and community-based recovery services provided
SUD Clinically Managed Population-Specific High-Intensity Residential (ASAM 3.3)	**Withdrawal risk:** At minimal risk of severe withdrawal **Biomedical conditions and complications:** None or stable, or receiving concurrent medical monitoring **Emotional, behavioral, or cognitive conditions and complications**: Mild to moderate severity;	Skilled treatment services include a range of cognitive, behavioral, and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; educational groups; occupational and recreational therapies; art, music, or movement therapies; physical therapy; clinical and didactic motivational	Adults only (no adolescent equivalent)

Level of Care	Acuity of Need Served	Services/Treatment Approaches	Definition
	needs structure to focus on recovery	interventions; and related services directed exclusively toward the benefit of the Medicaid-eligible individual	
SUD Clinically Managed High-Intensity Residential (ASAM 3.5)	**Withdrawal risk:** At minimal risk of severe withdrawal **Biomedical conditions and complications:** None or stable, or receiving concurrent medical monitoring **Emotional, behavioral, or cognitive conditions and complications**: Demonstrates repeated inability to control impulses or unstable and dangerous signs/symptoms require stabilization		High intensity for adults, medium intensity for adolescents

Source: HMA provider survey

Withdrawal Management

The ASAM criteria include five levels of WM services. These services are routinely provided concurrently with other addiction services, by the same clinical staff, and in the same treatment setting.

Among the 13 provider respondents, five (38%) indicated they offer WM for adults. The most common WM is ambulatory without extended on-site monitoring (Outpatient 1.0 WM), which two providers (15%) offer, followed closely by clinically managed residential (3.2 WM), which one provider (8%) accommodates. Ambulatory WM with extended on-site monitoring (Outpatient 2.0 WM) and medically managed intensive inpatient WM (4.0 WM) were each offered by one provider. One respondent indicated, as a "general hospital by default, managing high-risk or complicated alcohol withdrawal and adverse medical consequences of other substance use" reported that it can begin MAT for OUD as a bridge to further therapy, with inpatient social workers who coordinate with outpatient treatment providers.

Table 4. Levels of WM Care for Adults

What WM levels of care for adults do you offer? Select all that apply.			Count	Percent
Ambulatory WM without Extended On-Site Monitoring (Outpatient WM) (1.0 WM)	Services include individual assessment, medication/ nonmedication WM,	Regularly scheduled sessions	**2**	**15%**

What WM levels of care for adults do you offer? Select all that apply.			Count	Percent
Ambulatory WM with Extended On-Site Monitoring (Outpatient WM) (2.0 WM)	education, clinical support, and discharge planning	Regularly scheduled sessions daily with extended on-site services	**1**	**8%**
Clinically Managed Residential WM (Residential WM) (3.2 WM)	Daily therapies to assess progress, medical services, individual and group therapy, withdrawal support, and health education services	24 hours daily structure and support	**1**	**8%**
Medically Monitored Inpatient WM (3.7 WM)	Clinical consultation; supervision for cognitive, biomedical, emotional, and behavioral challenges; medical nursing care; and direct addiction with other levels of care	24 hours daily with observation, monitoring, and treatment.	0	0%
Medically Managed Intensive Inpatient WM (4.0 WM)	Specialized medical consultation, full medical acute services, and intensive care	24 hours daily with observation, monitoring, and treatment.	**1**	**8%**

Source: HMA provider survey

SUD Treatment Approaches

Survey responses represented the diversity and comprehensiveness of treatment approaches available. Motivational interviewing and SBIRT are the most common approaches offered (62%, n=8) followed by individual therapy, cognitive behavioral therapy (CBT), and dialectical behavioral therapy (DBT), which 54% (n=7) of the provider survey respondents offer (see Table 4). Other treatment approaches include:

- Eye movement desensitization and reprocessing (EMDR) therapy (2)
- Peer support recovery services (2)
- Intravenous ketamine for SUD

Table 2. SUD Treatment Approaches Offered

What SUD treatment approaches do you or your organization offer? Select all that apply.	Count	Percent
Motivational interviewing	8	62%
SBIRT	8	62%
Individual therapy	7	54%
CBT	7	54%
DBT	7	54%
Family therapy	6	46%
Group therapy	5	38%
Other, please describe	5	38%
MAT	4	31%

What SUD treatment approaches do you or your organization offer? Select all that apply.	Count	Percent
Community reinforcement and contingency management	4	31%
Seeking safety and other trauma-focused therapies	4	31%
12-step facilitation	3	23%
Therapeutic community	1	8%
Matrix model	1	8%
Total	13	

Source: HMA provider survey

Crisis Services

The National Guidelines for Behavioral Health Crisis Care that SAMHSA released in early 2020, identify three pillars of services that every person experiencing a behavioral health crisis, including mental health or SUD, should be able to access, including:

- Someone to call (988, answered by 24/7 local call centers)
- Someone to respond (mobile crisis teams staffed with behavioral health professionals)
- Somewhere to go (crisis stabilization facilities that provide an alternative to EDs)[17]

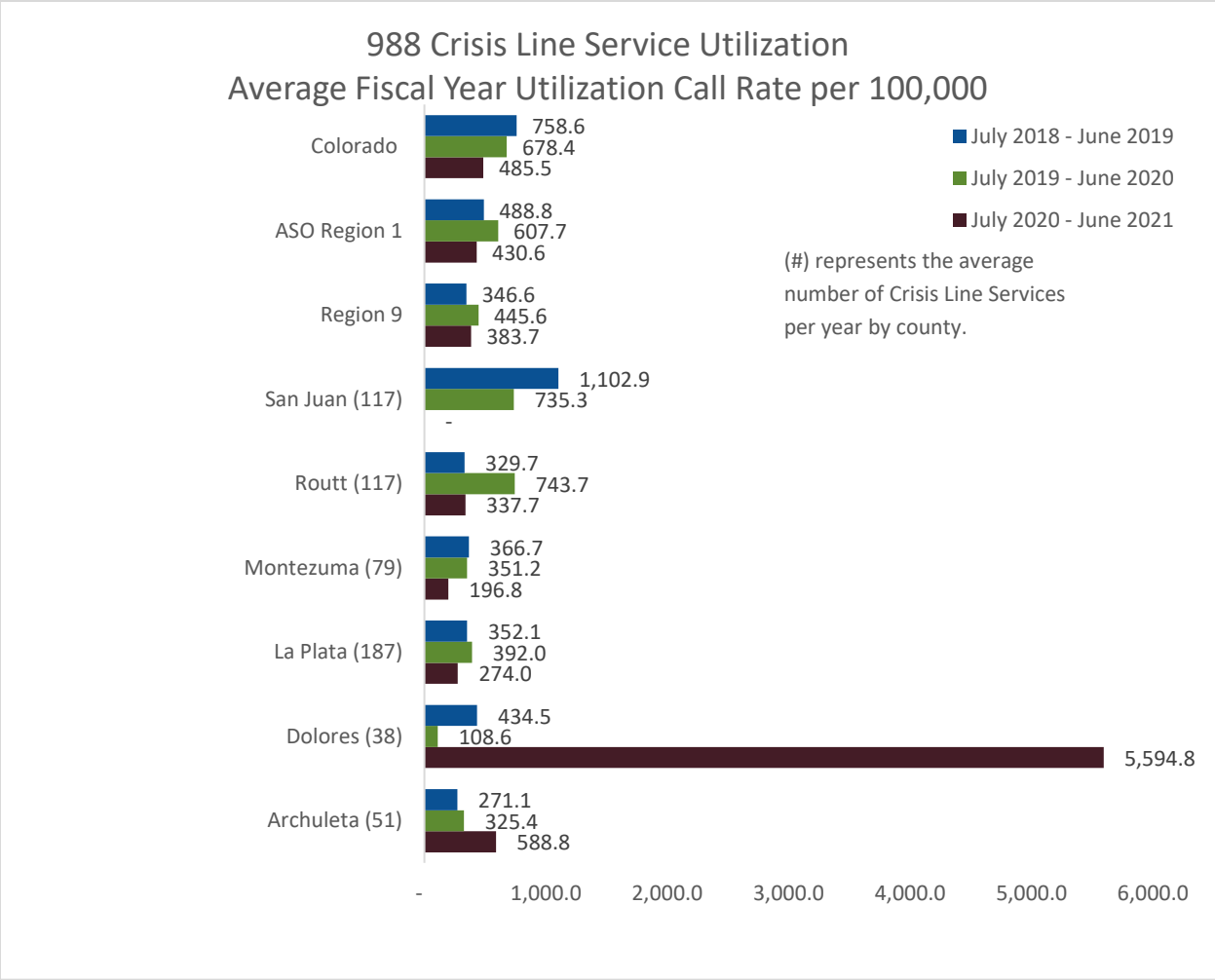
Below we describe to what extent these three pillars of service exist within Region 9.

Someone to call (988, answered by 24/7 local call centers)

Region 9 has two crisis hotlines operating, including Colorado's 988 Hotline[18] and Axis Health Systems Care Line (970-247-5245). According to the Colorado Crisis Services Dashboard, inclusive of only the 988 hotline, residents in Region 9 made 30 or fewer 988 calls per month in 2019−2021.[19] As Figure 11 illustrates the crisis service use rate per 100,000 residents in Region 9 increased in July 2018−June 2021, from 346.6 per 100,000 residents to 383.7 per 100,000 residents, respectively. Crisis line service use reportedly declined during this time for Administrative Services Organization (ASO) Region One, which is the Colorado Behavioral Health Administration's funded network of walk-in crisis centers, crisis stabilization centers, and respite and mobile crisis services in Colorado. Of note, these data do not include use of the 24/7 Axis Care Line, which would show additional usage in the region.

[17] Substance Abuse and Mental Health Services Administration. *National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit Knowledge Informing Transformation.* Published 2020. Last accessed July 25, 2023.
[18] Colorado Behavioral Health Administration. 988 in Colorado. Available at: https://bha.colorado.gov/behavioral-health/988
[19] Colorado Behavioral Health Administration. Colorado Crisis Services. Available at: https://tableau.state.co.us/t/CDOBH_Ext/views/RMCPWeeklyDashboard/CrisisLineStatewideMap?%3Aiid=3&%3AisGuestRedirectFromVizportal=y&%3Aembed=y. Last accessed July 25, 2023.

Figure 11. 988 Crisis Hotline Service Use per 100,000 Coloradans



Source: Colorado crisis services, including hotline, lifeline, support line, and text use

Someone to respond (mobile crisis teams staffed with behavioral health professionals)

Numerous interviewees described mobile crisis services as an asset, specifically Montezuma County's Community Intervention Program (CIP) and Durango's Co-Responder (CORE) program.

- The CIP, a collaboration between Montezuma, Cortez, Mancos, and Dolores counties, the Cortez Fire Protection District, and Axis Health System, provides mobile crisis response. Teams of emergency medical technicians (EMTs) and social workers use an unmarked sprinter van to respond to noncriminal behavioral health, medical, and social crises, including those related to mental health issues, alcohol or drug addiction, suicidal ideation, overdose, homelessness, hunger, illness, or injury, or a personal or family emergency. The CIP program was established as a new cross-county department, and Montezuma, Cortez, Mancos, and Dolores counties share the costs. Startup expenses were approximately $408,000 for the first year. Initially the American Rescue Plan Act (ARPA) supplied funding to cover post-pandemic relief. Using ARPA funds, Montezuma County paid $292,000, Cortez paid $177,000, Mancos paid $32,000, and Dolores paid $18,500 toward the program. Funding after the first year will come from state and federal grants, along with community fundraising efforts.[20]

> Emergency calls for noncriminal situations continue to increase in Montezuma County, including for well-being checks, substance abuse, mental health crises, suicidal threats, and overdoses. "We have seen this problem getting worse and worse. After a lot of discussion and collaboration with area towns and police and fire agencies, a countywide intervention program was seen as something to try. We are offering a hand up for people in need."
> – *Montezuma Co. Key Informant*

- The Durango Police Department (DPD) and Axis Health System collaborated to launch the CORE program and provide a nuanced response for behavioral health-related police calls regarding people experiencing mental health, addiction, and homelessness crises. CORE helps people access primary care for chronic conditions, provides support to youth and older adults, problem solves with family members, and connects people to resources.
  CORE responded to 1,419 initial calls since it started in June 2021. A *Durango Herald* article reported people have placed 185 unique calls to CORE in 2023 and 260 total when follow-up calls are included. CORE referrals come from DPD, Manna Soup Kitchen, Espero Apartments (supporting housing in Durango), Axis Health Systems Mobile Crisis Team, and the mental health hotline when safety concerns may be involved. The program operates on $400,000 a year. The Durango CORE team includes two DPD officers and two Axis behavioral health providers who rotate in two-person teams to provide uninterrupted year-

> "I don't have the numbers, but anecdotally I can say that it seems like there's been a decrease in jailed transports and hospital transports for many of our patients or clients. We are having success for sure, working with people over time and figuring out solutions other than jail." – *Durango Co. key informant*

[20] Mimiaga J. Montezuma County Launches Community Intervention Program. *The Journal*. Published May 2, 2022. Available at: https://www.the-journal.com/articles/montezuma-county-launches-community-intervention-program/?fbclid=IwAR0SWJQ3zzlQEgdWN5umkJ9nWxxTZaHx12znsJdO0jb9G_c51ihChDN2q1U. Last accessed July 25, 2023.

round daily service. CORE has expanded to include La Plata County Sheriff's Office deputies and Axis behavioral health providers as of May 2023.[21]

Both CIP and CORE are well regarded in the region, and interviewees expressed a need to expand these types of services.

Somewhere to go (crisis stabilization facilities that provide an alternative to EDs)[22]

Region 9 is without a crisis stabilization facility, and many individuals in crisis end up in the ED or criminal justice system. The nearest walk-in center location for Region 9 residents is in Montrose, which serves the Western Slope Region. This location offers walk-in services and in-person, confidential crisis support, information, and referrals. Axis Health Systems does offer an acute treatment unit (ATU), which provides short-term psychiatric stabilization for people in crisis and admits patients after they have undergone withdrawal management, as well as walk-in crisis and respite services. The ATU is voluntary treatment for mental health, as established in Colorado statute (Title 27, Article 65, C.R.S., commonly referred to as 27-65).

Medication Assisted Treatment

MAT is evidence-based treatment with US Food and Drug Administration (FDA)-approved medications, oftentimes in combination with counseling and other therapeutic techniques, to provide a whole-patient approach to the treatment of SUD/OUD. MAT addresses withdrawal symptoms, decreases substance use, eases cravings, prevents overdose deaths, and reduces complications of intravenous drug use and other risky behaviors.

Medications for Opioid Use Disorder

It is considered the gold standard for treating OUD and can be provided in outpatient settings. The FDA has approved three medications for opioid use disorder (MOUD): methadone (full agonist), buprenorphine (partial agonist), and naltrexone (antagonist).

- Buprenorphine suppresses and reduces cravings for opioids.
- Methadone reduces opioid cravings and withdrawal and blunts or blocks the effects of opioids.
- Naltrexone blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria. [23]

MOUD is evidence-based and can treat withdrawal from OUD, blunt or block the effects of illicit opioids, and curb cravings for opioids. Access to all three medications in the substance use service delivery system is important to assure that access to treatment is aligned with standards of care. This includes

[21] Jaros G. Pairing Durango Police with Mental Health Professionals Proves Successful. *Durango Herald*. Available at: https://www.durangoherald.com/articles/paring-durango-police-with-mental-health-professionals-proves-successful/. Last accessed July 25, 2023.
[22] Substance Abuse and Mental Health Services Administration. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit.
[23] Substance Abuse and Mental Health Services Administration. Medications, Counseling, and Related Conditions. Updated March 22, 2023. Available at: https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions. Last accessed July 26, 2023.

each individual with OUD having access to all three forms of MOUD, with the decision of which is prescribed for their treatment based on a clinical decision-making process by the prescriber and with the person's input and choice.

No "one size fits all" approach works for everyone who needs OUD treatment to achieve recovery. Factors determined by and for each individual based on their clinical needs and situation include whether to use MOUD to seek recovery from OUD; length of time on MOUD; and use of other services and supports such as counseling or support groups.

Standards of care also include treating all SUDs as chronic medical conditions with the goal of helping people stabilize, achieve remission of symptoms, and sustain their recovery journey. This chronic care model includes focusing on continuing care through connection to other needed healthcare services and supports. [24]

Prescribing Information

- Methadone is administered via observed dosing at SAMHSA-certified and Drug Enforcement Administration-regulated OTPs.
- Any medical practitioner with an unrestricted DEA license can prescribe buprenorphine for OUD. Prescribing buprenorphine used to require an "X-waiver" from the DEA, but this requirement was eliminated in January 2023. The patient must be in moderate opioid withdrawal before beginning buprenorphine to avoid precipitated withdrawal.
- Extended-release naltrexone is not a controlled substance and can be prescribed by any licensed prescriber. The patient must be opioid free for 5-10 days before beginning naltrexone.

The Bureau of Justice Assistance's withdrawal management guidelines released June 6, 2023, state:

> "Buprenorphine and methadone are first-line treatments for opioid withdrawal and OUD. All patients at risk for opioid withdrawal should have rapid access to treatment with these medications. Because opioid withdrawal management without ongoing OUD treatment increases the risk for overdose and overdose death, the appropriate clinical strategy is to prevent opioid withdrawal by initiating ongoing treatment for OUD with buprenorphine or methadone. Naltrexone is not a treatment for opioid withdrawal. Extended-release naltrexone is a treatment option for OUD in patients who are no longer physiologically dependent on opioids. However, this medication will exacerbate withdrawal in patients who are dependent on opioids."[25]

[24] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) 63*. Updated 2021. Available at: https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf. Accessed July 26, 2023.

[25] US Department of Justice. Office of Justice Programs. *Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals*. Published June 2023. Available at: https://www.cossapresources.org/Content/Documents/JailResources/Guidelines_for_Managing_Substance_Withdrawal_in_Jails_6-6-23_508.pdf. Accessed July 26, 2023.

MAT for AUD

Evidence-based MAT modalities are available to treat alcohol use disorder (AUD) as well. Though alcohol overdoses are less common than overdoses from other substances in Region 9, AUD and its detrimental effects are a significant issue in Region 9, like most of the country. Acamprosate, disulfiram, and naltrexone are the most common drugs used to treat AUD.[26]

- Acamprosate is for people in recovery, who are no longer drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol but does not curtail withdrawal symptoms.
- Disulfiram treats chronic alcoholism and is most effective in people who have already stopped drinking alcohol or are in the initial stage of abstinence.
- Naltrexone blocks the euphoric effects and feelings of intoxication and allows people with AUD to reduce alcohol use and remain motivated to take the medication, continue treatment, and avoid relapses.[27]

Successful Implementation

Key informants noted that MAT is working well in Region 9 and should be expanded to support SUD treatment and recovery. Though all interviewees said access to MAT remains limited in the region, in areas where it has been available, treatment has been successful. For example:

- Both the La Plata County Jail located in Durango and drug court offer MAT, and interviewees described supportive collaboration and political will as key factors in implementing and sustaining MAT in these settings.
- In Cortez, Southwest Health Primary Care offers buprenorphine and has high demand and a waitlist for the service.
- Axis Health System offers MAT at three locations in the region.

Five of the 13 providers who responded to the survey reported they offer MAT. Among the five, four (80%) reported having the capacity to start MAT on the same day as the patient is initially evaluated and one provider reported they can initiate same-day treatment sometimes. Suboxone (combination buprenorphine and naloxone) (100%, n=5), naltrexone (80%, n=4), and buprenorphine (60%, n=3) are provided. No provider reported offering methadone.

Nonetheless, among the 15 providers[28] who shared their perspectives, 53 percent (n=8) strongly agree and 40 percent (n=6) agree that MAT is an unmet need in Region 9. Southwest Colorado, like many other regions, is facing various barriers to MAT for SUD/OUD, including:

[26] Substance Abuse and Mental Health Services Administration. Medications, Counseling, and Related Conditions. Updated March 22, 2023. Available at: https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions. Last accessed July 26, 2023.
[27] Ibid.
[28] All three Axis Health System provider responses were included in the analysis of the question "To what extent do you agree that MAT is an unmet need in Region 9?"

- *Limited Access to MAT Providers:* One significant barrier is the limited availability of healthcare providers who choose to prescribe MAT. As a rural/frontier area, Southwest Colorado, may have fewer physicians or healthcare facilities specialized in addiction treatment. However, given the recent repeal of the X waiver, any clinician with an unrestricted license from the US Drug Enforcement Administration can prescribe buprenorphine for OUD. Provider education may be needed to raise awareness of this change and encourage prescribing.
- *Stigma and Misconceptions*: Stigma associated with SUD/OUD and MAT can be a significant barrier to treatment. Some individuals, including healthcare providers, have negative attitudes or misconceptions about MAT, perceiving it as substituting one addiction for another. This stigma can deter people from seeking or receiving MAT, as well as affect the willingness of healthcare providers to offer such treatment.
- *Financial Barriers:* The cost of MAT can present a significant hurdle for individuals seeking treatment, especially people who are uninsured or have limited financial resources. The expenses associated with medications, medical appointments, counseling, and laboratory tests can be substantial and function as a barrier to accessing and sustaining MAT. Colorado Medicaid and some commercial payers, for example, cover MAT. Opioid settlement dollars also can be used to pay for MAT treatment.
- *Transportation and Geographic Challenges:* Southwest Colorado's rugged terrain often poses transportation barriers. Limited public transportation options and long distances between treatment facilities can make it difficult for individuals to reach MAT providers regularly. This issue is particularly problematic for people without access to private vehicles or reliable transportation options and for individuals seeking to access methadone, which typically requires daily dosing at an OTP. See more on proximity to residential treatment below.
- *Fragmented Healthcare System:* Fragmented healthcare systems and the lack of coordination between various treatment providers can make accessing MAT challenging. Further, a lack of communication and integration between primary care providers, addiction specialists, mental health providers, and other relevant stakeholders can lead to disjointed care and a dearth of comprehensive treatment options.
- *Regulatory and Administrative Hurdles:* Regulatory requirements, such as mandatory counseling or prior authorizations for medications, can create administrative burdens for both providers and patients. These requirements can delay access to treatment and increase the complexity of the treatment process.

Recovery Supports

SUD/OUD are complex conditions that affect various aspects of life, including physical, psychological, and social well-being. Recovery supports provide a holistic approach to address these diverse needs, ensuring that individuals receive comprehensive care that addresses the multifaceted aspects of addiction, promotes sustained sobriety, and improves overall well-being.

Despite differences in care delivery and reimbursement, SUD/OUD treatments have approximately the same rates of positive outcomes as treatment for other chronic illnesses. Relapse rates for SUD/OUD

(40−60%) are comparable to those for chronic diseases, such as diabetes (20−50%), hypertension (50−70%), and asthma (50−70%).[29]

In 2021, the National Survey on Drug Use and Health (NSDUH) estimated that of the 11.5 percent of adults ages 18 or older who perceived that they ever had a substance use problem, 72.2 percent considered themselves to be in recovery or recovered.[30] Applying these 2021 NSDUH estimates to the Region 9's 79,138 adults (18 years and older), this would translate to an estimated 9,100 people who perceive that they have had a substance use problem.[31] Of these 9,100 people, therefore, an estimated 6,570 people (72.2%) consider themselves in recovery or recovered.

Peer support professionals are one type of recovery support. Peer support professionals are individuals who use their lived experience to help others and can work in a variety of settings and offer support in any area where a patient is receiving care. Peers are an addition to an individual's care team, offering practical solutions and focused problem solving to help individuals practice building skills needed to maintain their health and well-being.

Key informant interviewees in the region suggested that peer supports are a recovery support service that is working well in the region and would benefit from expansion. Peer organizations including Advocates for Recovery, Young People in Recovery, Alano Club (alcohol use), and Wellbriety Recovery Circle (native-led peer support group) were described as important resources for people seeking community with others working to move away from substance use. Interviewees said that these groups should be expanded and better funded to increase their reach. Additionally, several local treatment providers, including Axis and Cortez Recovery Center, offer peer recovery support that interviewees described positively.

Behavioral management, skill building (social, daily living, etc.), and peer support are the three most common recovery support services surveyed providers (n=13) offer.

Table 3. Community Support Services

What community/recovery support services do you or your organization provide? Select all that apply.		
Options	Count	Percent
Behavioral management	7	54%
Skill building (social, daily living, etc.)	6	46%
Peer support	5	38%

[29] Ciulla A. (2017). Addiction Relapse Rates Compared to Those for Other Chronic Illnesses. *Beach House Center for Recovery*. Published May 30, 2017. Available at: https://www.beachhouserehabcenter.com/addiction-relapse-rates-compared-to-those-for-other-chronic-illnesses/. Last accessed July 26, 2023.
[30] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Published January 4, 2023. Available at: https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report. Last accessed July 26, 2023.
[31] US Census Bureau. 2017-2021 ACS 5-Year Estimates. Table 21010. Published November 30, 2022. Available at: https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2021/5-year.html. Last accessed July 26, 2023.

Supported employment	4	31%
Housing support	4	31%
Supported education	4	31%
Care coordination	4	31%
Parent/caregiver support	3	23%
Transportation	3	23%
Coordinated entry system	3	23%
Mental health advance directives	3	23%
Other supports for self-directed care	3	23%
None	2	15%
Traditional healing services	2	15%
Personal care	2	15%
Other, please describe	2	15%
Respite	1	8%
Wellness recovery action planning (WRAP)	1	8%
Clubhouse	0	0%

Source: HMA provider survey

Case Management

According to SAMHSA, "Case management has been variously classified as a skill group, a core function, service coordination, or a network of 'friendly neighbors'."[32] It is a "coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals," and includes assessment, planning, linkage, monitoring, and advocacy.[33] Case management is important to include in an SUD/OUD treatment plan because:

- Retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery.
- Treatment may be more successful when a client's other challenges are addressed concurrently with substance misuse.
- Case management facilitates movement to different levels of care or systems.

Among the provider survey respondents, nearly all offer some type of case management. Specifically, 31 percent (n=4) offer SUD targeted case management (TCM), while 46 percent (n=6) offer care coordination/case management services. The Colorado Medicaid State Plan Amendment defines SUD/OUD TCM services as assistance available to individuals diagnosed as alcohol or drug dependent who need access to medical, social, educational, and other services. SUD/OUD TCM services must be

[32] *TIP 27: Comprehensive Case Management for Substance Abuse Treatment*. (2015). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf
[33] *TIP 27: Comprehensive Case Management for Substance Abuse Treatment*. (2015). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf

provided by licensed healthcare practitioners certified in addiction counseling or licensed clinicians, including advanced practice nurses (APNs), physicians/psychiatrists, and physician assistants.

Table 4. TCM Services that Providers in Region 9 Offer

	Count	Percent
Care coordination/case management services	6	46%
SUD targeted case management	4	31%
Total providers	13	

Housing Support

Nearly all providers (80%, n=12) selected housing supports as a community/recovery support service that is lacking in Region 9, although 33 percent of providers (n=5) report offering housing support. Supportive housing programs in Region 9 include:

- Espero Apartments (Durango): Axis Health Systems provides intensive case management and day-to-day support for residents at Espero, but Axis is owned and managed by Housing Solutions for the Southwest. Many residents have chronic medical conditions co-occurring with behavioral health needs. The on-site staff has been successful in helping these individuals access primary care and consistently engage in counseling, coaching, and problem-solving. Residents also use Axis's outpatient mental health and SUD/OUD treatment, psychiatric services, and community-based programs like assertive community treatment, first episode psychosis, and vocational services.
- Lumien (Durango): Axis provides similar support for Lumien and trained the current managers and case managers to continue providing services. Nine of Lumien's affordable housing units are permanent supportive and the others are available to individuals without supportive service needs.
- Piñon Project and Ute Mountain Ute Tribe (Cortez): This effort broke ground in April 2023, with 42 units to be made available with preference to Indigenous people. Axis will be the service provider for intensive case management at Piñon. Axis is working with Blue Line Development and using a new markets tax credit (NMTC) structure to encourage investment in low-income community businesses, while also effectively reducing the borrowing or financing costs to the businesses.[34] It will be across the street from Axis Health System's clinic in Cortez.

Transportation

A commonly noted barrier to service delivery among key informants was transportation, which is exacerbated by the rurality of much of Region 9 and has posed an ongoing challenge to accessing many SUD/OUD services. This situation is particularly relevant for people who are receiving methadone, which typically involves daily or weekly administration. Furthermore, transportation to inpatient or other services in Grand Junction or Denver is costly and logistically complicated.

[34] Holland & Knight LLP. New Markets Tax Credit Basics. Available at: http://services.housingonline.com/nhra_images/NMTC%20Basics.pdf. Last accessed July 26, 2023.

Four of the 13 surveyed providers (31%) say they offer transportation assistance, with two (15%) reporting "sometimes." None of these providers indicated they bill Medicaid for the costs associated with providing transportation assistance, despite the reimbursement opportunities.

For Axis Health System, transportation service is a problem-solving step, rather than a service available to everyone. Axis has vehicles at most of its locations that staff can use to visit patients in the community, jails, other healthcare facilities, and support agencies. Additional transportation opportunities in the region include:

- Axis Health System's Healthcare for the Homeless program connects individuals and families experiencing homelessness to appropriate healthcare providers; however, stakeholder input suggests the availability of this service could be improved.
- Axis Health System's community-based programs can transport patients as a part of their care (assertive community treatment, peer programs, first episode psychosis, and vocational services).
- Axis's crisis team can transport patients to out-of-area placements when available and if the patient meets safety criteria.
- The community responder programs (CORE in Durango and La Plata County, CIP in Montezuma) also can transport patients to appointments, hospitals, shelters, food pantries/meal kitchens services, or community resources.

Table 5. Available Transportation Assistance Programs

Do you or your organization provide transportation assistance?		
	Count	**Percent**
Yes	4	31%
No	6	46%
Sometimes	2	15%
Total	13	

Source: HMA provider survey

Harm Reduction

Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve the physical, mental, and social well-being of people served; and offer low-threshold options for accessing SUD/OUD treatment and other healthcare services. These services decrease overdose fatalities, acute life-threatening infections related to unsterile drug injection, and chronic diseases such as HIV/HCV. Harm reduction is a key pillar of the multifaceted US Department of Health and Human Services' (HHS) Overdose Prevention Strategy.

Survey respondents said a variety of harm reduction services are available. More than half (54%, n=7) reported offering Narcan/naloxone distribution, followed by wound care (38%, n=5). Approximately one in 10 providers (13%, n=2) offer HIV/STI/Hep C testing and education, syringe services/exchange, or safer drug use supplies or resources (8%, n=1). San Juan Basin Public Health (SJBPH) offers one notable harm reduction program, which began in 2021 and has expanded with the help of $331,187 from American Rescue Plan Act funds distributed by La Plata County. The expansion establishes a comprehensive harm reduction site at Manna Soup Kitchen. This location offers access to free naloxone and fentanyl test strips, as well as educational resources, testing for hepatitis C and HIV, and ways to

access various recovery care providers. It also provides safe needle disposal and access to sterile needles. Acceptance of these programs, which can be controversial, is growing across the country.[35]

Table 6. Safe Drug Use Resources

	Count	Percent
Narcan/naloxone distribution	7	54%
Wound care	5	38%
HIV/STI/Hep C testing and education	2	13%
Syringe services/exchange	1	8%
Safer drug use supplies or resources	1	8%
Total providers	13	

Source: HMA provider survey

SUD Treatment Utilization Analysis

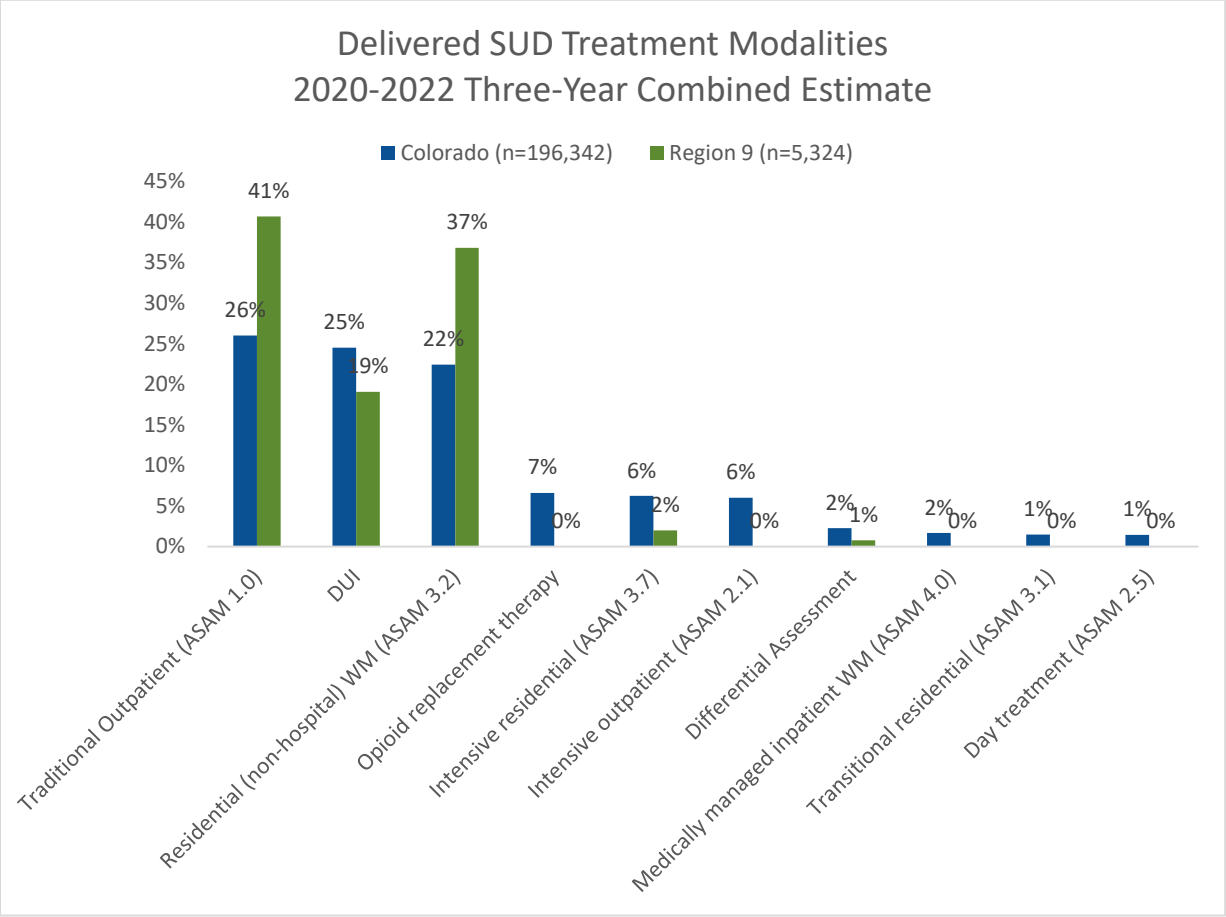
An analysis of Colorado Behavioral Health Administration (BHA) Colorado Drug/Alcohol Coordinated Data System (DACODS),[36] in combination with behavioral health encounter data, suggests that nearly all the service use (97%) at BHA licensed facilities in Region 9, regardless of payer, was traditional outpatient (41%), residential WM (ASAM 3.2) (37%), and DUI programs (19%). **Little to none of the service utilization is MAT (such as methadone or buprenorphine), intensive outpatient, or residential that occurs at licensed facilities in Region 9**.[37] Compared with statewide data, Region 9 SUD/OUD treatment as a proportion of the services that DACODS captures was higher for traditional outpatient (ASAM 1.0) and residential WM (ASAM 3.2). Outpatient and residential WM were used in the region at a higher rate relative to the state. People who access the other services on this continuum (described in Figure 12), must be traveling out of Region 9.

[35] Schafir R. Opioid Harm Reduction Efforts Advance in La Plata County. *The Durango Herald.* Published March 7, 2023. Available at: https://www.durangoherald.com/articles/opioid-harm-reduction-efforts-advance-in-la-plata-county/. Last accessed July 26, 2023.

[36] DACODS is the BHA's primary SUD client level treatment data collection instrument. SAMHSA requires that BHA collect and report on the data elements in DACODS as a requirement of funding. BHA uses this information to monitor service quality, utilization, and effectiveness, and to report to the legislature on treatment outcomes and service needs in Colorado. BHA requires completion of DACODS as a requirement of agency licensure.

[37] For definitions of each treatment modality, see page 58 in the 2023 DACODS User Manual, available at: https://bha.colorado.gov/sites/bha/files/documents/FINAL%20FY23%20DACODS%20User%20Manual.pdf

Figure 12. SUD Treatment Modalities, 2020–2022



Note: The DACODS dataset all Coloradans who use or who has used drugs or alcohol and receives services in a BHA-licensed facility, regardless of payer; anyone court-ordered or required by Child Welfare to attend a substance use treatment, detoxification, or DUI education and/or therapy program; and adolescents enrolled in Minors in Possession (MIP) treatment programs. Source: BHA, 2023.

The Colorado Department of Health Care Financing and Policy (HCPF) analyzed both behavioral health fee-for-service and encounter data to better understand where residents in each county go for their behavioral health services.[38] As Table 9 demonstrates, Region 9 residents receive behavioral healthcare primarily in three counties: Archuleta, La Plata, and Montezuma. Approximately 2 percent of services

[38]Definitions for the HCPF analysis are as follows. *Behavioral Health Service:* Distinct Claim #, Provider, Procedure Code, Diagnosis Code as submitted by the Colorado Health First Regional Accountability Entities (RAEs). *Provider Service County:* The billing provider's service county. For behavioral health services, this was identified based on the provider's NPI number. Some providers worked at multiple locations in different counties. In these cases, if the provider location was the same as the client's residence county, it was assumed that was where the service was provided. Otherwise, the minimum county number was taken to narrow it down to one county per provider for that service. This method affected a small number of services overall but is worth noting. *Client residence county:* the client's residence county was determined using the client's address listed in the client monthly snapshot table during the month the service was rendered. If clients aren't in the snapshot table, we used their listed address (as of 3/2/23).

were rendered in counties outside of Region 9, including Arapahoe, Mesa, Broomfield, Denver, Moffat, Montrose, Adams, Delta, and El Paso. San Juan residents were most likely to leave Region 9 for behavioral health services, relying upon Montrose, Adams, and Delta Counties.

HCPF behavioral health service utilization county analysis also suggests that to a limited extent, Coloradans were coming to Region 9 for their behavioral healthcare, including from Lake (53 services), San Miguel (33 services), and Mineral (2 services).

Table 7. Counties Where Services Are Rendered Compared with Counties Where Clients Reside

		*County Residents living in … (% of BH services delivered)					
	County where BH services are Received	Archuleta	Dolores	La Plata	Montezuma	San Juan	Region 9
get services in….	Archuleta	78.2%	36.7%	50.8%	0.0%	23.8%	39.4%
	La Plata	17.8%	15.0%	47.4%	22.0%	46.9%	35.7%
	Montezuma	0.0%	47.2%	0.0%	76.0%	0.0%	22.6%
	Arapahoe	2.7%	0.0%	0.0%	0.6%	0.0%	0.5%
	Mesa	0.6%	0.0%	0.4%	0.5%	0.0%	0.5%
	Broomfield	0.0%	0.0%	0.8%	0.0%	0.0%	0.4%
	Denver	0.0%	0.0%	0.6%	0.0%	0.0%	0.4%
	Moffat	0.0%	0.0%	0.0%	0.9%	0.0%	0.2%
	El Paso	0.8%	0.0%	0.0%	0.0%	0.0%	0.1%
	Montrose	0.0%	0.0%	0.0%	0.0%	16.3%	0.0%
	Adams	0.0%	1.1%	0.0%	0.0%	6.1%	0.0%
	Delta	0.0%	0.0%	0.0%	0.0%	6.8%	0.0%
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Non-Region 9 service utilization	**4.0%**	**1.1%**	**1.8%**	**2.0%**	**29.3%**	**2.2%**

Source: Department of Health Care Policy and Financing, March 2023

Telehealth

Telehealth is a mode of service delivery that has been used in clinical settings for more than 60 years and empirically studied for more than 20 years. This approach to service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous (e.g., real-time interactive client and provider interactions) and asynchronous methods (e.g., sharing of health information that is collected at one point in time and responded to or interpreted

at a later time to direct the next steps of a client's treatment or care plan and complement synchronous treatment).[39]

Psychiatrists, primary care providers, mental health counselors, social workers, psychologists, addiction counselors, case managers, opioid treatment providers, peer workers all deliver services via telehealth regularly or as means of adding flexibility to their schedules. Indeed, telehealth has the potential to address treatment gaps, make treatment services more accessible and convenient, improve health outcomes, and reduce health disparities.

- Telehealth use for behavioral health has continued to remain steady. In the first quarter of 2022, of all telehealth visits, 59.9 percent were used for behavioral health services, up from 32.4 percent of telehealth visits in the first quarter of 2019.[40]
- Data from SAMHSA's Behavioral Health Treatment Services Locator indicated that the availability of virtual substance use treatment services increased by 143 percent in January 2020–January 2021, such that by January 2021, more than half of substance use treatment facilities were offering virtual services.[41]

Several interviewees shared their thoughts on if and how telehealth can be leveraged to increase access to SUD/OUD services. They agreed that telehealth has improved by mitigating transportation barriers and allowing providers to see more patients. Interviewees suggested that telehealth could be particularly useful for addiction counseling and crisis response. Nonetheless, barriers exist, including the financial burden of having a cell phone, Wi-Fi, or cellular data; technology literacy; and the difficulty of establishing a close connection with a provider virtually. Moreover. the percentage of households without broadband access was significantly higher in five Region 9 counties:[42]

- La Plata County: 37 percent lack access to 100 Mbps, and 16 percent lack access to 25 Mbps
- Montezuma County: 42 percent lack access to 100 Mbps, and 11 percent lack access to 25 Mbps
- Dolores County: 76 percent lack access to 100 Mbps, and 15 percent lack access to 25 Mbps
- Archuleta County: 57 percent lack access to 100 Mbps, and 13 percent lack access to 25 Mbps
- San Juan County: 81 percent lack access to 100 Mbps, and 6 percent lack access to 25 Mbps

[39] Substance Abuse and Mental Health Services Administration. *Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders*. Published 2021. Available at: https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf . Last accessed July 26, 2023.
[40] Larson C. Behavioral Health Visits Up 17% of Pre-COVID Levels. *Behavioral Health Business*. Published October 24, 2022. Available at: https://bhbusiness.com/2022/10/24/behavioral-health-visits-up-17-of-pre-covid-levels/. Last accessed July 26, 2023.
[41] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Published December 2022. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf. Last accessed July 26, 2023.
[42] Krause D. Region 9 Economic Development Southwest Colorado Council of Governments Broadband Roadmap. NEO Connect. Published May 2023. Available at: https://www.region9edd.org/uploads/Region_9_Broadband_Roadmap_05_2.pdf. Last accessed July 26, 2023.

Geographic Distance and Demand

Access to ASAM Levels of SUD Residential Care

HCPF offers a map of Medicaid SUD/OUD residential care in Colorado. Facilities are included if:

- Licensed to provide care at a specific ASAM level
- Enrolled as Health First Providers at that ASAM level

HMA used time and distance standards in accordance with state and federal law and regulations to ensure current and anticipated clients have adequate access to residential SUD/OUD services. Network adequacy standards for adult and pediatric behavioral health providers, including mental health providers, psychiatrists and psychiatric prescribers, and SUD/OUD providers include:

- Urban counties (no counties in Region 9): 30 miles or minutes
- Rural counties (Archuleta, Montezuma, La Plata): 60 miles or minutes
- Frontier counties (Dolores, San Juan): 90 miles or minutes

To demonstrate compliance with time or distance standards, HMA conducted network adequacy analyses that demonstrate coverage of Region 9 with the HCPF SUD/OUD provider list.[43] To this end, HMA populated the network adequacy standards for each county type and region into our mapping software utilizing census block mean center points or centroids as a proxy for population origin. In addition, the software generates points along the county boundary that are proportional to the population density and county area. For example, San Juan received 117 origin points, whereas La Plata received 543 origin points along the boundary. HMA calculated driving time in minutes and distance in miles for an average from each point of origin to the nearest provider. Nearest providers may include those located outside the county, county type, or region. Drive time and distance calculations were based on pre-COVID-19 data.

Percent of Resident Locations within Adequate Network Standards

A provider location that offered ASAM 3.2 WM was the only SUD residential provider (ASAM level 3.1-3.7) that met the network adequacy standards.

- By mileage: For Region 9, 66.6 percent of the member locations were within the 60 or 90 miles standard, ranging from a low of 47 percent in Montezuma County to a high of 99.5 percent in La Plata County.
- By travel time: For Region 9, 43.5 percent of the member locations were within the 60- or 90-minute standards, ranging from a low of 17.2 percent in San Juan to a high of 92.6 percent in La Plata County.

See Table 10 for details.

[43] HCPF (2023) HCPF SUD Providers – Google Maps. Available at: https://www.google.com/maps/d/u/0/viewer?mid=1a24YvAw2KpjHuFgX3tFdwgFS62tOuiGs&ll=38.74107282613595%2C-103.64886583905205&z=7.

Table 8. Percent of Resident Locations within Driving Distance to ASAM 3.2 WM Services

	ASAM 3.2 WM	
	Percent of Resident Locations within Adequate Mileage Standards	Percent of Resident Locations within Adequate Travel Distance (minutes) Standards
Archuleta	45.58%	43.11%
Dolores	62.71%	14.12%
La Plata	99.47%	92.64%
Montezuma	47.00%	26.82%
San Juan	89.08%	17.24%
Region 9	**66.56%**	**43.46%**

Source: HCPF SUD/OUD Provider List

Average Travel Time and Mileage

As Table 11 indicates, on average, it takes 1.2 hours (71.9 minutes) for Region 9 residents to access ASAM 3.2 WM, with a travel distance of 56.9 miles. For other levels of care, the average time and mileage increases, ranging from 3.8 hours (195.2 miles) for ASAM 3.1 to 7.5 hours (425.6 miles) for ASAM 3.3.

Table 9. Average Travel Time and Mileage for ASAM Seervices

County	ASAM 3.1		ASAM 3.2 WM		ASAM 3.3		ASAM 3.7		ASAM 3.7 WM	
Average	**Time**	**Miles**	**Time**	**Miles**	**Time**	**Miles**	**Time**	**Miles**	**Time**	**Miles**
Archuleta	4.2	224.2	1.2	61.7	6.4	365.3	4.1	221.8	4.8	273.3
Dolores	3.1	170.2	1.8	89.2	7.7	456.3	3.1	170.2	6.5	360.9
La Plata	3.9	185.1	0.5	21.3	7.1	399.6	3.9	185.1	5.6	318.3
Montezuma	3.9	215.8	1.3	64.2	7.9	456.4	3.9	215.8	6.5	365.1
San Juan	3.3	139.3	1.9	67.6	7.7	408.1	3.2	135.1	6.4	307.8
Region 9	**3.8**	**195.2**	**1.2**	**56.9**	**7.5**	**425.6**	**3.7**	**194.6**	**6.0**	**335.5**

Source: HCPF SUD/OUD Provider List

Network adequacy by county varies widely, as the minimum and maximum mileage and minutes to each level of SUD/OUD residential/inpatient level of care for Region 9 demonstrates. For example, the minimum mileage to travel for ASAM 3.1 is 101.4 miles with a maximum for some locations in Region 9 of 274.8 miles (or 2.2 hours to 5.1 hours). Results of the minimum and maximum mileage and minutes are provided in Table 12.

Table 10. Maximum and Minimum Mileage and Travel Times

Region 9	ASAM 3.1		ASAM 3.2 WM		ASAM 3.3		ASAM 3.7		ASAM 3.7 WM	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Mileage	274.8	101.4	127.4	1.1	533.0	318.2	274.8	101.4	463.7	229.1
Hours	5.1	2.2	3.2	0.0	9.1	5.8	5.0	2.2	7.7	2.2

Source: HCPF SUD Provider List

Access to Pharmacy

Pharmacy accessibility is key for the emerging role of community pharmacists as providers of patient-centered medication management services in addition to their traditional dispensing roles. In 2017, the number of pharmacy locations per Region 9 county was:[44]

- Archuleta: Three
- Dolores: Zero
- Montezuma: Five
- LaPlata: Six
- San Juan: Zero[45]

Buprenorphine is a controlled substance that also requires pharmaceutical dispensing.[46] Pharmacy location as well as whether a pharmacy provides a medication is important. In 2021, a study found that in areas with high overdose death rates, one in five pharmacies indicated that they would not dispense buprenorphine.[47]

- Data indicates that San Juan County residents receive care and fill their controlled substance prescriptions in Ouray and La Plata Counties. San Juan County prescribers wrote less than 1 percent of the prescriptions dispensed to San Juan County residents. Instead, 43 percent of the prescriptions were written by providers in La Plata County and 39 percent by prescribers in Ouray. Of those controlled substances prescribed to San Juan County residents, pharmacies in La Plata County dispensed 51 percent of the prescriptions, and pharmacies in Ouray dispensed 35 percent.
- Archuleta County prescribers wrote 65 percent of the controlled substance prescriptions dispensed to county residents, and 86 percent of prescriptions were dispensed within the

[44] Berenbrok LA, Tang S, Gabriel N, et al. Access to Community Pharmacies: A Nationwide Geographic Information Systems Cross-Sectional Analysis. *Journal of the American Pharmacists Association*. 2022;*62*(6):1816–1822.e2. doi: 10.1016/j.japh.2022.07.003

[45] US Department of Health and Human Services Office of Minority Health. Minority Health Social Vulnerability Index. Available at: https://www.minorityhealth.hhs.gov/minority-health-svi/. Last accessed July 26, 2023.

[46] Reports that the CDPHE released in 2016 provided the following Prescription Drug Monitoring Program on location of patient residence and service location for Region 9 counties. Although these data are not an exact measure of where people receive care, they can be used as an indicator of the distance traveled between residence, care location, and pharmacy and to get an idea of the distance traveled related to controlled substance prescribing.

[47] Kazerouni NJ, Irwin AN, Levander XA, et al. Pharmacy-Related Buprenorphine Access Barriers: An Audit of Pharmacies in Counties with a High Opioid Overdose Burden. *Drug and Alcohol Dependence*. Published July 1, 2021. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0376871621002246?via%3Dihub. Last Accessed July 26, 2023.

county. Prescribers in the neighboring county of La Plata wrote 28 percent of the prescriptions dispensed to Archuleta County residents.

- La Plata County prescribers wrote 91 percent of the controlled substance prescriptions to county residents and 94 percent of prescriptions were dispensed within the county, indicating that care and pharmacies are available there.
- Montezuma County prescribers wrote 69 percent of the controlled substance prescriptions dispensed to Montezuma County residents; however, county of residence may differ from the county where prescriptions were obtained. For instance, prescribers in La Plata County wrote 18 percent of the prescriptions dispensed to Montezuma County residents, which suggests that in Montezuma County, access to prescriptions is adequate compared with other counties in the region.

Core Structures and Competencies of the Continuum of Care

Appropriate and quality services are essential to constructing an effective SUD/OUD prevention, treatment, and recovery system, but high-quality care is only meaningful if people can access the services they need successfully. Easy and open access to care for all individuals and families, at all points on the continuum of care, and through any service sector, requires the presence of core system structures and competencies.

Workforce

As Table 13 demonstrates, nearly all surveyed providers indicated that recruiting and sustaining an SUD/OUD treatment workforce was a barrier to delivering SUD/OUD services (67%, n=10). Nearly all survey respondents (88%, n=7) reported that their need for SUD/OUD clinical staff is greater today than at this time in 2019. (One provider reported it was the same/no change.)

All behavioral health providers and MAT prescribers interviewed said the workforce shortage was a significant barrier to behavioral health care. A particular challenge has been hiring credentialed and licensed staff, especially people who reflect the local community and are willing and able to work in rural areas of Region 9. One provider reported, “If we had more people, we could provide more services.” Survey respondents said that recruiting and sustaining an SUD/OUD treatment workforce was a top barrier in the delivery of SUD/OUD treatment services and supports (67%, n=10). Recruiting and maintaining staff with needed experience and training in evidence-based models to support services is the second most predominant barrier (53%, n=8).

Table 11. Barriers to the Delivery of SUD Treatment and Supports

What barriers do you or your organization experience in the delivery of SUD treatment services and supports? Select all that apply.		
Option	**County**	**Percent**
Recruiting and sustaining an SUD treatment workforce	10	67%
Recruiting and maintaining staff with needed experience and training in evidence-based models to support services	8	53%
Lack of licensure status for services levels in demand	7	47%
Limited staff with necessary experience and training in evidence-based models to support services	6	40%
Workforce recruitment and retention	6	40%

Source: HMA provider survey

The top recruitment priorities among the SUD/OUD provider organizations that responded to the survey were:

- Licensed addiction counselors
- Licensed clinical professional counselors
- Licensed clinical social workers
- Bachelor's level social workers
- Certified behavioral health peer support specialists
- Community health workers
- Master's level social workers
- Registered nurses
- Paraprofessionals (e.g., case managers, homeless outreach specialists, or parent aides)
- Peer support specialists
- Recovery coaches
- SUD/OUD counselors

The top causes of turnover were:

- Lack of competitive salary
- Caseload size
- Administrative burden (i.e., paperwork)
- Feeling overworked
- Work-related stress/distress/secondary trauma
- Navigation of system and complexity of care

According to CDPHE, 95 percent of Colorado communities would be considered SUD health professional shortage areas (HPSAs).[48] No single data source can provide a comprehensive picture of the behavioral health provider network across Colorado; however, the CDPHE's *Colorado Health Services Directory* (*CHSD*) does offer a provider list that is useful in understanding the providers available to the general population. Developed and administered by the Primary Care Office, the CHSD provides comprehensive data on licensed clinicians and healthcare sites in Colorado, which the agency uses to determine where health professional workforce shortages exist. An assessment of behavioral health disciplines from this

[48] Estimated Accessible SUD Encounters Per Adult (In Deciles). (2019). CDPHE. https://cdphe.maps.arcgis.com/apps/SimpleViewer/index.html?appid=9f17f6155cde42aab58b0ccf65a179d5

directory suggests that professional counselors (LPCs) were the most abundant behavioral health providers in Region 9, with an estimated ratio of 2.4 LPCs per 1,000 residents ages five and older, followed by clinical social workers at 1.8 per 1,000 residents. La Plata has the higher provider ratio per 1,000 residents at 5.6, followed by Montezuma (2.7 per 1,000), Archuleta (2.6 per 1,000) and San Juan (0.2 per 1,000). Dolores County had no reported providers in the CHSD (see Table 14).

Table 12. Providers per 1,000 Region 9 Residents Ages Five and Older

	Provider Ratio per 1,000 Residents Ages 5+ Years				
Provider Type	**Archuleta**	**La Plata**	**Montezuma**	**San Juan**	**Provider Ratios by Type**
Number of Providers	**33**	**297**	**66**	**2**	**398**
Certified Addiction Counselor II	-	0.1	0.1	-	0.1
Certified Addiction Specialist	0.1	0.4	0.4	-	0.6
Certified Addiction Technician	0.1	0.1	0.1	-	0.3
Clinical Social Worker	0.6	1.8	0.6	-	1.8
Licensed Addiction Counselor	0.2	0.3	0.1	-	0.5
Licensed Professional Counselor	1.3	1.8	0.9	0.1	2.4
Marriage & Family Therapist	-	0.2	-	-	0.2
Physician	-	0.2	0.1	-	0.2
Physician Assistant	0.1	0.2	0.1	0.1	0.3
Psychologist	0.4	0.4	0.1	-	0.5
Registered Nurse	-	0.1	0.1	-	0.1
Registered Psychotherapist	-	0.0	0.1	-	0.0
Provider Ratios	**2.6**	**5.6**	**2.7**	**0.2**	**7.0**

Source: CDPHE Colorado Health Services Directory

Partnerships

Partnerships for SUD/OUD prevention and treatment continuums include school-based treatment services, local EDs, community-based organizations (CBOs), correctional and justice systems, and other public-private partnerships that drive quality and work toward positive outcomes. Among key informants, the consensus was that cross-sector collaboration is key to implementing effective strategies for SUD/OUD prevention, treatment, and recovery, particularly given the relatively small size of communities in Region 9. Notable partnerships in the region included:

- Archuleta, Dolores, La Plata, Montezuma, and San Juan Counties created a regional council, the SouthWEST Opioid Response District, to manage the distribution of opioid settlement funds.
- The collaboration between Hilltop House Community Corrections and local small businesses, wherein small businesses hire individuals with criminal previous legal system involvement to attain job experience and financial stability.
- The City of Durango Police Department (DPD) and Axis Health System partner to offer CORE, which deploys a DPD crisis intervention team officer and an Axis behavioral health specialist to respond to non-criminal 911 calls.
- The partnership between Fort Lewis College (FLC) and the University of Colorado-Anschutz to offer a four-year undergraduate nursing degree from FLC. FLC has a large Native American

student population, so this program was highlighted as a promising opportunity to increase the healthcare and behavioral health workforce for tribal communities in the region.

- The Sih Hasin Street Medicine team, led by Dr. Asha Atwell, an emergency physician with the Northern Navajo Medical Center, provides primary and preventive care, wound care, medication, food, clothing, harm reduction resources, connection to housing, and more to individuals experiencing homelessness in Shiprock and Farmington, NM, and Cortez. Dr. Atwell, with funding from the IHS, provides services to tribal members, and collaborates with local physicians to serve non-tribal patients. In Cortez, she partners with Southwest Health.

Approximately three in 10 surveyed providers (33%, n=5) indicated that "developing strong working relationships with staff of key agencies (e.g., justice organizations, housing providers) to facilitate transitions of care, make special arrangements as needed, and eliminate unnecessary barriers for clients during the delivery of SUD/OUD treatment services along the continuum of care" is a barrier to service delivery. Some interviewees also noted that behavioral health services often are siloed from physical health services, and that primary care clinicians should be encouraged to provide SUD/OUD services like SBIRT or buprenorphine. Lastly, a few interviewees described the territorial nature of providing SUD/OUD services in the region, with provider organizations often competing for staff and patient populations. To address these barriers, information sharing and bringing all relevant stakeholders to the table to collaborate on planning and implementation were cited as necessary.

Funding and Payment Strategies

Interviewees described insufficient reimbursement for SUD/OUD services, particularly inpatient rehabilitation, residential, and sober living facilities. Nearly all surveyed providers indicated that inadequate SUD/OUD treatment service reimbursement was a barrier to service delivery (67%, n=10), similar to "sustainable funding for services" (67%, n=10).

Many interviewees noted that insurers will not cover comprehensive SUD/OUD services and that obtaining prior authorization is burdensome. One key informant noted that accessing services is particularly challenging for individuals who are ineligible for Medicaid, are uninsured, and can't afford to pay out of pocket. Hence, financial support for un- or underinsured individuals may be a priority. In fact, some federally qualified health centers, such as Crossings Healthcare in Illinois, use revenue from their prospective payment system (PPS) to support outpatient behavioral health services such as sober living. The funding for the sober living facilities themselves came from a generous donation. See Table 15 for details.

Table 13. Barriers to the Delivery of SUD/OUD Treatment

What barriers do you or your organization experience in the delivery of SUD/OUD treatment services and supports? Select all that apply.		
Option	**Count**	**Percent**
Inadequate SUD treatment service reimbursement	10	67%
Sustainable funding for services	**10**	**67%**
Total	**15**	

Culturally Relevant Services

The development of culturally responsive and relevant clinical services and skills is vital to the effectiveness of SUD/OUD services. According to HHS, cultural competence "refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services."[49] Culturally responsive services and skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Cultural competence is essential to decreasing disparities in behavioral health.

Key informant interviews explored what Region 9 can do to address gaps in providing SUD/OUD services that are culturally competent, particularly for priority populations, including tribal and LGBTQ+ communities. Existing resources for tribal and LGBTQ+ communities that could be expanded to meet these needs. For tribal communities, SAMHSA's Treatment Improvement Protocol Series 61 offers an array of evidence-based and otherwise culturally validated approaches to behavioral health and SUD treatment service delivery.[50] Wellbriety Recovery Circles, facilitated by White Bison, are an established local option for Indigenous populations. For the LGBTQ+ community, 4 Corners Support for Transgender people, Allies, and Relatives (4 S.T.A.R) is an existing resource in Region 9.

Region 9 should consider opportunities to collaborate with tribal partners to improve the availability of culturally validated care. Strategies to consider include:

- Coordinate with and build capacity for Southern Ute's efforts to develop a new SUD treatment center
- Offer treatments and modalities that work for AI/AN populations such as White Bison Wellbriety and tribally operated peer support services
- Prioritize hiring Native American providers and leadership to better reflect the populations served in Region 9

The primary need interviewees identified as necessary to increase cultural competency was workforce training and education on topics including substance misuse, MAT, stigma, harm reduction, trauma-informed care, and population-specific considerations. Interviewees noted that organizations and their staff often are uninformed about where they can access cultural competency training, and paying for such trainings can be a barrier. One option suggested was a centralized local training solution with scholarship opportunities. Additionally, an important element of culturally responsive care raised during one interview is the understanding that a "one size fits all" solution to SUD/OUD services is ineffective, and services must take into consideration individual circumstances, histories, and traumas.

[49] Substance Abuse and Mental Health Services Administration. Improving Cultural Competence: Treatment Improvement Protocol (TIP) 59. Published 2014. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf. Last accessed July 26, 2023.
[50] Substance Abuse and Mental Health Services Administration. Behavioral Health Services for American Indians and Alaska Natives: Treatment Improvement Protocol (TIP) 61. Published 2019. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf. Last accessed July 26, 2023.

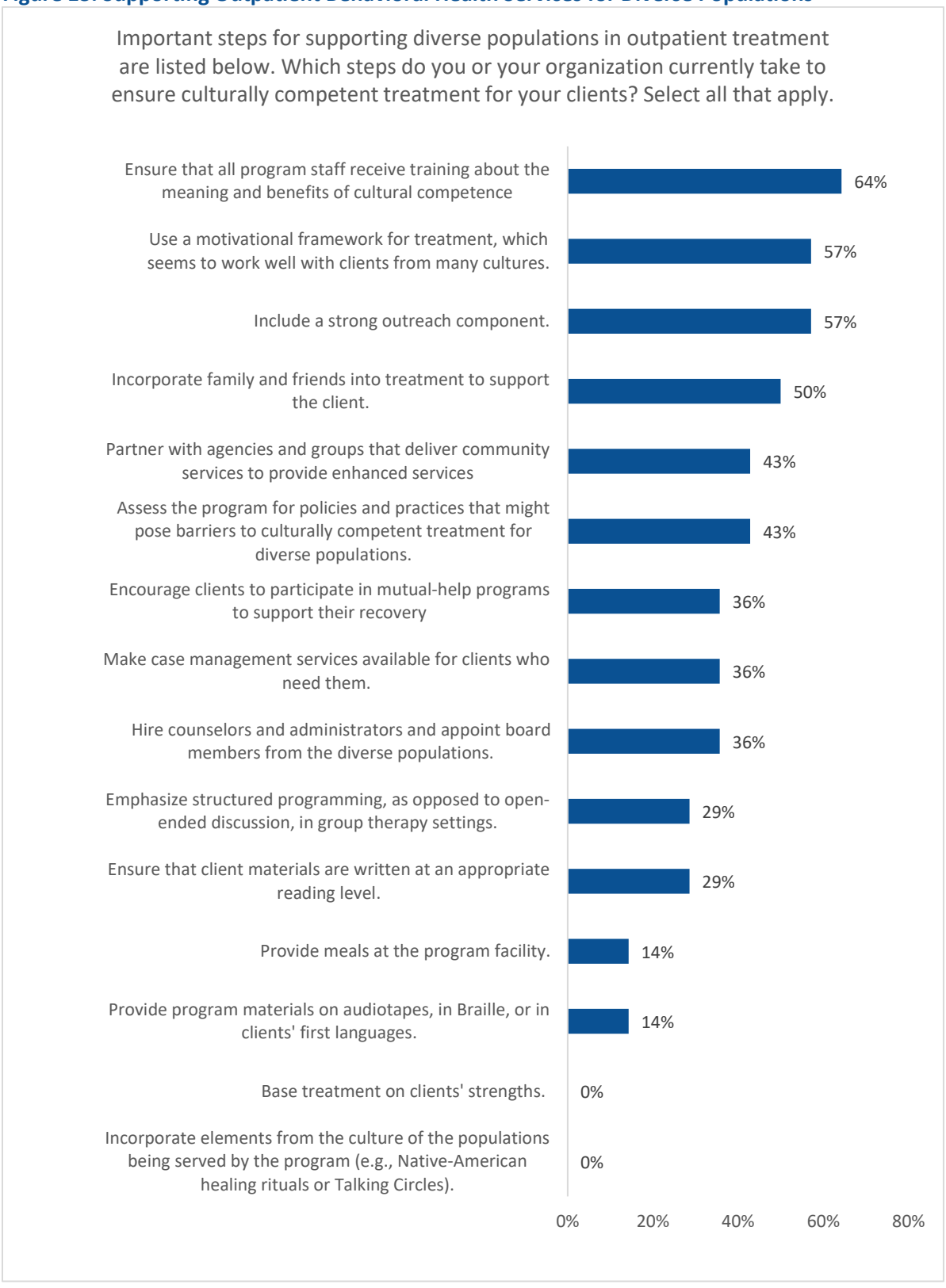
Provider survey respondents were asked to select the steps their organizations are taking to ensure they deliver culturally competent care. The top three actions taken are:

- Ensure that all program staff receive training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves (67%, n=10)
- Use a motivational framework for treatment, which seems to work well with clients from many cultures (60%, n=9)
- Include a strong outreach component (53%, n=8)

Approximately one-third of providers reported that they hire counselors and administrators and appoint board members from diverse populations. According to the 2020 Colorado Statewide Behavioral Health Assessment, Coloradan stakeholders from priority populations described an urgent need for providers who reflect their communities and who have an innate understanding of cultural and community concerns, including providers of color, individuals who have grown up and lived in communities, individuals with lived experience of criminal justice involvement, and tribal members (see Figure 14).[51]

[51] Colorado Department of Human Services. 2020 Statewide Behavioral Health Needs Assessment. Published 2020. Available at: https://cdhs.colorado.gov/2020-behavioral-health-needs. Last accessed July 26, 2023.

Figure 13. Supporting Outpatient Behavioral Health Services for Diverse Populations



Infrastructure

Interviewees described the infrastructure at SUD/OUD treatment facilities as a barrier to quality care. Contributing factors cited include insufficient available property and space, zoning, and community pushback. Interviewee expressed concern about using the former Robert E. DeNier Youth Center to house SUD/OUD services because a former detention center could be at odds with the concept of trauma-informed care. Approximately one-third (29%, n=4) of the provider survey respondents said finding physical space or locations to provide SUD/OUD treatment services is a barrier to expanding access to SUD/OUD care.

Regulatory Oversight

Surveyed providers cited the regulatory oversight and requirements for certain licensures for reimbursement and/or aligning services with individual eligibility as two barriers to delivering SUD/OUD services. Specifically, 47 percent (n=7) of survey respondents noted the lack of licensure status for services levels in demand and 20 percent (n=3) identified navigating individual eligibility for SUD/OUD treatment services as barriers to SUD service delivery.

Political Will and Community Support

Several interviewees described NIMBYism (not in my backyard) among community members' views regarding SUD/OUD treatment services and facilities. Several noted that perspective likely stems from stigma and could be mitigated with education around substance misuse and the benefits of increasing access to treatment (e.g., community safety, job opportunities). Among the community survey respondents, nearly half (46%, n=22) reported that stigma/NIMBYism was a challenge or barrier to treating SUD/OUD in their community. Regarding political will, the general sentiment among interviewees is that there is a lack of passion about SUD/OUD services among elected officials, and one informant noted that local policy initiatives often promote abstinence-based solutions rather than more holistic and harm reduction-oriented services.

Region 9 Community Priorities

Priority Population in Need

Across all key informant interviews, the substances of deepest concern were alcohol, methamphetamines, and opioids, specifically fentanyl. Co-occurring substance use and mental health challenges are common in the region. One interviewee noted, "Virtually all patients with mental health needs have substance use needs, too; they go hand in hand."

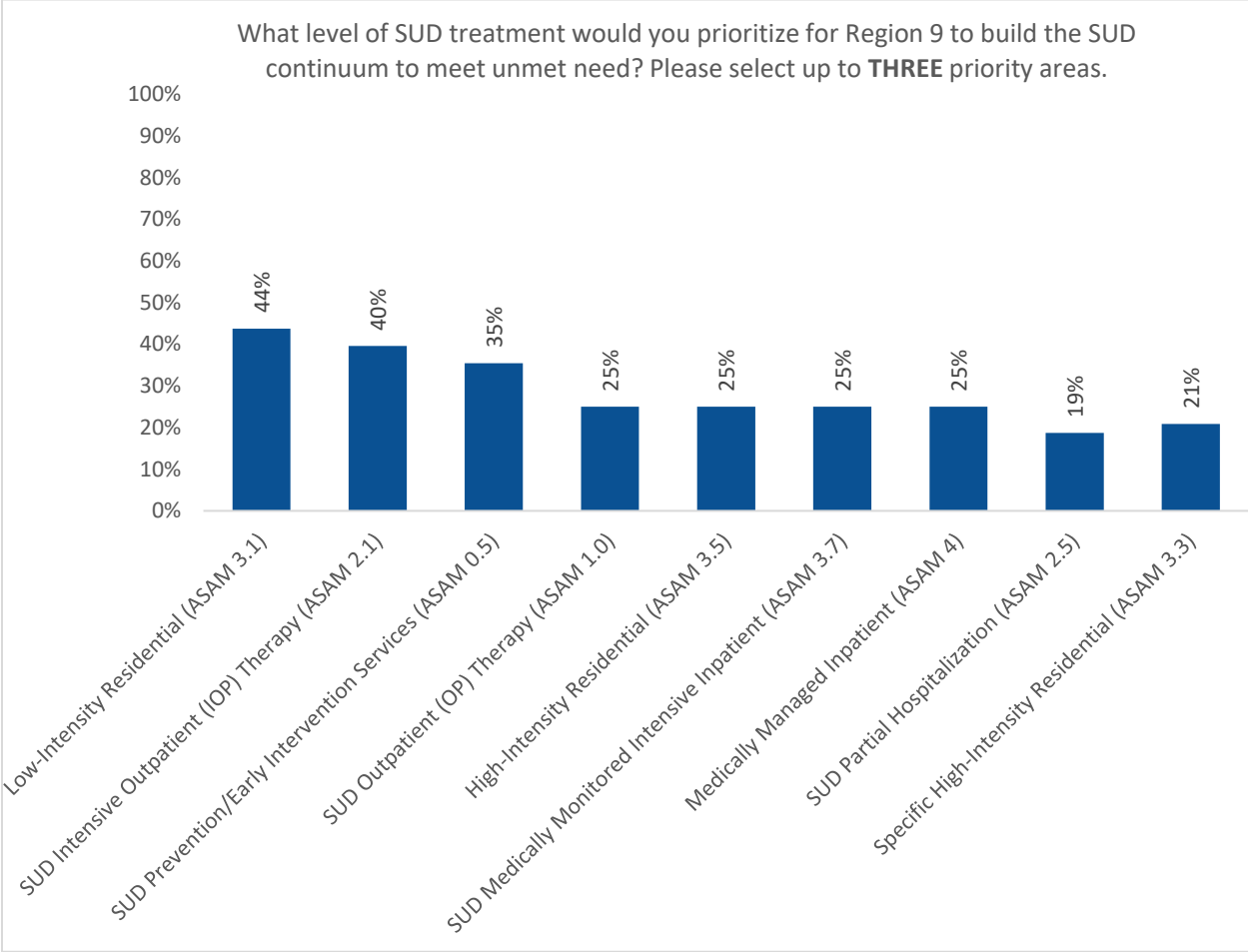
When asked to select the populations in Region 9 with unmet SUD/OUD treatment needs, the top two populations selected by both community members and SUD/OUD providers are adults with serious mental illness (SMI) service and support needs (73%, n=35) and youth with serious mental health service and support needs (SED) (67%, n=32). Among provider survey respondents, 73 percent (n=11) report offering dual diagnosis/co-occurring disorder treatment and five (33%) report psychiatry. Tribal populations ranked third (65%, n=31) as the population in need of access to SUD/OUD care.

Priority SUD Treatment Services

Survey respondents were asked to select the level of SUD/OUD treatment they would prioritize for Region 9 to build the SUD/OUD prevention, treatment, and recovery continuum of care. As Figure 14 illustrates, the top three levels of SUD/OUD treatment prioritized among all survey respondents were:

1. Clinically managed low-intensity residential (ASAM 3.1) (44%, n=21)
2. SUD/OUD (IOP) therapy (ASAM 2.1) (40%, n=19)
3. SUD/OUD prevention/early intervention services (ASAM 0.5) (35%, n=17)

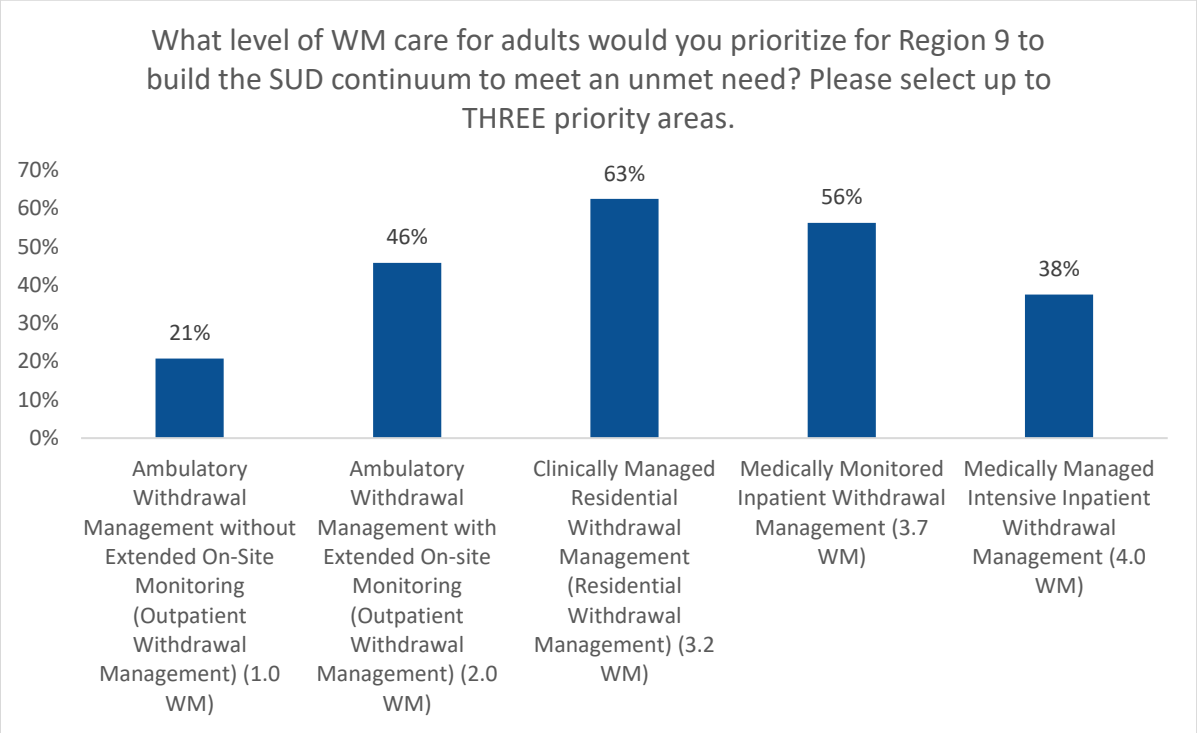
Figure 14. Region 9 Priorities for Meeting SUD Treatment Needs



Survey respondents were asked to prioritize a level of WM care for adults in Region 9 to build the SUD/OUD continuum to address unmet need. The top three levels of WM were:

- Residential WM (3.2 WM) (63%, n=30)
- Medically monitored inpatient WM (3.7 WM) (56%, n=27)
- Outpatient WM (2.0 WM) (46%, n=22)

Figure 15. Level of WM Care Priorities in Region 9



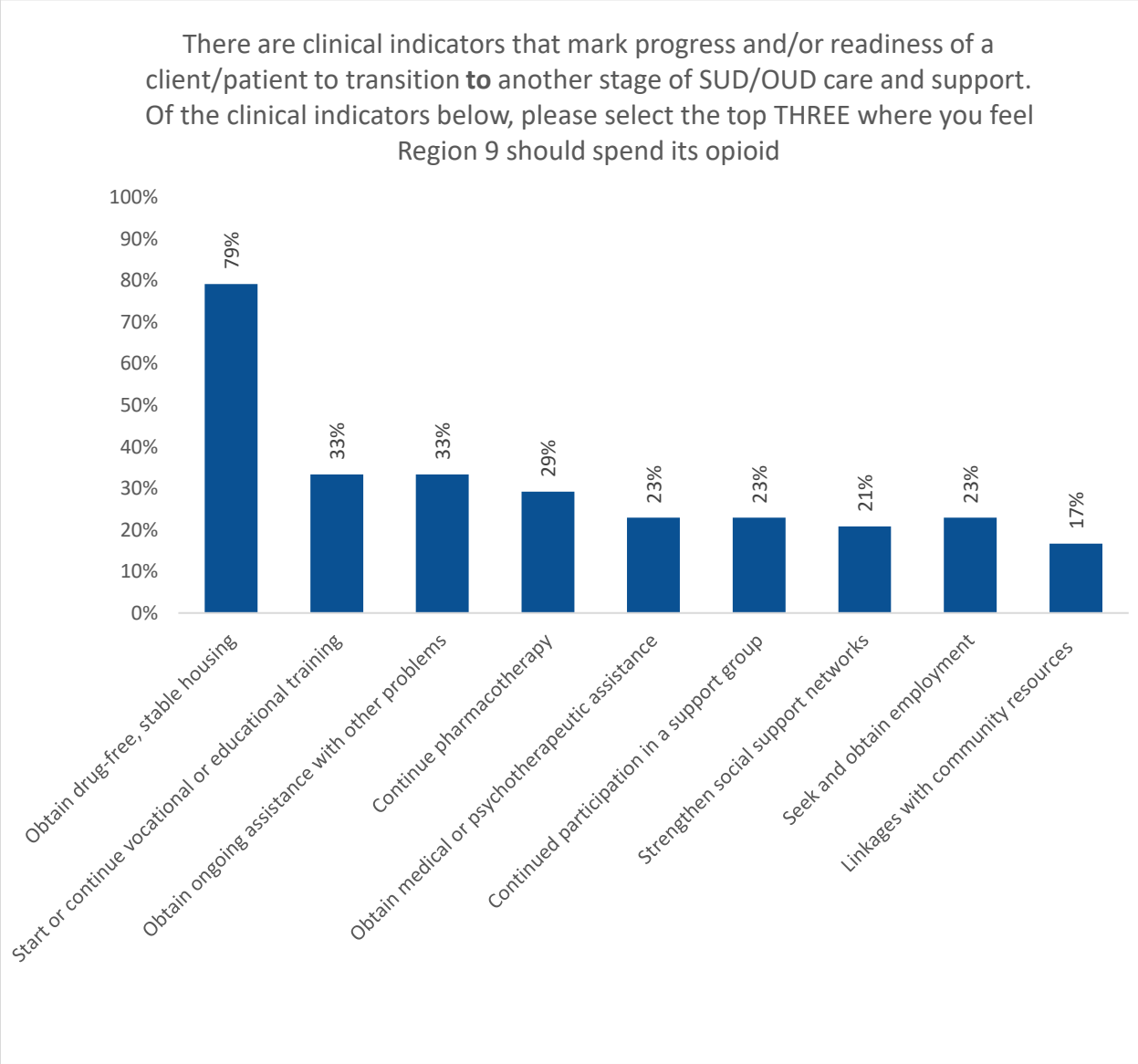
Priority Social Drivers of Health

The biggest social determinants of health (SDOH) challenges that interviewees identified are high cost of living, lack of affordable and supportive housing, unemployment and lack of jobs that pay a living wage, and transportation. Lack of transitional housing was the most commonly selected barrier to SUD/OUD treatment in Region 9 (75%, n=36). Three in four survey respondents (73%, n=35) report that an "individual's concerns about the cost of treatment" is a challenge or barrier to treating SUD/OUD in Region 9.

Clinical indicators mark a client's readiness to transition to another stage of SUD/OUD care and support.[52] As Figure 16 shows the **top three clinical indicators that respondents** reported would benefit from opioid settlement dollars in support of individuals with SUD/OUD were related to SDOH:

- Obtain drug-free, stable housing (79%, n=38)
- Strengthen social support networks (33%, n=16)
- Linkages with community resources that foster clients' interests and offer needed services for accomplishing life goals (33%, n=16)

Figure 16. Top Priorities for Distributing Opioid Settlement Dollars



Treatment varies depending on substance(s) used, severity of SUD, comorbidities, and the individual's preferences. Treatment typically includes medications and counseling as well as other social supports, such as linkage to community recovery groups depending on the individual's needs and level of family and social support.

Existing and Future Service Demands

Existing Demand

Treatment Needs

National Survey on Drug Use and Health (NSDUH) respondents in 2021 were classified as needing treatment an SUD or AUD or if they received substance use treatment at a specialty facility in the past year. Based on this definition, nationally, 15.6 percent of people ages 12 or older needed substance use treatment in the past year.

NSDUH 2021 also indicates that among people ages 12 and older in 2021 with an illicit drug or alcohol use disorder in the past year who *did not* receive treatment at a specialty facility, 96.8 percent said they did not need treatment, 2.1 percent said they needed treatment but did not make an effort to get it, and 1.1 percent said they needed treatment and tried to get it.[53] For Region 9, applying these estimates to the population would translate into an estimated 12,502 people (16 years or older) with a SUD/OUD who did not receive care in a specialty facility (unmet demand)—12,102 who felt they could forego treatment, 263 who felt they needed treatment but chose not to seek it, and 138 people who thought they needed treatment and sought it (see Table 16).

Table 14. Youth and Adults with SUD Who Did Not Receive Care in a Specialty Facility

				Among people with SUD (16+ years) who did not receive care in a specialty facility…		
County	Population Estimate (16 years and over)	Estimated # of People (16+ years) with SUD (15.6%)	Estimated # who did not receive care in a specialty facility (98.8%)	Estimated # felt they did not need treatment (96.8%)	Estimated # felt that they needed treatment but did not try to get treatment (2.1%)	Estimated # felt that they needed treatment and tried to get treatment (1.1%)
Archuleta	11,118	1,734	1,715	1,660	36	19
Dolores	2,057	321	317	307	7	3
La Plata	46,374	7,234	7,155	6,926	150	79
Montezuma	20,883	3,258	3,222	3,119	68	35
San Juan	602	94	93	90	2	1
Region 9	**81,034**	**12,641**	**12,502**	**12,102**	**263**	**138**

Note: Population estimates for 12 years and older are not available via Census. Age group 16 years and older was selected instead as the closest proxy. Therefore, the estimates are likely lower. Results should be interpreted with caution as the estimates do not take into consideration the demographics of Region

[53] Substance Abuse and Mental Health Services Administration. . Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health.

9 but rather apply national estimates to the region. Source 1: For population estimate, Census 2017-2021 5-year estimate, Table S0101. Source 2: For SUD estimates, NSDUH, 2021.

The NSDUH reports that among people ages 12 and older in 2021 with a past year of SUD/AUD who did not receive treatment at a specialty facility and perceived a need for treatment, the following were common reasons for forgoing treatment:

- Not being ready to stop using (36.7%)
- Having no healthcare insurance and unable to afford treatment (24.9%)
- Not knowing where to go for treatment (17.9%)
- Not finding a program that offers the type of treatment they wanted (15.8%)
- Thinking they could manage the problem without treatment (15.0%)
- Being concerned that treatment might negatively affect their job (14.7%)

To estimate demand based on SUD level of acuity, the assessment relied upon a Kaiser Family Foundation study that used 2020 data from the NSDUH to estimate prevalence of mild, moderate, and severe SUD among adults ages 18−64.[54] Based on the estimated need, the demand is greatest for Level 2.1, 2.5, 3.1, and 3.3; however, none of these services is accessible within the region for the estimated 5,883 people in need.

Table 15. Estimated Number of People Needing SUD Treatment Based on Acuity

	NSDUH 2020 Estimate (as in KFF)	Region 9 Estimated Number of Adults (Ages 18-64 years) With SUD Need (Census 2017-2021 Population Estimate)	ASAM Levels of Care Needed (based on ASAM Adult Criteria Cross Walk[55])
Any Mental Illness and/or SUD	33%	19,414	
SUD Only	18%	10,589	
Mild Acuity	10%	5,883	Level 2.1, Level 2.5, Level 3.1, Level 3.3
Moderate Acuity	4%	2,353	Level 2.5, Level 3.3, Level 3.7
Severe Acuity	3%	1,765	Level 3.5, Level 4

[54] Kaiser Family Foundation, Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. Published June 6, 2022. Available at: https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/#:~:text=As%20of%202020%2C%20an%20estimated,privately%20insured%20people%20(16%25). Last accessed July 26, 2023.

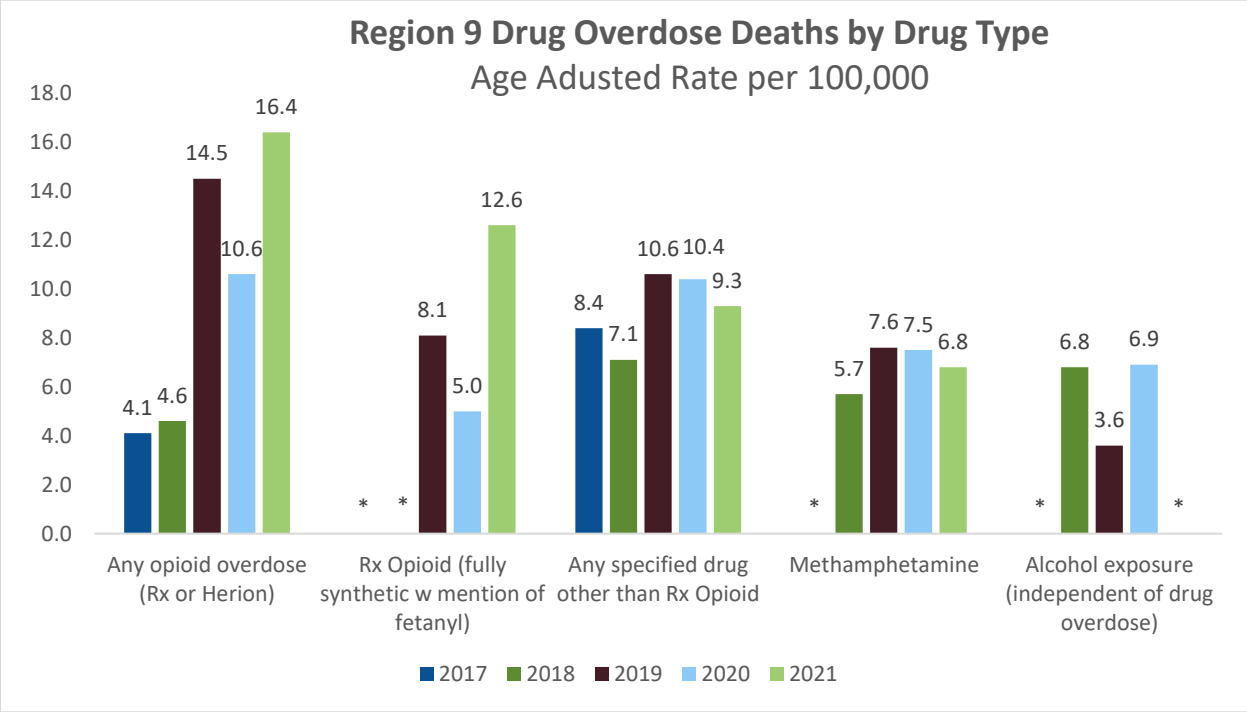
[55] Montana Primary Care Association. The ASAM Criteria Crosswalk: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions. Available at: http://www.mtpca.org/wp-content/uploads/ASAM-Adult_Criteria_Crosswalk.pdf. Last accessed July 26, 2023.

Deaths and ED/Hospital Utilization

Drug overdose deaths and ED/hospital utilization rates are important indicators used in this assessment to measure unmet need.

- Drug overdose deaths continue to rise in both Region 9 (not significant) and Colorado.
- While drug overdose deaths were increasing, hospital and ED admissions decreased, an indicator that people may not be going to or being transported to the ED or hospital for care or an increase in the use of drugs that are more lethal, such as fentanyl, where people are dying before the need to go to the ED arises, as shown in the figure below.

Figure 17. Drug Overdose Deaths in Region 9 by Drug Type



*Fewer than three deaths, including zero deaths, suppressed for confidentiality. Source: CDPHE Drug Overdose Dashboard.

Future Needs

Poor Mental Health and Dual Diagnosis

SUD/OUD needs in the region are likely to grow in line with national trends and the impact of COVID-19 on mental health. People with an SUD may also have other mental health disorders, vice versa. Though not everyone with poor mental health have a co-occurring SUD, they are commonly linked for several reasons:

- Certain substances can cause people with an addiction to experience one or more symptoms of a mental health condition.
- Mental health problems can sometimes lead to alcohol or drug use, as some people with a mental health problem may misuse these substances to self-medicate.

- Mental health and substance use disorders share some underlying causes, including changes in brain composition, genetic vulnerabilities, and early exposure to stress or trauma.[56]

For these reasons, examining trends in mental health may shed light on the potential change in risk for SUD.

- Poor mental health among youth and adults has been increasing. The percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row during the past 12 months that they stopped doing some usual activities in Region 9 significantly increased to 37.6 percent in 2021 from 30.5 percent in 2019.[57]
- In 2021, 27.8 percent of people ages five and older reported poor mental health in Region 9—a significant increase from 7.9 percent in 2017.[58]
- The population ages five and older who reported not receiving needed mental health services when they needed it increased to 14.7 percent in 2021 from 10.8 percent in 2017. [59]

People with co-occurring disorders also are unlikely to receive treatment for more than one disorder, even though research demonstrates that simultaneous, coordinated treatment for multiple diagnoses produces better outcomes compared with separate treatment for only a mental health condition or an SUD/OUD.[60] Based on NSDUH self-reported survey data for 2017−2019:

- Only one in 10 adults with co-occurring disorders (10%) received treatment for both conditions.
- About two in five adults with co-occurring disorders (42%) received neither substance use nor mental health treatment of any kind in the prior year.
- Black and Hispanic adults with co-occurring disorders were less likely to receive mental health or substance use treatment (47% and 43%, respectively) than White adults (64%).

Fentanyl and Xylazine

Opioids remain the main driver of drug overdose deaths today, with 82.3 percent involving fentanyl or a similar synthetic opioid.[61] Fentanyl is largely undetectable and is often cut into drugs such as cocaine, methamphetamine, and counterfeit prescription pills. As of April 2023, a veterinary tranquilizer called xylazine is increasingly being found in the US illicit drug supply and linked to overdose deaths. Xylazine is

[56] Substance Abuse and Mental Health Services Administration. Mental Health and Substance Use Co-Occurring Disorders.
[57] Colorado Children's Campaign. The 2021 Healthy Kids Colorado Survey Results Are in, and They Show a Growing Need for Youth Mental Health Support. Published July 22, 2022. Available at: https://www.coloradokids.org/the-2021-healthy-kids-colorado-survey-results-are-in-and-they-show-a-growing-need-for-youth-mental-health-support/. Accessed July 26, 2023.
[58] Colorado Health Institute. Colorado Health Access Survey. Available at: https://www.coloradohealthinstitute.org/programs/colorado-health-access-survey. Last accessed July 26, 2023.
[59] Ibid.
[60] Kelly TM, Daley DC. Integrated Treatment of Substance Use and Psychiatric Disorders. *Social Work in Public Health*. 2013;28(3-4):388-406.
[61] Centers for Disease Control and Prevention. Death Rate Maps & Graphs. Updated June 2, 2022. Available at: https://www.cdc.gov/drugoverdose/deaths/index.html. Last accessed July 26, 2023.

especially dangerous when combined with opioids like fentanyl.[62] Because of its impact on the opioid crisis, the White House's Office of National Drug Control Policy fentanyl adulterated with xylazine has been declared an emerging threat by the White House's Office of National Drug Control Policy.

Polysubstance Abuse

In 2019, nearly half of drug overdose deaths involved multiple drugs.[63] Overdose deaths involving methamphetamine and other psychostimulants also have been on the rise going into 2023. Many overdoses from fentanyl and methamphetamine involve polysubstance use, intentionally or unintentionally. Mixing drugs can make the drugs' effects stronger and more unpredictable, which is what makes polysubstance use particularly dangerous. The CDC's most recent data show that more than half of all overdose deaths involve the use of multiple substances.[64]

Impact of Trauma

Trauma and its effects also gaining wider acceptance as contributors to the development of mental health conditions and substance misuse. The ability to identify signs and symptoms of trauma gives healthcare providers more tools for aiding patients in their recovery. A regional asset includes Resilient Colorado, a training that when offered collaboratively with tribal communities, has shown they can support healing, pride, and self-determination. When offered to non-Native community members, providers can improve the understanding of the impact of colonization and thus contribute to reducing stigma Indigenous people experience.

[62] The White House. Biden-Harris Administration Designates Fentanyl Combined with Xylazine as an Emerging Threat to the United States. Published April 12, 2023. Available at: https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/. Last accessed July 26, 2023.

[63] O'Donnell J, Gladden RM, Mattson CL, Hunter CT, Davis NL. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants—24 States and the District of Columbia, January–June 2019. *MMWR Morb Mortal Wkly Rep*. 2020;69:1189–1197.

[64] Centers for Disease Control and Prevention. Death Rate Maps & Graphs. Updated June 2, 2022. Available at: https://www.cdc.gov/drugoverdose/deaths/index.html. Last accessed July 26, 2023.

Recommendations for Strengthening Region 9's SUD/OUD Prevention, Treatment, and Recovery Ecosystem

HMA assessed the complete SUD/OUD continuum of care, from prevention to treatment and recovery services, in Region 9. The assessment identified known assets, resources, and gaps in the current state of the regional SUD/OUD services delivery system. Table 18 lists the results of this assessment.

Recommendations in this report were developed based on the underlying premise that the SWORD priority is to ensure any new treatment services are regional in scope. Existing treatment assets, which are primarily located in La Plata County, are highlighted, but recommendations also consider the needs of community members outside the county.

When considering options for enhancing the SUD/OUD service delivery system in Region 9, resource feasibility factors also are applied. Brick and mortar facilities and ongoing operations at such facilities are expensive, requiring large amounts of capital and ongoing funding. Workforce to staff such facilities is limited everywhere as the nation faces a critical shortage of behavioral health providers, nurses, counselors, and other key staff. Counties in Region 9, especially those outside of La Plata County, are fiscally challenged. With these factors in mind, HMA's recommendations consider how to best leverage and maximize existing assets and resources in the region and capitalize on opportunities to enhance or create new facilities or programs in a way that is efficient and actionable.

Table 16. Identified Needs and Assets

Identified Needs and Services Gaps	Identified Assets and Resources

• Limited access to MAT Providers
• Limited sober living/affordable housing
• Finding physical space or locations where SUD/OUD treatment services can be provided
• Services that address the following levels of acuity:
  ○ **Withdrawal risk:** People with moderate risk of severe withdrawal
  ○ **Biomedical conditions and complications:** People with a need for concurrent medical monitoring
  ○ **Emotional, behavioral, or cognitive conditions and complications:** Mild to moderate severity, including needing 24-hour care in a structured setting and/or stabilization.
Prioritized Services
• Clinically managed low-intensity residential (ASAM 3.1)
• SUD/OUD IOP therapy (ASAM 2.1)
	• Facility and location (former Robert E. DeNier Youth Services Center "DeNier Center")
	• Century Mercy Hospital ED bump out
	• Collaborative partners, including co-responder programs
	• Existing peer support services programs and organizations

• SUD/OUD prevention/early intervention services (ASAM 0.5) • Residential WM (3.2 WM) • Medically monitored inpatient WM	

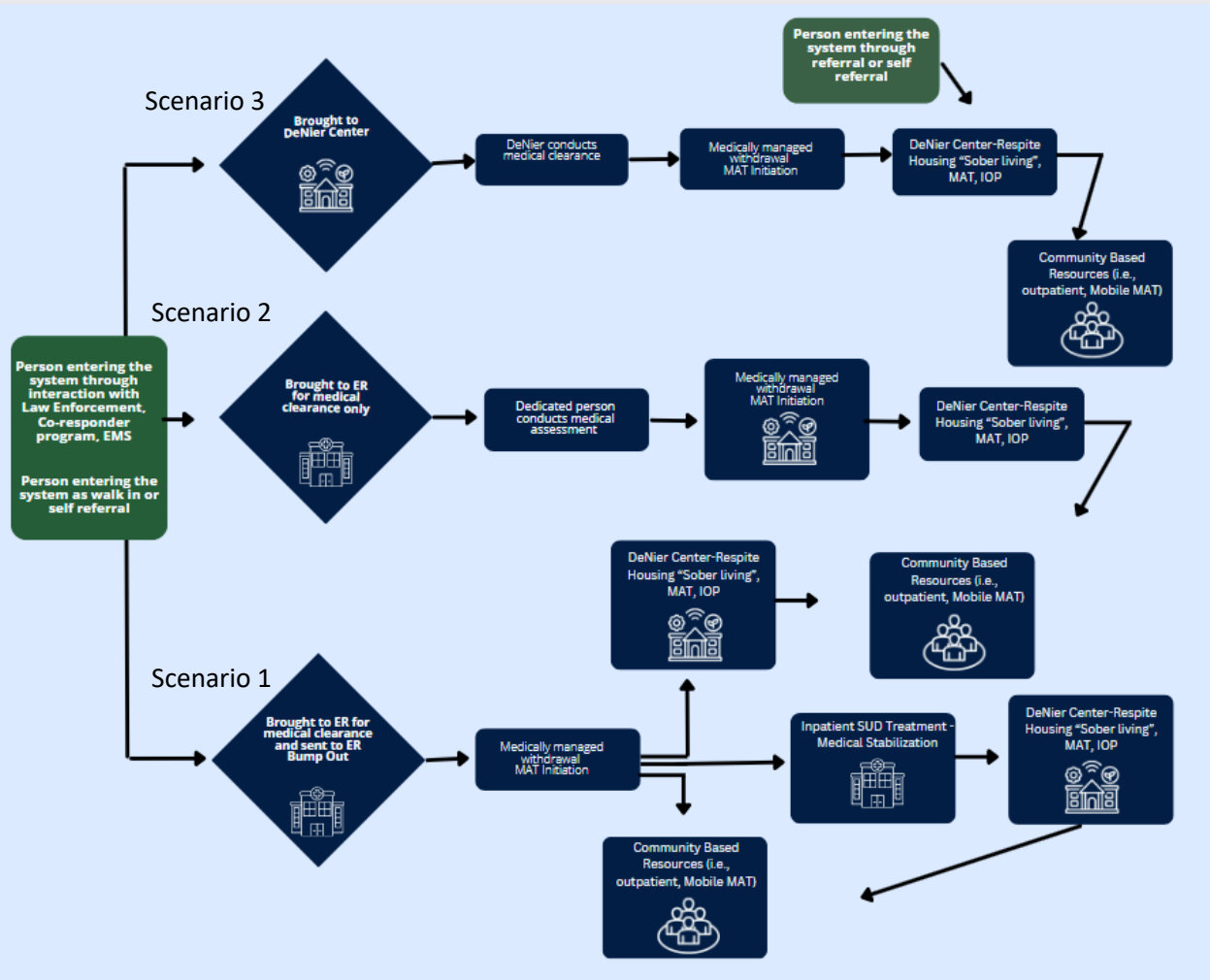
With these considerations in mind, HMA developed three scenarios for how people experiencing SUD crisis or needs could enter a new continuum of services that leverages the community assets to fill the identified gaps in services (see Figure 18).

- Scenario 1: Centura Mercy provides a new specialty unit at the hospital that offers medically managed withdrawal and MAT initiation. Centura Mercy also continues to offer medical screening/assessment and medical stabilization in the ED, as well as SUD inpatient admissions and MAT initiation. Centura Mercy would then transition patients to the DeNier Center (renamed in the future), a peer-led, recovery-oriented setting with a community living room, transitional housing, sober living, MAT, and IOP, or transitions patients to another community-based SUD provider for outpatient services. The DeNier Center would offer peer support services to support transition to the facility or another community-based SUD provider.

- Scenario 2: Centura Mercy offers medical screening/assessment and medical stabilization in the ED for individuals presenting with a substance use-related condition and provides a dedicated staff member to conduct the medical clearance for these patients. Centura Mercy would also continue to provide SUD inpatient admissions. However, a unit at the DeNier Center would provide the medically managed withdrawal and MAT initiation, and once individuals were medically cleared at Centura Mercy, they would be transported to the DeNier Center for care or referred to a community-based SUD provider. The DeNier Center would offer peer-support services to support for the transition to the facility or another community-based SUD provider.

- Scenario 3: The DeNier Center operational model would include a minor medical clinic that could be staffed and have medical oversight from the hospital. The center would provide medical screening/assessment and medical stabilization for individuals without the need for individuals with SUD related conditions having to go through the ED. The center would also offer medically managed withdrawal and MAT initiation, community living room, transitional housing, sober living, MAT, and IOP. The center would provide peer-support services to enable transition to any other level of care needed, including SUD inpatient treatment at Centura Mercy or community-based SUD services.

Figure 18. SUD Service Options



Proposed Service Model at DeNier Facility

The culture and environment at the DeNier Center primarily would be peer-led or strongly informed by peer specialists/organization(s); individualized to each person's needs, recovery-oriented, strengths-based, trauma informed, and evidence-based.

As part of the care coordination model tailored to each person's needs, the facility would need to leverage medical transportation options; have dedicated funds for transportation between key sites of care and include transportation expenses for peers conducting hot handoffs.

Additional key elements of the model include:

Element 1: Community living room model (modified clubhouse) where all interactions are seen as an opportunity to engage people in recovery.

The living room is a peer-led alternative to the traditional ED for people with mental health conditions who are in crisis.[65] It is a comfortable, non-clinical setting that provides a safe and calming atmosphere where guests can talk with a peer counselor. Each guest is first assessed for safety and is asked for preliminary information. The guest is then paired with a peer counselor, who can talk the guest through the immediate crisis and offer empathetic listening, practical solutions, and additional resources.

Attributes	How this addresses regional needs/gaps
• Drop in/walk in, greeted by peers/staff; can get water and a snack, use the restroom, take a shower • Have a resource center staffed with information about where and how to access SUD/OUD treatment and other needed services and supports • Peer-led recovery support and other groups (e.g., seeking safety) • Offer specific skill- and capacity-building workshops that support stability and recovery • Offer training in cultural competency/responsiveness to staff of partner agencies/providers, including addressing stigma toward SUD/OUD and MAT (provided in a centralized systematic way that helps lift the whole system in a common vision and commitment) • Distribute Narcan and training its administration • Street medicine unit could be on site at times on a schedule so people know when to come for assistance	• Meets need for social connectedness • Shown to be effective in engaging people who may not otherwise present for services or treatment (except at an acute care setting or when in crisis) • Meets community's interest in early intervention and harm reduction

Element 2: Peer Engagement and Follow Up with connections at Centura Mercy via ED, inpatient release and/or law enforcement, co-responder team(s).

Attributes	How this addresses regional needs/gaps
• Peer engagement, recovery supports service and planning; Connection/hot handoff to SUD and support providers • Peers support transitions with individualized support between sites of service/treatment with hot handoffs • Work with consumers to clarify goals and develop personal empowerment and recovery plans	• Dynamic approach to the problem of people not engaging in, or being lost to, care • Maximizes limited resources through coordination services

[65] https://namidupage.org/services-and-support/support/living-room/

• Case managers/coordinators interface in a coordinated, cross-sector manner with counterparts from other facilities with responsibility for the individual, including health plans, provider agencies, jails, etc. • Street medicine unit could be onsite at times on a schedule so people know when to come in for assistance	

Specific services to be considered for operationalization at the DeNier facility include:

- Behavioral management
- Skill building (social, daily living, etc.)
- Supported employment
- Housing support
- Supported education
- Parent/caregiver support
- Transportation
- Coordinated entry system
- Mental health advance directives
- Other supports for self-directed care
- Traditional healing services
- Personal care
- Respite
- Wellness recovery action planning (WRAP)

Element 3: Short-Term Respite Housing (or short-term transitional housing) with single-room occupancy (SRO), with individual rooms for sleeping, personal possessions, shared living, cooking, and laundry space. While it is a sober living space, it should ensure active incorporation of individuals receiving MAT.

Attributes	How this addresses regional needs/gaps
• Based on the facility's brick and mortar footprint and regional need for transitional housing, determine number of SROs to create/operate (capacity) • Define target population for this service as determined by the stakeholder groups through an evidence-based methodology • Regarding the community's concern/consideration about the facility's past purpose being traumatizing, other similar facilities have made successful conversions, and some architecture firms specialize in creating new, or retrofitting existing facilities for the mental health/SUD population	• Lack of transitional housing was the most commonly cited barrier to SUD/OUD treatment in Region 9 (75%, n=36 survey respondents and community member key informant interviews) • Key informants stressed that housing must be flexible to meet people's different needs and stages of recovery; low barrier and follow a "housing first" model; and offer ancillary supportive services

Element 4: Withdrawal Management – ASAM Levels 1.0; 2.0; 3.2.

Attributes	How this addresses regional needs/gaps
• Hospital could provide staffing and medical oversight of services provided at the DeNier facility • Opportunities to use telehealth to extend medical provider and nursing capacity • Increased access by mitigating transportation and technology barriers (patients who can't be seen via telehealth at their home because of technology issues could be seen at the DeNier facility)	• Inadequate withdrawal management resources to meet the regional need in a timely manner

Element 5: SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) and SUD Outpatient (OP) Therapy (ASAM 1.0) for recovery or motivational enhancement therapies.

Attributes	How this addresses regional needs/gaps
• Use the facility as a central location to staff and operate this level of care; providers offering this service could have a satellite presence	• Inadequate IOP and OP resources to meet the regional need in a timely manner

Map the Region 9 SUD/OUD Prevention, Treatment, and Recovery Ecosystem

HMA recommends increasing understanding and use of SUD/OUD resources across Region 9 to strengthen transitions of care for individuals with these conditions as well as the social supports and services necessary to sustain recovery. To increase understanding and use of SUD/OUD resources in Region 9, convene relevant SUD/OUD stakeholders to map their current process of engaging individuals with SUD/OUD from the point that they enter services/program to the point they leave it. Have stakeholders share their current process map with other each other for discussion about gaps in processes and opportunities to improve transitions in care. During such a meeting, stakeholders can collaborate to create a future state process map that reflects the entire SUD/OUD prevention, treatment, and recovery ecosystem—one that represents seamless transitions in care and complete information about existing resources.

Many communities have engaged in mapping to understand and develop their SUD/OUD prevention, treatment, and recovery ecosystem, especially given the availability of resources to address the nation's opioid crisis. For example. HMA has been leading a multi-year effort known as the California Systems of Care project. A component of this project includes the selection of counties across the state to participate in two-day countywide mapping and improvement events followed by a year of ongoing technical assistance to support the county in achieving its ideal future state ecosystem.

During the two-day process mapping and improvement events, stakeholders from different aspects of government, healthcare, addiction treatment, payors, people with lived experience, representatives from the social work sector and education participated in intense work sessions focused on identifying current processes, barriers and gaps in these processes and a future state that will support individuals with or at risk for SUD/OUD. Time is spent during the process improvement event contemplating the current state of the SUD ecosystem and the many barriers that exist within this system. These conversations, along with the determination of the most desired features of the future system, inform the whole group discussion of the ultimate future state map. Once the most desired features are determined, they are mapped into an ideal future state SUD/OUD prevention, treatment, and recovery ecosystem.

The two-day events conclude with the development of this group-based consolidated vision of the future that includes, but is not limited to, upstream prevention efforts, ubiquitous and standardized screening for OUD/SUD establishing every contact across all systems and sectors as points of identification and potential entry into the treatment and recovery system. The group contemplates the most effective referral systems and how to support seamless transitions in levels of care, including what needs to be enabled by technology to simplify the experience for everyone.

For any communitywide transformation to occur, it is a powerful and important exercise for community stakeholders to identify clearly where they are now. Though much good work and effort is taking place in Region 9 to address addiction, stakeholders agreed many challenges remain, particularly with respect to system integration, communication, stigma, and access to services in more rural areas.

HMA recommends that the future state include standardized movement of protected patient health information, standardized screening pathways, greater information sharing and public communication, increased capacity for providing access to all levels of addiction treatment, and further development of evidence-based care. Understanding the current state processes related to the SUD/OUD prevention, treatment and recovery ecosystem and then creating together the desired future state will provide a strong steppingstone for Region 9 to achieve its goals related to substance misuse.

Establish Regional Care Compacts

HMA recommends that partners in the Region 9 SUD/OUD treatment and recovery system establish care compacts. A care compact is a formalized agreement between healthcare and service providers that specifies referral protocols, care transition expectations, and care management responsibilities so that people served receive coordinated, effective, efficient care.

Care compacts aim to enhance communication between providers and patients through shared preferences and expectations regarding referrals. Putting care compacts in place in a service delivery system helps overcome perceived and actual gaps in care by maximizing existing providers and other resources to create a seamless, no-fail system in which people in the region with SUD/OUD receive coordinated, well-managed care through a network of providers in various sectors who can address their substance use, mental health, physical health, social, and safety needs. Care compacts between providers will serve to increase access to the right services, individuals will have less contact with

systems that are not designed as treatment settings (e.g., criminal justice, child welfare, etc.) and will require less contact with acute care services (e.g., EDs, hospitals, etc.). Individuals engaged with multiple systems, such as those with co-occurring SUD/OUD and mental health conditions, will experience better coordination between sectors with providers working toward shared goals.

Through the development of care compacts, partners will effectively divert individuals from settings not intended to provide treatment and will prevent poor health outcomes associated with unmet health and social needs. Care compacts can reduce duplicative services, improve transitions of care, and fill gaps in treatment.

HMA recommends that SWORD and its partners determine where to begin with the creation of care compacts within the region. The focus for initial care compacts can be driven by need in the region, including population-based need, points on the continuum of care at which individuals are experiencing the most difficulty in transitions between levels of care or receiving the appropriate care, or where the greatest opportunity for care coordination can be established. Leverage the initial care compacts as pilots. Document lessons learned from these pilot care compacts to inform the development of future compacts between providers across the region.

An example of effective implementation of a care compact initiative is in Douglas County, Colorado. The Douglas County Mental Health Initiative (DCMHI) established The Care Compact program to "link existing care coordination service providers through a streamlined network to serve vulnerable individuals with complex mental health, SUD, and/or intellectual and developmental disability (IDD) needs."

DCMHI brought together providers from hospitals mental and physical health care, SUD providers, IDD providers, criminal justice, human services, community-based organizations, and faith-based organizations to address the safety net needs of adults with complex needs and co-occurring conditions and involved in multiple systems who, therefore, needed coordinated care.

DCMHI describes how it works in this way:

> Partner organizations respond to referrals from partners and share relevant treatment plan information for working toward person centered goals. A care compact navigator coordinates with the lead provider to ensure that all partners are coordinating instead of duplicating services by ensuring that everyone has a care coordinator and there is coordination across partner agencies. The lead provider collaborates most closely with the individual receiving care. The overarching goal is the streamline the individuals experience and reduce the likelihood of needs going unmet. Additional goals include increasing access to appropriate services, decreasing contact with emergency response and acute care systems and helping individuals experience better coordination across providers.

Collaborate with Assessment Work Under Way in Tribal Communities

Region 9 should continue to identify opportunities for coordination with tribal partners to enhance the SUD/OUD continuum of care for Native Americans living in and near tribal communities. The recently completed Southern Ute feasibility assessment is a helpful starting point for discussions between SWORD council leadership and Southern Ute Tribal leadership. Some of the most significant needs for the Native American population in the region are SUD/OUD and other behavioral health conditions.

Access to the full continuum of SUD/OUD treatment is a significant concern, particularly regarding inpatient treatment and services to support individuals transitioning back into the community, such as sober living options. Adequate workforce capacity and lack of Native representation in the workforce are also prevalent themes voiced by key informants in the region. Some key informants noted that capacity grants from the DHCPF have been extremely helpful in funding needed positions such as prevention coordinators and youth counselors for behavioral health.

Recommendations for Prioritization

SWORD and its partners have many opportunities and decisions to consider in the immediate and near-term. HMA recommends attention to the following actions, not presented in sequential order given that many of these activities may happen concurrently or may have unpredictable timing.

- Review and confirm the recommended services proposed by HMA for the DeNier Center. Based on decisions about services at the DeNier Center, determine how the region will maximize opportunities with the services provided at Centura Mercy and the potential for an ER "bump out." Leverage the HMA Feasibility Analysis Toggle Spreadsheet to support this work.
- Regardless of decisions made regarding the model for the DeNier Center and/or Centura Mercy, to ensure a regionalization of a treatment facility located in La Plat County:
  - Map the SUD prevention, treatment and recovery ecosystem in its current state and create a future state ecosystem
  - Establish initial care compact(s) where needed and possible (Centura Mercy and other providers may be good place to start during the DeNier build).
    - Evaluate the initial care compacts and continue to develop them as you understand the ecosystem and DeNier services are established.
  - Work across counties in the region to develop a sustainable funding strategy/ campaign to support services at DeNier and across the region.
- Build out DeNier in a phased approach adding services and workforce over time. Start with the Centura Mercy ER and their capacity for a bump out.

Feasibility of SUD/OUD Services Identified as Gaps in Region 9

HMA conducted a feasibility analysis related to the region addressing the gaps in services. The following presents the feasibility of addressing three identified gaps in SUD/OUD services along the ASAM Continuum of Care. Additional assumptions will drive different feasibility findings such as:

- Medicaid billing volume estimates

- Indian Health Service All Inclusive Rate (AIR) reimbursement for pharmacy claims – under consideration at HCPF
- Other payer mix and volume estimates depending on Tribal and neighboring region participation.

Service #1: Residential/Inpatient Facilities

The levels of care and service offerings identified in HMA's gap analysis are ASAM 2.5, ASAM 3.1, ASAM 3.3, and ASAM 3.5. The region is without a residential or inpatient treatment facility beyond one provider offering ASAM level 4 care. Stakeholders are assessing the feasibility of repurposing the DeNier Youth Services Center to provide residential treatment, among other levels of care. La Plata County estimates remodeling costs would total approximately $5 million. HMA has factored these estimates into three scenario proforma projections to estimate ongoing financial feasibility. See Appendix A, Methodology, for more detail.

As shown below, all three of the scenarios project annual loss based on available, current data.

Projected Demand: Based on the number of people in Region 9 who may have AUD and SUD, along with an estimated usage rate, HMA arrived at the following estimates were developed:

- Annual admissions = 240
- Average length of stay (LOS) = 30 days
- Average daily census = 20
- Bed needs = 21

Proforma: Based on these estimates, estimated reimbursement per diems, and local cost data (drawn from Medicare cost reports), HMA developed three scenarios to account for potential variation in payer mix and related rates. Each scenario projects an annual loss:

- Scenario A – Avg per diem reimbursement of $500 = Loss of S2.2 million
- Scenario B – Avg per diem reimbursement of $625 – Loss of $1.3 million
- Scenario C – Avg per diem reimbursement of $750 = Loss of $0.440 million

Losses could be reduced or eliminated through various adjustments in the assumptions regarding volume, payer mix, and reimbursement rates, as described in more detail in Appendix A. In addition, the analysis did not factor in other funding opportunities that may become available once a firm option has been established. HMA has provided an interactive model of the analysis to Region 9 SWORD Council leadership that will allow for the adjustment of key variables and the opportunity to add other funding that may become available. This interactive model will allow for sensitivity analysis around these key variables.

A model for consideration is the Thwajik Ke Residential Treatment Center in Chandler, AZ, which offers an array of SUD treatment services, from inpatient residential to IOP and transitional sober living. The leadership of Gila River Health Care, which operates Thwaik Ke, may share valuable experience from their process of determining how to expand and fund the center's programs.

Service #2: Crisis Stabilization Facility

Numerous stakeholders described the need for some level of crisis stabilization, particularly inpatient ASAM 3.7 medically monitored intensive inpatient services. HMA worked with Centura Mercy Hospital in Durango to gather data to develop a proforma feasibility estimate. See Appendix A for details.

Projected Demand: Based on the estimated population with AUD and SUD in the region, along with an estimated usage rate, HMA arrived at the following:

- Annual admissions = 800
- Average LOS = 6.5 days
- Average daily census = 14
- Bed needs = 15

Proforma: Based on the projected demand data cited above, information from Centura Mercy, estimated reimbursement per diems, and local cost data (drawn from Medicare cost reports) three scenarios were developed to account for potential variation in payer mix and related rates. Each of the three scenarios project an annual loss:

- Scenario A – Avg per diem reimbursement of $500 = Loss of $2.2 million
- Scenario B – Avg per diem reimbursement of $625 – Loss of $1.5 million
- Scenario C – Avg per diem reimbursement of $750 = Loss of $0.911 million

Given the relatively small size and more complex level of care, it would be best to engage with a local hospital to convert beds and operate such a unit within the confines of the facility. Costs to develop such a unit are not yet available. Losses could be reduced or eliminated through various adjustments in the assumptions regarding volume, payer mix, and reimbursement rates, as described in more detail in Appendix A.

For example, opioid settlement funds may be used for start-up costs. In addition, the analysis did not factor in other funding opportunities that may become available once a firm option has been established. HMA has provided an interactive model of the analysis to Region 9 SWORD Council leadership that will allow for the adjustment of key variables and will also provide for the opportunity to add other funding that may become available. This interactive model will allow for sensitivity analysis around these key variables.

Service #3: Methadone Clinic

As noted previously, only a DEA-regulated OTP can administer methadone. Region 9 has been without an OTP since the one in Durango closed in October 2021. The closest OTP now is in Farmington, NM, and it operates with limited hours. HMA did not conduct a financial analysis to determine the estimated costs, but we learned anecdotally from key informant interviewees familiar with running an OTP in the region that approximately 100 patients are needed to sustain an OTP without additional funding.

Action Steps

- Identify a clinician willing and able to run an OTP. Starting with providers who previously supported the OTP in Durango may be beneficial and most efficient.
- Support steps needed to obtain SAMHSA, DEA, and any other regulatory approvals.
- If a sufficient patient population is not established to sustain the OTP financially, provide supplementary financial support as needed.

Resource/partnership needed: Multiple interviewees raised an OTP as a potential area of collaboration between local tribes, the IHS, and counties. Models exist in other jurisdictions wherein a clinic that operates in a tribal community with IHS funding provides MAT and other SUD/OUD services to both tribal and non-tribal clients. Additionally, given much of the region is rural, transportation may be a barrier to operating a traditional OTP model. Region 9 should consider developing transportation supports or a mobile methadone clinic to decrease this barrier.

Two tribally operated MAT clinics may be good resources for Region 9. The Yurok Tribe in Klamath, CA, runs a successful MAT program and is considering options for expansion. The Confederated Salish and Kootenai Tribes in Montana (CSKT) also offer MAT services as a part of their tribally operated behavioral health programs. CSKT accepts all forms of insurance and self-pay for Native and Non-Native people.

Addressing the Funding Gap

Examples from Other Communities

Larimer County, CO

In 2018, Larimer County voters passed a sales tax increase of 0.25 percent dedicated to Larimer County Behavioral Health Services, with the goal of facilitating quality mental health care to meet the needs of community members through access to affordable and appropriate behavioral healthcare. The ballot language presented a two-pronged, local solution:

1. Expanded and enriched local behavioral health services across the county
2. Regional behavioral health facility to coordinate those integrated services

In 2022 total revenue for Larimer County Behavioral Health was $26.6 million—a direct result of the ballot initiative. Revenue generated also funded the grant program and the planning and design of the new behavioral health facility. The department has attained a cumulative fund balance that will be directed toward construction of the facility and will allow the county to build the facility without incurring debt.[66]

[66] For more information on Larimer County Behavioral Health Services, go to: https://www.larimer.gov/behavioralhealth/ourstory.

Douglas County, CO

In 2014, the Douglas County Mental Health Initiative (DCMHI) was established in response to a series of tragic events. By 2017, the Board of Douglas County Commissioners approved ongoing general funds to support a Community Response Team program following a successful pilot.

- By 2019, the Board of Commissioners extended general funds to include a youth Community Response Team (CRT).
- The DCMHI is now embedded into the newly established County Health Department.[67]

Bexar County, TX

The Restoration Center is situated within the larger crisis response and jail diversion system in Bexar County and includes a comprehensive continuum of services for BH crisis and law enforcement disposition. The Restoration Center has a crisis walk-in center, a 48-hour crisis observation unit, law enforcement drop-off, full continuum of care for mental health and SUD services, and primary care for triage/minor medical clearance. The Restoration Center was built with and has continued investment and involvement from county, city, state, and private entities, including community hospitals and a local private hospital foundation. The center is part of an advanced community initiative to address behavioral health crisis and criminal justice system diversion across the sequential intercept model and acuity level for behavioral health response.

Since its inception, the Bexar County jail diversion program has subscribed to the proof-of-concept model, using available funding sources to achieve positive outcomes that demonstrate results and accountability, which in turn attracts additional funding and supports scaling up and the addition of needed services. As of 2020 the Restoration Center had an annual operating budget of $36 Million, including braided funding from:

- State of Texas-HHS Dept. of State Health Services: One-time initial investment based on successful proof of concept/pilot diverting people with mental health conditions and/or SUD from jail
- State general funds: Crisis service provider
- Dept. of State Health Services: Health Care Services-Substance Use Authority for the county
- Dept. of State Health Services: MAT provider
- Texas HHS: MAT treatment
- Texas HHS: Cost reimbursement contracts
- Federal Medicaid funds: Crisis services
- Third party payers: Individual payer contracts
- City of San Antonio: Annual contract-cost offset from police department (ED diversion)
- City of San Antonio: Operating budget
- County of Bexar: Annual contract-general operations-cost offset from sheriff

[67] For more information on the DCMHI, visit https://www.douglas.co.us/mental-health/mental-health-initiatives/

- University Health System: Annual cost reimbursement contracts for capped number of unfunded individuals served
- Bexar County: Court diversion
- UHS Carelink: County health insurance program

Funding Opportunities

Region 9 has a variety of funding sources available to support expanding SUD/OUD treatment services throughout Archuleta, Dolores, Montezuma, La Plata, and San Juan Counties.

Opioid Settlement Funding

The State of Colorado anticipates receiving more than $700 million in opioid settlement dollars over 18 years and has established a detailed framework for distributing this funding to support addiction prevention, treatment, and recovery programs throughout the state. Details of the distribution framework and approved uses of settlement funds are described in the Colorado Opioid Abatement Council's Colorado Opioid Settlement Memorandum of Understanding.

As of June 9, 2023, the final approval of $17.3 billion in national opioid agreements was announced with drug makers Teva and Allergan and pharmacies CVS and Walgreens. These additional funds are expected to be distributed to state and local governments by the end of 2023. Colorado will receive approximately another $270 million over 15 years from these recent settlements, which is in addition to the approximately $400 million Colorado has begun receiving from prior opioid settlements.

Most (60%) opioid settlement funds will be distributed to 19 regional councils, including SWORD. Between July 1, 2021, and June 30, 2023, SWORD was allocated $813,799.78 (see Table 18). With the additional settlement allotments, the SWORD allocation is estimated at $1.55 million available in October 2023. On average, over 18 years, it is estimated SWORD will receive $444,000 annually (2022-2038). Updated figures will be made public on an ongoing basis via the Opioid Settlement Distribution Dashboard in August 2023. Figures will continue to be revised as settlements are finalized and additional settlements are included.

Table 17. SWORD Regional Opioid Settlement Funding Distribution

SWORD Regional Opioid Settlement Distribution	
	Funding Allocation
Year 1 (7/1/2021-6/30/2022)	$563,185.61
Year 2 (7/-1/2022-6/30/2023)	$250,614.17 ($987,000 estimated as of 7/21/23)
Estimated total funding over 18 years	$4,237,406.86 (7.5 million estimate as of 7/21/23)

Source: https://geoinfo.coag.gov/portal/apps/sites/#/settlement-distributions/pages/regional-funds

Local governments may opt out of receiving their allocated funds and instead redirect them to their region. In SWORD's region, all localities have opted to redirect their allocated funds to the region.

State Opioid Response Grants

SAMHSA provides state opioid response (SOR) grants to assist states in increasing access to FDA-approved medications for MOUD, also known as MAT, and to support the continuum of prevention, harm reduction, treatment, and recovery support services for OUD and co-occurring SUDs. The State of Colorado has received more than $60 million in SOR funding, which the BHA administers. The third and current round of funding will continue through September 2024.

Overdose Data to Action

The CDC's overdose data to action (OD2A) initiative "supports jurisdictions in collecting high quality, comprehensive, and timely data on nonfatal and fatal overdoses and in using those data to inform prevention and response efforts."[68] The initiative launched in September 2019 and included 66 recipients composed of state, territorial, county, and city health departments. Participating jurisdictions partner with the CDC to focus on improving collection and reporting of morbidity and mortality data, as well as innovative surveillance strategies to tailor overdose data collection to their community's needs. Colorado receives OD2A funding at the state level.

The CDC also offers funding directly to local city and county health departments through the Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL) grant. All local health departments, special district health departments, and territories are eligible. Applications for the 2023 funding cycle were due May 8, 2023, but Region 9 can stay informed of future notices of funding and consider applying for OD2A: LOCAL in coming years.

Health Resources & Services Administration Rural Communities Opioid Response Program

The Health Resources and Services Administration's (HRSA's) Rural Communities Opioid Response Program (RCORP) includes seven grant initiatives that address barriers to SUD treatment in HRSA-designated rural areas:

1. Planning
2. Implementation
3. MAT expansion
4. MAT access
5. Neonatal abstinence syndrome
6. Psychostimulant support
7. Behavioral healthcare support

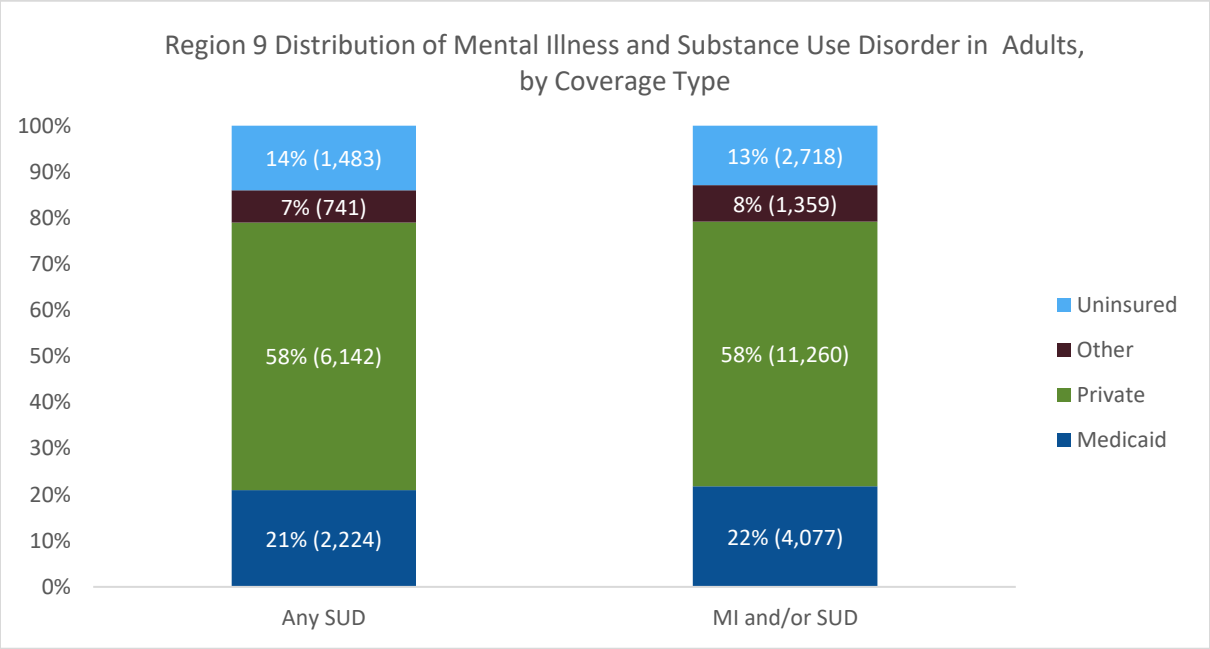
Any public or private, non-profit, or for-profit entity, including faith-based and community-based organizations and federally recognized tribes, may apply for RCORP grants.

[68] Centers for Disease Control and Prevention. About OD2A. Last reviewed September 2021. Available at: cdc.gov/drugoverdose/od2a/about.html. Accessed July 27, 2023.

Payer / Insurance Coverage

Payers are an important consideration for sustainably funding the SUD continuum in Region 9 once the short-term investments have been made. Understanding coverage among people with SUD or co-occurring mental illness/SUD is important to understand what the opportunity for a payer-funded continuum may be. According to 2020 NSDUH estimates, private insurance covers more than half of the SUD treatment among adults (58%).[69] Applying this estimate to the adult population estimate in Region 9, an estimated 6,142 people with SUD in Region 9 have private insurance coverage. Despite only covering 18 percent of the adult population, Medicaid covers 21 percent of people receiving SUD treatment—an estimated 2,224 people in Region 9. An estimated 1,483 uninsured adults with SUD live in Region 9 (see Figure 19).

Figure 19. Distribution of Adults in Region 9 with Mental Illness and SUD



Note: Includes people with mild, moderate, or severe mental illness (DSM-IV) or substance use disorder (DSM-V) according to NSDUH. Respondents may report having more than one type of coverage; however, individuals are sorted into only one category of insurance coverage.
Source: KFF analysis of National Survey on Drug Use and Health (NSDUH), 2020 PNG

Medicaid Funding

Peer Recovery Support Services

Many peer services are billable, according to Colorado Medicaid billing manuals. For a peer service to be billable, the member receiving care must have a covered diagnosis. Then, in accordance with the

[69] Saunders H, Rudowitz R. Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020. Kaiser Family Foundation. Published June 6, 2022. Available at: https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/. Last accessed July 27, 2023.

Uniform Services Coding Standards Manual,[70] any billable code that indicates a peer as a service provider may be eligible for reimbursement. HCPF, in partnership with the BHA, created a new provider type, recovery support services organization (RSSO), to clear an additional path to bill for peer support services. Organizations that provide recovery-focused services can apply for the RSSO license through the BHA.

Transportation

Colorado H. B. 21-1085 directed the Department of Health Care Policy & Financing (HCPF) to implement a behavioral health secure transportation (BHST) paid benefit by July 1, 2023. This legislation creates a standardized transport benefit to improve access to behavioral healthcare. It is a collaborative effort between the department, BHA, and CDPHE. Among the five counties in Region 9, Archuleta, La Plata, and Montezuma have BHST—a fee-for-service benefit though HCPF, meaning that HCPF enrolled providers will bill the department directly for provision of services to Health First Colorado members.

Table 18. Transportion Billing Codes and Payment Rates

Current Code	Modifier	Unit	Description	Proposed Rate
A0999	ET	One Way Loaded Trip	Behavioral Health Secure Transport	$262.66 per trip
A0425	ET	Mile	Ground mileage, per statute mile	$6.10 per mile

Source: Department of Health Care Policy and Financing, 2023. Table displays current codes and initial draft rates, subject to change.

Emergency medical transportation (EMT) regulations allow interfacility transfers between hospitals, which can include transportation of people who are experiencing a mental health or SUD crisis.

Non-emergent medical transportation (NEMT) provides rides to and from medically necessary services covered by Health First Colorado (Colorado's Medicaid program) for members who have no other means of transportation, including free transportation. NEMT can only be used to access non-emergency services.

Urgent NEMT can only be used to transport eligible members to and from Health First Colorado participating providers. NEMT must be used to access the closest emergency provider. Urgent NEMT should only be used to transport members to urgent care facilities when these individuals are unable to provide advanced notice. This includes:

- Transportation after discharge from a hospital
- Failure of a NEMT provider to pick up a member from an appointment within one hour of the scheduled pick-up time
- Transportation to and from critical, unplanned medical appointments

[70] Colorado Department of Health Care Policy & Financing. *Uniform Service Coding Standards Manual*. Published January 2023. Available at: https://hcpf.colorado.gov/sites/hcpf/files/Uniform%20Service%20Coding%20Standards%20Manual%20January%202023.pdf. Last accessed July 27, 2023.

Appendix A: Methodology

Literature Scan/Past Assessments

Reports reviewed included:

Document Reviewed	Document Description	Report Data/Findings
Southwestern Colorado Opioid Overdose Planning (SCOOP) Strategic Plan and Action Plan (July 2021)	Includes summary of population and priority populations (LGBTQ+), strengths, gaps, and challenges. Includes goals and objectives through 2024.	41% of Fort Lewis College student body is Native American/Alaska Native. Opioid use has decreased by 11% at Mercy Regional Medical Center (MRMC) but overdose deaths have increased 33.3% in the same period. Alcohol is also identified as a consistently large SUD issue. Strengths: Peer support models, committed organizations, people in recovery, LQBTQ+ resources exist. Gaps: Affordable housing, living wage jobs, social/community connection, access to treatment and recovery services for priority populations, as well as distance to services. Challenges: Cultural stigma and difficulty coordinating shared measurements for success.
Colorado Department of Law's Opioid Crisis Response Plan (April 2021)	Initial outline of suggested programs and strategies for abating the opioid epidemic through the state.	Priorities include prevention and education, treatment, criminal justice, harm reduction, recovery, and opioid abatement in rural Colorado. Alignment with Region 9 priorities like expanding access to services, including telehealth, mobile, outpatient, and residential. Pregnant and parenting people are identified as a priority population for improving access and care for OUD/SUD.
Behavioral Health Transformational Task Force Recommendations and Final Report (January 2022)	Final report on the recommendations from the Behavioral Health Transformational Task Force. Intended to use once-in-a-generation funding opportunity to institute transformational investments in CO's BH system.	Investments will: • Address residential behavioral health needs of Colorado's Native American Tribes. • Meet the needs of children, youth, and families through youth and family residential care, community services, and school and pediatric behavioral healthcare integrations. • Invest in increased adult inpatient and residential care. • Integrate primary care and behavioral health. • Address gaps in the continuum of care through grants to local governments and community-based organizations. • Expand and support Colorado's behavioral health workforce.

Document Reviewed	Document Description	Report Data/Findings
		• Invest in Colorado's behavioral health system through care navigation & coordination, and immediate pandemic relief.
Region 9 Economic Development District of SW Colorado – 2021 Performance Report		• La Plata County participated in SCOOP, Planning Grant for Opioid Settlement Regional Council • Archuleta, Dolores, La Plata, Montezuma, and San Juan County creation of a regional council to manage the opioid settlement funds
RCORP Community Needs Assessment and Gap Analysis – SCOOP Consortium by CHI and MRMC	Assessment report related to HRSA RCORP planning/implementation grant funds for SCOOP.	Community survey performed with 159 responses; topics of inquiry included questions related to: • Community sense of belonging, with 15% describing their sense of belonging as "very strong" • Culture/traditions are reflected in the community, with 17% responding with "very strong" • Stigma, about 10% suggested strong blame for individuals with SUD. In 2020, Mercy Regional Medical Center (MRMC) reported 53 patients in with an opioid-related diagnosis. Indicators in which Region 9 was higher than the state average are listed below respectively: • % of patients prescribed long-duration opioids who were opioid naïve (21%|12%) • Youth binge drinking (20.7%|16%) • Rate per 100,000 of fatal alcohol overdoses (6.8|1) • AUD related deaths per 100,000 (6.4|4.0) • % of adults who report binge or heavy drinking (75.9%|60.1%) • Psychostimulant related deaths per 100,000 (10.3|5.7) Report contains results of 2019 HKCS data as well as naloxone training numbers. G numbers. G numbers.
CDHS Behavioral Health Assessment Regional Profile	Behavioral Health Assessment Profile on Region 1 showcasing the safety net population distribution, mental health drivers of ED visits, behavioral health workforce, and continuum of services.	• 0.226 population safety net score in Region 1 vs 0.239 statewide. • Mental health drivers for ED visits include: mental illness (67%), depression (25%), intellectual/developmental disability (I/DD) co-occurring behavioral health need (5%), and self-harm (3%). • Alcohol-related ED visit (60.5%, higher than state average). • 2 out of 14 counties exceed the state age-adjusted rate of drug overdose deaths per 100,000 residents, with 1,986 deaths. • Lower behavioral health workers in Region 1: 1.95 per 1,000 rate vs 2.44. • Region 1 has fewer outpatient SUD, MAT, transitional services relative to other regions.

Document Reviewed	Document Description	Report Data/Findings
CDHS Behavioral Health Assessment LGBTQ+ Populations	Summary of available data on behavioral health prevalence, stakeholder feedback on the specific needs and barriers to care. Ideas to improve care including evidence-based practices and innovations within Colorado and nationally are also included.	• Higher use of tobacco, marijuana, alcohol, and other drugs • Lack of access to behavioral health services • Lack of understanding, training, and knowledge about unique LGBTQ+ needs • Needs for individuals that needs to be addressed: staff training that is culturally competent, expanded demographic forms containing LGBTQ+, and access to behavioral health services • Queer informed Narrative Therapy (QINT)
Healthy Kids Colorado Survey – Region 9 Snapshot	Summary snapshot of 2013 HKCS for Health Statistics in Region 9.	• Tobacco, Alcohol, and Marijuana use was overall higher in Region 9 than the rest of the state. • Other drugs were offered higher in Region 9 than the rest of the state. • Students who have ever used prescription drugs and steroids (without Dr. prescription) was higher in Region 9 than in the state
Colorado Drug Overdose Dashboard	• Dashboard showcasing drug overdose deaths, hospital admissions and ED visits, and perception dispensed.	• Increase in drug overdose deaths due to any drug per year from 2020 to 2021 in Region 9 • Decrease in number of ED visits per year for overdose involving all drugs from 2020 to 2021 in Region 9 • Decrease in total number of opioid analgesic and miscellaneous drug prescriptions dispensed per year from 2020 to 2021 in Region 9 • Total number of stimulant prescriptions dispensed per year decreased in 2018 to 2019, but not by a lot.

Key Informant Focus Groups / Interviews

HMA conducted 12 focus groups / interviews with 24 community leaders identified by SWORD. The goal of the conversations was:

- To understand from the key informants their professional experience with substance use prevention, treatment and recovery in Region 9 and their perspective on community needs.
- To accurately determine the current state of substance use prevention, treatment, and recovery services in the area, including how individuals obtain treatment services and existing gaps in care.
- To understand the strengths of the current SUD services available, gaps in care, needed partnerships, and top community priorities related to care.

The key informants who participated in the discussion represented different sectors, including:

- Criminal Justice (6)
- MAT Providers (2)
- Public Health (5)
- Tribal - Southern Ute Indian Tribe (2)
- Behavioral Health Providers (5)
- Homeless Services (1)
- Human Services (2)
- Peers/People with Lived Experienced (2)

Each interview lasted approximately 90 minutes and involved one HMA facilitator and one HMA note taker. The discussions were recorded to aid in recall and clarification. A facilitation guide was used to structure the group interviews and ensure consistency across the KII groups. Ten of the 12 focus groups were conducted in person in Region 9 on March 8–9, 2023. Two discussions occurred virtually April 7 and April 12, 2023.

Notes and transcripts were analyzed using Excel and included rigorous coding of themes and identification of contradictory data. The analysis was both systematic and verifiable, relying on a constant comparative method. Every member of our analysis team also helped facilitate the focus group, either as a moderator or note taker. Analysis started immediately following each focus group session, guided by the following questions:

- What were the important ideas that came out of the discussion?
- Were there any quotes that seemed to stand out?
- How was this interview or group different/similar to other discussions?
- Anything surprising from the discussion?
- Anything to change about the discussion guide or facilitation?

The facilitation guide was to organize the data into a set of broad themes, including:

- Description of trends noted among participants
- What is working well and should be strengthened/expanded with substance use prevention, treatment, and recovery services in Region 9
- Largest gaps in substance use prevention, treatment, and recovery services in Region 9
- Barriers to offering these services in Region 9
- Cultural relevance of the service continuum
- Partnership/collaboration

Each comment was then coded to a subtheme. Once all the notes were analyzed and coded, analysts re-read the codes and themes to determine whether any should be combined or split into an independent theme. Themes were weighted based on the word choice of respondents and the context around responses, as well as the frequency, extensiveness, and intensity with which topics were discussed.

SUD Provider and Community Survey

This survey was designed to build on information gathered in previous assessments and focused on existing services, gaps, challenges, and solutions related to opioid use disorder (OUD) and other SUD in the region. Two types of respondents were selected for this survey:

- SUD providers: Individual, group, or facility providers serving Coloradans in Archuleta, Montezuma, Dolores, San Juan, and La Plata Counties and/or the Ute Mountain Ute Tribe and Southern Ute Indian Tribal Communities
- Other community stakeholders who do not provide direct SUD services but have an important perspective to share on the SUD treatment needs and supports in Archuleta, Montezuma, Dolores,

San Juan, and La Plata Counties and/or the Ute Mountain Ute and Southern Ute Indian Tribal Communities.

Survey respondents were notified that their participation was voluntary and that any information they provided would be aggregated and deidentified in the published feasibility study. The length of the survey was dependent on the survey respondent type:

- Other community stakeholders who do not provide direct SUD services (estimated at 8 minutes)
- SUD treatment provider (estimated at 20 to 25 minutes)

The survey was administered via Qualtrics on May 2, 2023, and disseminated by SWORD council members and shared with a broad community stakeholder list. It closed May 31, 2023. HMA received 48 completed responses, of which 69 percent (n=33) were community stakeholders who do not provide SUD treatment services.

Survey analysis prioritized understanding the perspectives of SUD providers and community members. We conducted cross-tabulations to analyze the relationship between two or more variables, with one variable representing the demographic group (e.g., SUD provider organizations, individual or independent SUD providers, or community stakeholders) and the second variable representing one or more of their experiences or perceptions.

The tables below describe the ***survey respondent*** demographics.

In what capacity are you responding to this survey?		
	Count	**Percent**
SUD provider organization	6	13%
Individual or independent SUD provider	7	15%
Community stakeholder who does not provide SUD treatment services	33	72%
Total	46	100%

Below is a list of the provider organizations who responded to the survey:

Provider Survey Respondents	**In what capacity are you responding to this survey?**
Individual SUD provider (n=2)	Individual or independent SUD provider
New Awakenings, LLC	Individual or independent SUD provider
Studio B	Individual or independent SUD provider
San Juan Basin Public Health	Individual or independent SUD provider
Southern Ute Tribal Health Department, Behavioral Health Division	Individual or independent SUD provider
Century Mercy Regional Medical Center	Individual or independent SUD provider
Authentic Solutions Consulting	SUD provider organization
Axis Health System (n=3)*	SUD provider organization

Community Compassion Outreach	SUD provider organization
Centura Mercy	SUD provider organization
Community Intervention Program Montezuma County	SUD provider organization
Colorado Addiction Treatment Services	SUD provider organization

*Note: Three respondents represented Axis Health System. Questions related to service offerings and staffing were verified and incorporated into the assessment as one response for Axis Health System; however, questions on perception of needs and priority areas were treated as three unique responses.

Among community stakeholders, from what perspective did you respond to this survey?		
	Count	**Percent**
Social services	8	24%
Public health	5	15%
Advocacy organization	5	15%
Colorado Opioid Settlement Regional Council (voting members)	3	9%
Person with lived SUD experience	1	3%
Criminal justice	1	3%
Education	1	3%
Colorado Opioid Settlement Regional Council member's advisory/non-voting member	1	3%
Business owner/employer	0	0%
Other, please describe.	0	0%

Among community stakeholders, for what counties and/or reservations in Region 9 does your survey response best speak to? Select all that apply.		
	Count	**Percent**
Montezuma	21	64%
Archuleta	5	15%
San Juan	5	15%
Ute Mountain Ute Reservation	4	12%
Dolores	0	0%
La Plata	0	0%
Southern Ute Indian Reservation	0	0%
	33	

The tables below describe the ***provider respondent*** demographics.

What type of provider best represents you? Select all that apply.		
	Count	**Percent**
Licensed addiction counselor (LAC)	7	54%
Physician	4	31%
Licensed professional counselor (LPC)	3	23%
Peer specialist (PS)	3	23%
Unlicensed master's degree	3	23%

Certified addiction specialist (CAS)	2	15%
Intern	2	15%
Licensed clinical social worker (LCSW)	2	15%
Licensed psychologist	2	15%
Professional nurse	2	15%
Other, please describe	2	15%
Bachelor's degree (social work, counseling, psychology, or a related health care field)	1	8%
Certified addiction technician (CAT)	1	8%
Certified prevention specialist	1	8%
Licensed marriage and family therapist (LMFT)	1	8%
Physician assistant (PA)	1	8%
Psychiatrist	1	8%
Qualified medication administration person (QMAP)	0	0%
Unlicensed doctorate (PhD, PsyD, EdD)	0	0%
Total	13	

In what type of facility do you deliver SUD treatment services? Select all that apply.		
	Count	**Percent**
Independent group practice provider-based facility	5	38%
SUD treatment facility	3	23%
Other, please describe	3	23%
General hospital	2	15%
Federally qualified health center (FQHC)	2	15%
Community mental health center	1	8%
Pharmacy	1	8%
IHS Tribal 638 provider freestanding facility	1	8%
Prison/correction facility	1	8%
Public health clinic	1	8%
School	0	0%
Homeless shelter	0	0%
IHS freestanding facility	0	0%
IHS provider-based facility	0	0%
Military treatment facility	0	0%
Inpatient psychiatric facility	0	0%
Rural health clinic	0	0%
Total	13	

Please select the counties and/or tribal communities that are "primary service areas" in Region 9. Primary service areas are counties and/or tribal communities where you have the largest number of patients across the SUD treatment continuum. Select all that apply.	Count	Percent
All counties via telehealth	3	23%
Archuleta	6	46%
Montezuma	5	38%
Dolores	3	23%
San Juan	2	15%
La Plata	10	77%
Southern Ute Indian Tribe	0	0%
Ute Mountain Ute Tribe	0	0%
Total	13	

In what counties and/or tribal communities do you have physical locations from which you offer SUD treatment services? Select all that apply.	Count	Percent
Archuleta	2	15%
Montezuma	2	15%
Dolores	1	8%
San Juan	0	0%
La Plata	11	85%
Southern Ute Indian Tribe	0	0%
Ute Mountain Ute Tribe	0	0%
Total	13	

What payers do you accept? Select all that apply.	Count	Percent
Medicaid	10	77%
Medicare	7	54%
Private/commercial insurance	9	69%
Indian Health Services/Tribal	5	38%
Self-pay	9	69%
Other, please describe	8	62%
Total	13	

Other responses included:

- Victims compensation, offender services funds, behavioral health vouchers
- EAP
- Services free to unhoused population
- Grants, probation, and other funding sources as they arrive on case-by-case basis
- Grant-run program

- Non-profit
- Sliding-fee scale
- Accept all payers

Are you currently taking new patients?		
	Count	**Percent**
Yes	12	92%
Maybe	1	8%
No	0	0%
Total	13	

For what age groups do you or your organization offer substance use treatment services? Select all that apply.		
	Count	**Percent**
Adolescents 12 to 18 years	10	77%
Young adults 19 to 24 years	12	92%
Adults 25 to 64 years	13	100%
Older adults 65 years or older	12	92%
Total	13	

What substance use disorders do you treat? Select all that apply.		
	Count	**Percent**
Alcohol related disorders	12	92%
Opioid related disorders	11	85%
Cannabis related disorders	9	69%
Sedative, hypnotic, or anxiolytic related disorders	10	77%
Cocaine related disorders	10	77%
Other stimulant related disorders	11	85%
Hallucinogen related disorders	10	77%
Nicotine dependence	11	85%
Inhalant related disorders	6	46%
Other substance related disorders	2	15%
Total	13	

Feasibility Assessment and Proformas

Inpatient treatment

Volume:

- Used regional ED visits for alcohol and substance-related conditions, not admitted

- Applied an estimated admission use rate that also considered potential bed capacity of 20–25 maximum
- Used an average length of stay of 30 days for this type of unit
- In consideration of above, derived annual patient days of 7,200 (average daily census of 20)

Net Revenue

- Because of the sensitivity of key assumptions, three scenarios were developed that adjusted payer mix and average per diems, as follows:

Scenario A:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	30%	2,160	1,000	2,160,000
Medicaid	40%	2,880	500	1,440,000
Self	30%	2,160	-	-
Total	100%	7,200	500	3,600,000

Scenario B:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	35%	2,520	1,100	2,772,000
Medicaid	35%	2,520	600	1,512,000
Self	30%	2,160	100	216,000
Total	100%	7,200	625	4,500,000

Scenario C:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	40%	2,880	1,200	3,456,000
Medicaid	30%	2,160	700	1,512,000
Self	30%	2,160	200	432,000
Total	100%	7,200	750	5,400,000

Expenses

- Staffing
  - Nursing
    - Patient to nurse ratio of 7:1 (headcount of 3 per day)
    - Paid time off factor of 10%
    - Average hourly rate of $45
    - Benefits factor of 25%
  - CNA
    - Headcount of two per day
    - Paid time off factor of 10%

        - Average hourly rate of $20
        - Benefits factor of 25%
    - Other
        - Unit manager at $85,000 per year
        - Clinical support at $65,000 per year
        - Benefits factor of 25%
- Medical director: 10 hours per week at $125 per hour
- Ancillaries (mainly pharmaceuticals and labs): Based on similar unit cost per patient day using Medicare cost reports
- Support and overhead: Based on similar unit cost per patient day or bed using Medicare cost reports

Inpatient Treatment Unit

	Scenario: A	B	C
Beds	21	21	21
Days/Units	7,200	7,200	7,200
Admissions	240	240	240
ALOS	30	30	30
Occupancy %	95%	95%	95%
Average Daily Census	20	20	20
Average Reimbursement Per Day	$ 500	$ 625	$ 750
Operating Revenue			
Total Patient Net Revenue	$3,600,000	$4,500,000	$5,400,000
Other Revenue/Community Support	$0	$0	$0
Total Operating Revenue	$3,600,000	$4,500,000	$5,400,000
Operating Expenses			
Nursing (RN)	$1,300,860	$1,300,860	$1,300,860
C N A	$385,440	$385,440	$385,440
Other	$150,000	$150,000	$150,000
Total Salaries	$1,836,300	$1,836,300	$1,836,300
Fringe Benefits	$459,075	$459,075	$459,075
Total Salaries and Fringe Benefits	$2,295,375	$2,295,375	$2,295,375
Medical Director (10hrs/Wk @ 125/hr)	65,000	65,000	65,000
Ancillaries	$183,600	$183,600	$183,600
Support/Overhead	$3,296,378	$3,296,378	$3,296,378
Total Operating Expenses	$5,840,353	$5,840,353	$5,840,353
Net Margin/ (Loss)	***($2,240,353)***	***($1,340,353)***	***($440,353)***
Margin %	***-62.2%***	***-29.8%***	***-8.2%***

IP Crisis Unit Volume

- Used Century Mercy Hospital study that revealed:
    - Annual admissions of 800
    - Average LOS of 6.5

- Annual patient days of 5,200 (average daily census of 14)

Net Revenue

- Because of the sensitivity of key assumptions, three scenarios were developed that adjusted payer mix and average per diems, as follows:

Scenario A:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	30%	1,560	1,000	1,560,000
Medicaid	40%	2,080	500	1,040,000
Self	30%	1,560	-	-
Total	100%	5,200	500	2,600,000

Scenario B:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	35%	1,820	1,100	2,002,000
Medicaid	35%	1,820	600	1,092,000
Self	30%	1,560	100	156,000
Total	100%	5,200	625	3,250,000

Scenario C:

Payer	Mix	Patient Days	Est Per Diem	Net Reimb
Insurance	40%	2,080	1,200	2,496,000
Medicaid	30%	1,560	700	1,092,000
Self	30%	1,560	200	312,000
Total	100%	5,200	750	3,900,000

Expenses

- Staffing
  - Nursing
    - Patient to nurse ratio of 7:1 (Headcount of 2 per day)
    - Paid time off factor of 10%
    - Average hourly rate of $45
    - Benefits factor of 25%
  - CNA
    - Head count of one per day
    - Paid time off factor of 10%
    - Average hourly rate of $20

        - Benefits factor of 25%
    - Other
        - Unit manager at $85,000 per year
        - Clinical support at $65,000 per year
        - Benefits factor of 25%
- Medical Director – 10 hours per week at $125 per hour
- Ancillaries (mainly pharmaceuticals and labs) – Based on similar unit cost per patient day using Medicare Cost reports
- Support and Overhead – Based on similar unit cost per patient day or bed using Medicare Cost Reports

Inpatient Crisis Unit

	Scenario: A	B	C
Beds	15	15	15
Days/Units	5,200	5,200	5,200
Admissions	800	800	800
ALOS	6.5	6.5	6.5
Occupancy %	95%	95%	95%
Average Daily Census	14	14	14
Averarge Reimbursemetn Per Day	$ 500	$ 625	$ 750
Operating Revenue			
Total Patient Net Revenue	$2,600,000	$3,250,000	$3,900,000
Other Revenue/Community Support	$0	$0	$0
Total Operating Revenue	$2,600,000	$3,250,000	$3,900,000
Operating Expenses			
Nursing (RN)	$867,240	$867,240	$867,240
C N A	$192,720	$192,720	$192,720
Other	$150,000	$150,000	$150,000
Total Salaries	$1,209,960	$1,209,960	$1,209,960
Fringe Benefits	$302,490	$302,490	$302,490
Total Salaries and Fringe Benefits	$1,512,450	$1,512,450	$1,512,450
Medical Director (10hrs/Wk @ 125/hr)	65,000	65,000	65,000
Ancillaries	$132,600	$132,600	$132,600
Support/Overhead	$3,101,003	$3,101,003	$3,101,003
Total Operating Expense	$4,811,053	$4,811,053	$4,811,053
Net Margin/(Loss)	***($2,211,053)***	***($1,561,053)***	***($911,053)***
Contribution Margin %	***-85.0%***	***-48.0%***	***-23.4%***

Appendix B: Cross sector community leader interviews and focus group discussion guide

Introduction to Focus Group

Welcome and thank you for taking the time to participate in today's focus group/interview session. My name is _____ and with me is _____. The Region 9 Economic Development District of Southwest Colorado hired us to learn more about the regional needs, community needs, and the most feasible solutions to address substance use and overdose. Specifically:

- To understand your professional experience with substance use prevention, treatment and recovery in your community and your perspective on community needs.
- To accurately determine the current state of substance use prevention, treatment, and recovery services in the area, including how individuals obtain treatment services and existing gaps in care.

Region 9 is looking to invest significant resources into building better services to address the rising overdose epidemic in Archuleta, Dolores, Montezuma, La Plata, and San Juan counties. We want to understand the strengths of the current SUD services available, gaps in care, needed partnerships, and top community priorities related to care. Additionally, of any new investments, we would like to understand what the key attributes, qualities, and must-haves of any service offering should be.

Your participation is completely voluntary, and you are welcome to stop at any time. Your responses will be reported in aggregate and any quotes used will remain anonymous. Thank you again for coming today. Let's start with a brief round of introductions before we start with a couple of questions to prompt today's discussion.

Questions and Prompts

Identified Needs and Gaps

An important part of a SUD treatment feasibility assessment is first understanding Region 9's system's capacity to serve current and projected populations – It is important to understand how well the current population of Region 9 is being served (and by whom) and to consider the future needs of those who will require services (and how).

1. So first, tell us what population do you serve?
    - Geographically?
    - Demographically?
2. What substance use/misuse trends are you seeing in this population?
    - Substance use issues (e.g., alcohol and/or drugs)?
    - Service utilization?
    - Social drivers of need (e.g., housing, employment, poor mental health, etc.)
3. ***[For service providers only]*** We are interested in learning more about the decisions related to service delivery, array, and access.
    - What informs your decisions about the service array being offered?
    - What informs your decisions regarding what populations are served?

4. What is working well and should be strengthened/expanded with substance use prevention, treatment, and recovery services in Region 9 as it relates to the trends you mentioned?
    - Prompts include:
        - Inpatient substance treatment - adults and youth
        - Methadone (other) clinic
        - Dual diagnosis treatment capacities
        - Medical detox
        - Sober living/recovery housing
        - Transportation to out-of-region services
        - Expand jail-based treatment and post-jail resources
        - Residential programs
        - Additional step programs to address or manage recovery
        - Others?
5. What do you perceive as the largest gaps in substance use prevention, treatment, and recovery services in Region 9 in response to these trends?
    - Prompts include:
        - Inpatient substance treatment - adults and youth
        - Methadone (other) clinic
        - Dual diagnosis treatment capacities
        - Medical detox
        - Sober living/recovery housing
        - Transportation to out-of-region services
        - Expand jail-based treatment and post-jail resources
        - Residential programs
        - Additional step programs to address or manage recovery
        - Others?
6. What are the barriers to offering these services in Region 9, and in what ways do these barriers vary by county?
    - Possible Prompts, if needed:
        - Funding
        - Lack of local policy support
        - Limited local resources
        - Lack of specialized training
        - Partnerships
        - Physical location / space
        - Workforce
        - Geography
        - Transportation
        - Lack of Pharmacies?

Access to Care

7. In the recent needs assessment, people mentioned several missed opportunities when they were ready for recovery but the appointment was too far away, they were waiting to be invited to a faith-based community, or they didn't know who to call to get help for their friend/relative. Others mentioned avoiding treatment (that could have led to recovery) because they felt judged or misunderstood. Related, providers varied in their responses to questions about cultural

sensitivity. Some were eager to learn more about how they could be responsive but more than a few felt that treating everyone the same and with respect was what really matters. This was often coupled with a desire to amplify the real need as being inpatient care.

In what ways can the assets identified in the needs assessment be leveraged to reduce these barriers?

- Peer supports
- Committed and capable organizations
- People in recovery ready and willing to share their stories
- Other assets?

8. In what ways could telehealth be a long-term strategy?
    - Possible prompts, if needed:
        - For which populations would telehealth be most beneficial?

Cultural Relevance of the Service Continuum

9. What is needed in Region 9 to address gaps in providing SUD services that are culturally relevant?
10. What is needed in Region 9 to address gaps in providing SUD services that are trauma informed?

Partnership/ Collaboration

11. As SUD treatment undergoes significant transformation, there is an opportunity to be creative about public sector provider networks— building on the strengths of the long-standing community behavioral health system while addressing some of the gaps in care with new providers. What partnerships currently exist in Region 9 that drive quality and work toward positive outcomes?
    - Where are the strengths in the existing partnerships?
    - Where are the silos and the need to focus on continuing to build strong relationships to improve the continuum of care for individuals impacted by substance use?
    - Where do you see opportunity for Recovery Community Organizations in Region 9?
        - Prompts, if needed:
            - School based services
            - Local emergency department pathways
            - Community organization networks
            - Correctional health and justice system leadership
            - Public-private partnerships
            - Employers
12. What else would you like to add or for the group to consider when using resources to address SUD in the Region?

Appendix C: Provider and Community Survey

The Region 9 Economic Development District and SouthWEST Colorado Opioid Response District (SWORD) retained the services of Health Management Associates (HMA), a national research and consulting firm, to conduct a regional substance treatment feasibility study and implementation plan. This study and implementation plan will inform the dedication of opioid settlement dollars and other financial resources to increase and sustain substance use disorder (SUD) treatment resources in the region. This survey builds on information gathered in previous assessments and focuses on existing services, gaps challenges and solutions related to opioid use disorder (OUD) and other SUD in the region.

There are two intended respondents for this survey:

- SUD providers—individual, group, or facility providers—serving Coloradans in Archuleta, Montezuma, Dolores, San Juan, and La Plata counties and/or the Southern Ute or Ute Mountain Ute tribal communities.
- Other community stakeholders who do not provide direct SUD services but have an important perspective to share on the SUD treatment needs and supports in Archuleta, Montezuma, Dolores, San Juan, and La Plata counties and/or the Southern Ute or Ute Mountain Ute tribal communities.

Your participation in this survey is voluntary. Information from this survey will be aggregated and deidentified in the published feasibility study. The information will be used to determine the opportunities for investment in the SUD continuum.

The length of the survey is dependent on the perspective you have to offer:

- Other community stakeholders who do not provide direct SUD services (estimated at 8 minutes)
- SUD treatment provider (estimated at 20−25 minutes)

You may leave the survey and reenter to finish it later.

If you have any questions about the survey, please contact Robyn Odendahl with Health Management Associates at rodendahl@healthmanagement.com.

Thank you for your willingness to participate.

End of Block: Introduction

Start of Block: Respondent Information

The data from this survey will be used to understand services offered across Region 9 (Archuleta, Montezuma, Dolores, San Juan, and La Plata counties and Southern Ute or Ute Mountain Ute tribal communities). The survey ***requires your organization or individual name*** to accurately identify locations of services. This can also support follow-up, as needed, to clarify information.

Q1 Please enter your name
Q2 Please enter the name of your organization, if applicable
Q3 In what capacity are you responding to this survey?

- SUD provider organization (1)
- Individual or independent SUD provider (2)
- Community stakeholder who does not provide SUD treatment services (3)

End of Block: Respondent Information

Start of Block: SUD Provider Information

Q4 What type of provider best represents you? Select all that apply.

- Bachelor's degree (social work, counseling, psychology, or a related health care field) (1)
- Certified Addiction Technician (CAT) (2)
- Certified Addiction Specialist (CAS) (3)
- Certified Prevention Specialist (4)
- Intern (5)
- Licensed Addiction Counselor (LAC) (6)
- Licensed Clinical Social Worker (LCSW) (7)
- Licensed Marriage and Family Therapist (LMFT) (8)
- Licensed Professional Counselor (LPC) (9)
- Licensed Psychologist (10)
- Peer Specialist (PS) (11)
- Physician (12)
- Physician Assistant (PA) (13)
- Professional Nurse (14)
- Psychiatrist (15)
- Qualified Medication Administration Person (QMAP) (16)
- Unlicensed Doctorate (PhD, PsyD, EdD) (17)
- Unlicensed Master's Degree (18)
- Other, please describe (19) _____

Q5 In what type of facility do you deliver SUD treatment services? Select all that apply.

- Not Applicable (1)
- SUD Treatment Facility (2)
- Community Mental Health Center (3)
- Pharmacy (4)
- School (5)
- Homeless Shelter (6)
- Indian Health Service Free-Standing Facility (7)
- Indian Health Service Provider-Based Facility (8)
- IHS Tribal 638 Provider Free-Standing Facility (9)
- Prison/Correction Facility (10)
- General Hospital (11)
- Military Treatment Facility (12)
- Federally Qualified Health Center (FQHC) (13)
- Inpatient Psychiatric Facility (14)
- Public Health Clinic (15)
- Rural Health Clinic (16)
- Independent Group Practice Provider Based Facility (17)
- Other, please describe (18) _____

End of Block: SUD Provider Information

Start of Block: SUD Service Area

Q6 Please select the counties and/or tribal communities that are "primary service areas" in Region 9. Primary service areas are counties and/or tribal communities where you have the largest number of patients across the SUD treatment continuum. Select all that apply.

All counties via telehealth (1)
Archuleta (2)
Montezuma (3)
Dolores (4)
San Juan (5)
La Plata (6)
Southern Ute tribal communities (7)
Ute Mountain Ute tribal communities (8)

Q7 In what counties and/or tribal communities do you have ***physical*** locations from which you offer SUD treatment services? Select all that apply.

- Archuleta (1)
- Montezuma (2)
- Dolores (3)
- San Juan (4)
- La Plata (5)
- Southern Ute tribal communities (6)
- Ute Mountain Ute tribal communities (7)

End of Block: SUD Service Area

Start of Block: Patient Population

Q8 What payers do you accept? Select all that apply.

- Medicaid (1)
- Medicare (2)
- Private/commercial insurance (3)
- Indian Health Services/Tribal (4)
- Self-pay (5)
- Other, please describe (6) _____

Q9 Please estimate your total number of unique (unduplicated) SUD treatment clients/patients in calendar year 2022.

Q10 Please estimate the total number of SUD treatment related visits in calendar year 2022.

Q11 For what age groups do you or your organization offer substance use treatment services? Select all that apply.

- Adolescents 12 to 18 years (1)
- Young adults 19 to 24 years (2)
- Adults 25 to 64 years (3)
- Older adults 65 years or older (4)

Q12 What substance use disorders do you treat? Select all that apply.

- Alcohol related disorders (1)
- Opioid related disorders (2)
- Cannabis related disorders (3)
- Sedative, hypnotic, or anxiolytic related disorders (4)
- Cocaine related disorders (5)
- Other stimulant related disorders (6)
- Hallucinogen related disorders (7)
- Nicotine dependence (8)
- Inhalant related disorders (9)
- Other substance related disorders, please describe (10)
  _____

Q72 Among the age groups to whom you offer substance use treatment services, are any of these age groups excluded from specific SUD treatment services?

- Yes (1)
- Maybe (2)
- No (3)

Display This Question:

If Among the age groups to whom you offer substance use treatment services, are any of these age gro... = Yes

Or Among the age groups to whom you offer substance use treatment services, are any of these age gro... = Maybe

Q73 If yes or maybe, what age group(s) and for what SUD(s)?

End of Block: Patient Population

Start of Block: Services

Continuum of care 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. The American Society of Addiction Medicine (ASAM) has established five main levels in a continuum of care for SUD treatment:

Level 0.5: Early intervention services

- Level 1.0: Outpatient services
- Level 2: Intensive outpatient/Partial hospitalization services (Level2 is subdivided into levels 2.1 and 2.5)
- Level 3: Residential/Inpatient services (Level III is subdivided into levels 3.1, 3.3, 3.5, and 3.7)
- Level 4: Medically managed intensive inpatient services

Q13 What ASAM levels of care do you provide? Hover over each option's text with your cursor to read a definition of each ASAM level. Select all that apply.

- SUD Prevention/Early Intervention Services (ASAM 0.5) (1)
- SUD Outpatient (OP) Therapy (ASAM 1.0) (2)
- SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) (3)
- SUD Partial Hospitalization (ASAM 2.5) (4)
- SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) (5)
- SUD Clinically Managed Population-Specific High-Intensity Residential (ASAM 3.3) (6)
- SUD Clinically Managed High-Intensity Residential (ASAM 3.5) (7)
- SUD Medically Monitored Intensive Inpatient (ASAM 3.7) (8)
- Medically Managed Inpatient (ASAM 4) (9)

Q13a What withdrawal management (WM) levels of care for adults do you offer? Hover over each option's text with your cursor to read a definition of each ASAM level. Select all that apply.

- Ambulatory Withdrawal Management without Extended On-Site Monitoring (Outpatient Withdrawal Management) (1.0 WM) (1)
- Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management) (2.0 WM) (2)
- Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management) (3.2 WM) (3)
- Medically Monitored Inpatient Withdrawal Management (3.7 WM) (4)
- Medically Managed Intensive Inpatient Withdrawal Management (4.0 WM) (5)

Q14 What SUD treatment approaches do you or your organization offer? Select all that apply.

- Individual therapy (1)
- Group therapy (2)
- Family therapy (3)
- Medication assisted treatment (MAT) (4)
- 12-step facilitation (5)
- Cognitive-behavioral therapy (CBT) (6)
- Dialectical behavioral therapy (DBT) (7)
- Motivational interviewing (8)
- Therapeutic community (9)
- Matrix model (10)
- Community reinforcement and contingency management (11)
- Screening, brief intervention, and referral to treatment (SBIRT) (12)
- Seeking safety and other trauma focused therapies (13)
- Other, please describe (14) _____

Q15 What additional types of service offerings do you or your organization offer to clients with SUD? Select all that apply.

- SUD targeted case management (1)
- Peer support/recovery services (2)
- Narcan/naloxone distribution (3)
- Syringe services/exchange (4)
- Wound care (5)
- Safer drug use supplies or resources (6)
- Chemical dependency support groups (psychoeducation) (7)
- HIV/STI/Hep C testing and education (8)
- Psychiatry (9)
- Dual diagnosis/co-occurring disorder treatment (10)
- Care coordination/case management services (11)
- Other SUD services, please describe. (12)

  _____

Q16, Do you provide MAT?

- Yes (1)
- No (2)

Display This Question:

If Do you provide medication assisted treatment (MAT)? = No

Q16a, You identified you do not provide MAT, why not?

_____

Display This Question:

If Do you provide medication assisted treatment (MAT)? = Yes

Q16b Do you have availability to start MAT on the same day the patient is initially evaluated?

- Yes (1)
- No (2)
- Sometimes (3)

Display This Question:

If Do you provide medication assisted treatment (MAT)? = Yes

Q16b-2 Which type(s) of MAT do you provide? Select all that apply.

- Buprenorphine (1)
- Methadone (2)
- Naltrexone (3)
- Suboxone (combination-medicine of buprenorphine/naloxone) (4)

Q17 To what extent do you agree that MAT is an unmet need in Region 9?

- Strongly agree (1)
- Agree (2)
- Undecided (3)
- Disagree (4)
- Strongly disagree (5)
- I don't know (6)

Q18 What community/recovery support services do you or your organization provide? Select all that apply.

- None (1)
- Parent/caregiver support (2)
- Skill building (social, daily living, etc.) (3)
- Behavioral management (4)
- Supported employment (5)
- Housing support (6)
- Peer support (7)
- Traditional healing services (8)
- Personal care (9)
- Respite (10)
- Supported education (11)
- Transportation (12)
- Care coordination (13)
- Coordinated entry system (14)
- Clubhouse (15)
- Mental health advance directives (16)
- Other supports for self-directed care (17)
- Wellness recovery action planning (WRAP) (18)
- Other, please describe (19)

Q19 What community/recovery support services do you feel the region lacks and needs more of to support transitions more effectively between different levels of SUD care? Select up to three services.

- None (1)
- Parent/caregiver support (2)
- Skill building (social, daily living, etc.) (3)
- Behavioral management (4)
- Supported employment (5)
- Housing support (6)
- Peer support (7)
- Traditional healing services (8)
- Personal care (9)
- Respite (10)
- Supported education (11)
- Transportation (12)
- Care coordination (13)
- Coordinated entry system (14)
- Clubhouse (15)
- Mental health advance directives (16)
- Other supports for self-directed care (17)
- Wellness recovery action planning (WRAP) (18)
- Other, please describe (19) _____

End of Block: Services

Start of Block: Telehealth services

Q20 Do you or your organization offer telehealth SUD treatment services?

- Yes (1)
- No (2)

Display This Question:

Do you or your organization offer telehealth SUD treatment services? = Yes

Q20a Has providing telehealth services positively impacted adherence rates?

- Yes (1)
- No (2)

Display This Question:

Has providing telehealth services positively impacted adherence rates? = Yes

Q20a-1 You selected yes, please elaborate.

_____

Display This Question:

Do you or your organization offer telehealth SUD treatment services? = Yes

Q20b Has providing telehealth services reduced no show rates?

- Yes (1)
- No (2)

Display This Question:

Has providing telehealth services reduced no show rates? = Yes

Q20b-1 How has providing telehealth services reduced no show rates?

_____

Display This Question:

Do you or your organization offer telehealth SUD treatment services? = Yes

Q20c Has providing telehealth services helped your services become more accessible to individuals (e.g., rural patients, custodial parents)?

- Yes (1)
- No (2)

Display This Question:

Has providing telehealth services helped your services become more accessible to individuals (e.g... = Yes

Q20c-1 How has providing telehealth services helped your services become more accessible to individuals?_____

End of Block: Telehealth services

Start of Block: Access To Services

Q21 In 2022, what was the average amount of time (days) a client waited between first contacting you or your organization and their initial assessment?

_____

Q22 Do you or your organization provide transportation assistance?

- Yes (1)
- No (2)
- Sometimes (3)

Display This Question:

Do you or your organization provide transportation assistance? = Yes

And do you or your organization provide transportation assistance? = Sometimes

Q22a Are you or your organization billing Medicaid for the costs associated with providing transportation assistance?

- Yes (1)
- No (2)

Display This Question:

Do you or your organization provide transportation assistance? = Yes

And do you or your organization provide transportation assistance? = Sometimes

Q22a-1 What kind of transportation assistance do you or your organization offer?

_____

Display This Question:

Do you or your organization provide transportation assistance? = No

Q22b Please describe the barriers you experience in providing transportation assistance.

_____

End of Block: Access To Services

Start of Block: Service Delivery Needs

Q23 What barriers do you or your organization experience in the delivery of SUD treatment services and supports? Select all that apply.

- *Establishing* information sharing agreements to ensure a smooth and timely transfer of clinical information or documents to or from treatment providers involved in a client's care before or after your involvement. (1)
- *Implementation* of information sharing agreements to ensure a smooth and timely transfer of clinical information or documents to or from treatment providers involved in a client's care before or after your involvement. (2)
- Maintaining a working knowledge of the services and resources that are available in the community. (3)
- Developing strong working relationships with staff of key agencies (e.g., justice organizations, housing providers) to facilitate transitions of care, make special arrangements as needed, and eliminate unnecessary barriers for clients during the delivery of SUD treatment services along the continuum of care. (4)
- Recruiting and sustaining an SUD treatment workforce (5)
- Navigating individual eligibility for SUD treatment services (6)
- Finding physical space or locations from which to provide SUD treatment services (7)
- Incomplete system or continuum of care (
- Lack of enough peers to support outreach and engagement in services (9)
- Lack of licensure status for services levels in demand (10)
- Limited ability to use data to drive program decisions (11)
- Limited staff with necessary experience and training in evidence-based models to support services (12)
- Meeting the demand for services (13)
- Recruiting and maintaining staff with needed experience and training in evidence-based models to support services (14)
- Sustainable funding for services (15)
- Waitlist/wait times to accessing programs and services (16)
- Workforce recruitment and retention (17)
- Inadequate SUD treatment service reimbursement (18)
- Other, please describe (19) _____

End of Block: Service Delivery Needs

Start of Block: Workforce Recruitment and Retention

Display This Question:

If In what capacity are you responding to this survey? = SUD provider organization

Q24 How has the number of current full-time equivalents (FTEs) of SUD clinical/treatment staff employed by your organization changed since 2019?

- Higher today compared with this time in 2019 (1)
- Same/no change today compared with this time in 2019 (2)
- Lower today compared with this time in 2019 (3)
- I don't know (4)

Display This Question:

In what capacity are you responding to this survey? = SUD provider organization

Q25 What is the number and percent of positions focused on SUD treatment services and supports that are currently vacant in your organization?

- How many total mental health or SUD treatment staff positions do you have: (1)
- How many total positions are devoted to SUD treatment services: (2)
- How many positions devoted to SUD treatment services are currently vacant: (3)

Display This Question:

In what capacity are you responding to this survey? = SUD provider organization

Q26 Please check the disciplines that represent your organization's top THREE priorities for recruitment and hiring in the next or upcoming year. Select up to THREE options.

- Administrative Staff (1)
- Bachelor's Level Social Workers (2)
- Behavioral Health Aids (3)
- Certified Behavioral Health Peer Support Specialists (4)
- Certified Prevention Specialists (5)
- Community Health Workers (6)
- Licensed Addiction Counselors (7)
- Licensed Clinical Professional Counselors (8)
- Licensed Clinical Social Workers (9)
- Licensed Marriage and Family Therapists (10)
- Licensure Candidates - Please Specify: (11) _____
- Master's Level Social Workers (12)
- Medical Assistants (13)
- Nurse - APRN or Advanced Practice Psychiatric Nurse (14)
- Nurse - LPN (15)
- Nurse - RN (16)
- Paraprofessionals (e.g., case managers, homeless outreach specialists, or parent aides) (17)
- Peer Support Specialists (18)
- Physician Assistants (19)
- Physician/Psychiatrist Credentialed in Addiction Medicine (20)
- Primary Care/Other Physician (Non-Psychiatry) (21)
- Psychiatric Aides and Technicians (22)
- Psychiatric Rehabilitation Specialists (23)
- Psychiatrists for Adults (24)
- Psychiatrists for Children and Youth (25)
- Psychologists (26)
- Recovery Coaches (27)
- SUD Counselors (28)
- Other, please describe (29) _____

Display This Question:

In what capacity are you responding to this survey? = SUD provider organization

Q27 What are the THREE most common causes of turnover in your organization? Select up to THREE options.

- Lack of competitive salary (1)
- Productivity standards (2)
- Caseload size (3)
- Administrative burden (i.e., paperwork) (4)
- Stress/distress/secondary trauma from work (5)
- Lack of supervision (6)
- Requiring staff to be 24/7 on call (7)
- Hired by competitor in community (8)
- Organizational culture (9)
- Lack of benefits including personal/vacation time (10)
- Lack of flexibility of position (11)
- Lack of opportunity for promotions (12)
- Feeling overworked (13)
- Lack of recognition (14)
- Navigation of system and complexity of care (15)
- None of the above (16)
- Other, please describe (17) _____

End of Block: Workforce Recruitment and Retention

Start of Block: Cultural Competence

It is widely agreed in the healthcare field that an individual's culture is a critical factor to be considered in treatment. The Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity* states, “Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these [ethnic] groups will improve utilization and outcomes.”

Q28 Important steps for supporting diverse populations in outpatient treatment are listed below. Which steps do you or your organization currently take to ensure culturally competent treatment for your clients? Select all that apply.

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as

rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves. (1)

- Ensure that all program staff receive training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves. (2)
- Incorporate family and friends into treatment to support the client. (3)
- Provide program materials on audiotapes, in Braille, or in clients' first languages. (4)
- Ensure that client materials are written at an appropriate reading level. (5)
- Include a strong outreach component. (6)
- Hire counselors and administrators and appoint board members from the diverse populations that the program serves. (7)
- Incorporate elements from the culture of the populations being served by the program (e.g., Native American healing rituals or Talking Circles). (8)
- Partner with agencies and groups that deliver community services to provide enhanced services, such as childcare, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. (9)
- Provide meals at the program facility. (10)
- Make case management services available for clients who need them. (11)
- Emphasize structured programming, as opposed to open-ended discussion, in group therapy settings. (12)
- Base treatment on clients' strengths. Experienced providers report that this approach works well with clients from many cultures and is the preferred approach for clients struggling with self-esteem or empowerment. (13)
- Use a motivational framework for treatment, which seems to work well with clients from many cultures. (14)
- Encourage clients to participate in mutual-help programs to support their recovery (15)

Q29 What is/are the biggest language barrier(s) to effectively serving clients? Select all that apply.

- Spanish (1)
- Chinese, including Mandarin and Cantonese (2)
- German (3)
- Vietnamese (4)
- French, including Cajun (5)
- Russian (6)
- Korean (7)
- Afro-Asiatic, including Amharic, Somali (8)
- Arabic (9)
- Other Indo-European (10)
- Tagalog, including Filipino (11)
- Japanese (12)
- Hindi (13)
- Western African (14)
- Italian (15)
- Other Asian (16)
- Other language, please describe (17)

  _____

Q30 In what languages do you or your organization provide resources or materials? Select all that apply.

- English (1)
- Spanish (2)
- Chinese, including Mandarin and Cantonese (3)
- German (4)
- Vietnamese (5)
- French, including Cajun (6)
- Russian (7)
- Korean (8)
- Afro-Asiatic, including Amharic, Somali (9)
- Arabic (10)
- Other Indo-European (11)
- Tagalog, including Filipino (12)
- Japanese (13)
- Hindi (14)
- Western African (15)
- Italian (16)
- Other Asian (17)
- Other language, please describe (18)

  _____

Q31 In what languages do you or your organization have providers who can provide services (e.g., speak and write in the language of that client)? Select all that apply.

- English (1)
- Spanish (2)
- Chinese, including Mandarin and Cantonese (3)
- German (4)
- Vietnamese (5)
- French, including Cajun (6)
- Russian (7)
- Korean (8)
- Afro-Asiatic, including Amharic, Somali (9)
- Arabic (10)
- Other Indo-European (11)
- Tagalog, including Filipino (12)
- Japanese (13)
- Hindi (14)
- Western African (15)
- Italian (16)
- Other Asian (17)
- Other language, please describe (18)

  _____

Q32 Do you or your organization have access to a language line to facilitate communication with patients/clients who speak non-English languages?

- Yes (1)
- No (2)
- I don't know (3)

Q33 Do you or another staff member in your organization have trauma treatment certification?

- Yes (1)
- No (2)
- I don't know (3)

Display This Question:

Do you or another staff member in your organization have trauma treatment certification? = Yes

Q33a What trauma treatment certification is it?

_____

End of Block: Cultural Competence

Start of Block: Regional SUD Services Needs

Q34 What population in your county has SUD treatment needs that are not yet being effectively addressed? Select all that apply.

- Adults with mild/moderate mental health (MH) service needs (1)
- Adults with serious mental illness (SMI) service and support needs (2)
- Youth with mild/moderate MH service needs (3)
- Youth with serious mental health service and support needs (SED) (4)
- Adults with co-occurring intellectual or developmental disability (I/DD) and MH and/or SUD (5)
- Youth with co-occurring I/DD and MH and/or SUD (6)
- Adults with co-occurring Traumatic Brain Injury and MH and/or SUD (7)
- Youth with co-occurring Traumatic Brain Injury and MH and/or SUD (8)
- Adults actively engaged with the criminal justice system in community settings (9)
- Adults actively engaged with the criminal justice system within correctional settings (10)
- Adults involved in court-ordered (civil commitment) treatment (11)
- Adults involved in court-ordered (forensic commitment) treatment such as transitions into the community (12)
- Youth actively engaged within the juvenile justice system in community settings (13)
- Youth actively engaged within the child welfare system (e.g., foster children, foster parents, families experiencing separation due to child welfare involvement) (14)
- Children and youth with fetal alcohol syndrome (15)
- Individuals with autism (16)
- Veterans (17)
- Tribal populations (18)
- Individuals with undocumented status (19)
- Individuals who are refugees (20)
- LGBTQ+ individuals (21)
- Individuals who are experiencing homelessness (22)
- Pregnant and postpartum people (23)
- Individuals on the sex offender registry (24)
- Youth, 13−18 years old (25)
- Adults, 19−64 years old (26)
- Older adults, age 65 or older (27)
- Individuals who are uninsured or underinsured (28)
- Individuals with commercial insurance (29)
- Other, please describe (30) _____

Q35 What are some challenges and/or barriers to treating SUD in your community(ies)? Select all that apply.

- Individuals' concerns about the cost of treatment (1)
- Individuals' lack of comfort talking with a professional about personal issues (2)
- Individuals' concern about what would happen if someone found out about their SUD (3)
- Hard time getting an appointment for an individual (4)
- Lack of health insurance coverage for an individual (5)
- Inadequate health insurance coverage for an individual (6)
- Maintaining a working knowledge of the services and resources that are available in the community (7)
- Strong working relationships with staff of key agencies (e.g., justice organizations, housing providers) to facilitate a transition an individual between SUD treatment services, make special arrangements as needed, and eliminate unnecessary barriers for the client during transition (8)
- Incomplete system or continuum of care (9)
- Lack of enough peers to support outreach and engagement in services (10)
- Lack of licensure status for in demand service levels (11)
- Lack of transitional or recovery housing (12)
- Limited ability to use data to drive program decisions (13)
- Limited staff with necessary experience and training in evidence-based models to support services (14)
- Meeting the demand for services (15)
- Transportation (16)
- Recruiting and maintaining staff with needed experience and training in evidence-based models to support services (17)
- Stigma and/or NIMBYisn ("not in my backyard") among community members (18)
- Sustainable funding for services (19)
- Waitlist/wait times to access programs and services (20)
- Workforce recruitment and retention (21)
- Reimbursement rates for services (22)
- None (23)
- I don't know (24)
- Other, please describe (25) _____

Q36 There are clinical indicators that mark progress and/or readiness of a client/patient to transition to another stage of SUD care and support. Of the clinical indicators below, please select the top **THREE** where you feel Region 9 should spend its opioid settlement dollars to support individuals with SUD.

- Obtain drug-free, stable housing (1)
- Continued participation in a support group (2)
- Obtain ongoing assistance with other problems, if necessary (3)
- Continue pharmacotherapy, as needed, and other medical or psychiatric assistance (4)
- Obtain medical or psychotherapeutic assistance as needed (5)
- Start or continue vocational or educational training or other courses (6)
- Seek and obtain employment (7)
- Strengthen social support networks (8)
- Linkages with community resources that foster clients' interests and offer needed services for accomplishing life goals (9)

Q76 What level of SUD treatment would you prioritize for Region 9 to build the SUD continuum to meet unmet need? Please select up to **THREE** priority areas. Hover over the text in each option to view the level's definition.

- SUD Prevention/Early Intervention Services (ASAM 0.5) (1)
- SUD Outpatient (OP) Therapy (ASAM 1.0) (2)
- SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) (3)
- SUD Partial Hospitalization (ASAM 2.5) (4)
- SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) (5)
- SUD Clinically Managed Population-Specific High-Intensity Residential (ASAM 3.3) (6)
- SUD Clinically Managed High-Intensity Residential (ASAM 3.5) (7)
- SUD Medically Monitored Intensive Inpatient (ASAM 3.7) (8)
- Medically Managed Inpatient (ASAM 4) (9)

Q37a For the level of care(s) you prioritized, please explain why.

_____

Q38 What level of withdrawal management (WM) care for adults would you prioritize for Region 9 to build the SUD continuum to meet an unmet need? Please select up to THREE priority areas. Hover over the text in each option to view the level's definition.

- Ambulatory Withdrawal Management without Extended On-Site Monitoring (Outpatient Withdrawal Management) (1.0 WM) (1)
- Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management) (2.0 WM) (2)
- Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management) (3.2 WM) (3)
- Medically Monitored Inpatient Withdrawal Management (3.7 WM) (4)
- Medically Managed Intensive Inpatient Withdrawal Management (4.0 WM) (5)

Q38a For the level of care(s) you prioritized, please explain why.

Q78 Please describe what you feel is working well in Region 9 when it comes to addressing the SUD need in your community.

End of Block: Regional SUD Services Needs

Start of Block: Block 13

Display This Question:

In what capacity are you responding to this survey? = Community stakeholder who does not provide SUD treatment services

Q75 From what perspective did you respond to this survey?

- Person with lived SUD experience (1)
- Public Health (2)
- Criminal Justice (3)
- Education (4)
- Business Owner/Employer (5)
- Colorado Opioid Settlement Regional Council Member – Voting Member (6)
- Colorado Opioid Settlement Regional Council Member – Advisory/Non-Voting Member (7)
- Advocacy Organization (8)
- Social Services (9)
- Other, please describe. (10) _____

Display This Question:

In what capacity are you responding to this survey? = Community stakeholder who does not provide SUD treatment services

Q74 For what counties and/or reservations in Region 9 does your survey response best speak to? Select all that apply.

- Archuleta (1)
- Montezuma (2)
- Dolores (3)
- San Juan (4)
- La Plata (5)
- Southern Ute Indian Reservation (6)
- Ute Mountain Ute Reservation (7)

End of Block: Block 13

Start of Block: Conclusion

Q39 Please share any other thoughts or comments regarding the continuum of care for those in need of substance use services and supports in Region 9.

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Q40 Thank you for completing this survey! We appreciate your participation.

End of Block: Conclusion