Boulder County Region
Opioid Operations Board
2024 Strategic Planning Data

How to use this document:

- **The purpose of this data brief is to prepare you for the April 23 Strategic Planning Retreat. The outcome of the retreat will be five strategic priorities for opioid abatement in Boulder County.**
- **Please review the document and identify the areas that you feel are the most harmful to the community or areas where allocating Opioid Settlement funds would have the greatest impact.**
    - ***For example, based on your expertise and the data, would you choose to allocate funds upstream such as community education about the dangers of fentanyl and stigma reduction for seeking support? Would you choose to support individuals in crisis? Or should funds go towards a specific population or geographic area?***
- **There will be a drop-in office hour on Thursday, April 18, from 1 – 2 p.m. should you have any questions. Please reach out to Tucker if you do not have the invitation. This will be the last time to ask questions or have discussion as a group about the data. There will not be dedicated time at the retreat.**

About the Data:

- Qualitative data was assembled from the County's 2022-2023 Behavioral Health Roadmap convenings as well as the landscape analysis completed by the Opioid Operations Board in May 2022. Any explicitly named mental health-related data was removed from the Roadmap data, then, remaining Roadmap data was combined with the landscape analysis and coded for themes. Common themes rose consistently across the continuum of care.
- Quantitative data was pulled from a variety of sources with the intention to illustrate the general impact of opioids in the community, specifically highlighting alignment with the qualitative data, and access and equity concerns experienced by the community.

Qualitative Data
“What is the community saying?”

All qualitative data came from the behavioral health roadmap challenges data across the prevention & early intervention, harm reduction, criminal justice, treatment & crisis response, recovery, and methamphetamine convenings, as well as the opioid landscape analysis completed by the Opioid Operations Board in 2022

Respondents Identified the Following Regarding the General Landscape:

- Many programs lack **sustainable funding**. Grants are short term, and often have strict limitations for service and lengthy reporting requirements. In the Criminal Justice system, any costs saved due to prevention, early intervention, or diversion are hard to measure and are not saved or reinvested back into the justice system.
- Many providers are seeing an **increase in the acuity** of substance use and mental health challenges leading to more individuals accessing crisis services and requiring more intensive and longer-term supports.
- Programs are broadly facing **workforce shortages** and the current workforce is overworked and burnt out, needing mental and behavioral health supports for themselves while also supporting the community. Continuing education for the behavioral health workforce, first responders, educators, parents, physicians, etc. to face the current mental health and substance use crisis is lacking.
- Individuals impacted by substance use, from those who use experimentally, individuals with a substance use disorder, those seeking harm reduction services or medication assisted treatment, individuals in the criminal justice system, and those in recovery are **stigmatized**.
- There is not enough substance use / misuse **education** for the community. The community needs more education related to the increase in fentanyl in the community and the dangers of counterfeit analgesics. Youth need more opportunities to learn about substance use / misuse in school, and there are few options for parents to learn how to support their children regarding substance use and mental health challenges. A harm reduction approach remains taboo, and many providers are not up to speed on the most current evidence informed practices to support individuals struggling with substance use.
- Across the system, **collaboration** between programs is lacking leading to siloing. Many programs and organizations working in parallel but not coordinating or collaborating. Cross-sector partnerships are a struggle – e.g., local government, hospitals, schools, community-based organizations, etc., and some partnerships are declining between programs and organizations leading to further siloing and gaps.
- **Data collection**, particularly in the prevention space and with youth, is a challenge. There are limited resources for collecting and analyzing data, many programs collect different data, and some programs don't participate, collaborate, or share with others.

Respondents Identified the Following Regarding General Barriers to Access & Utilization:

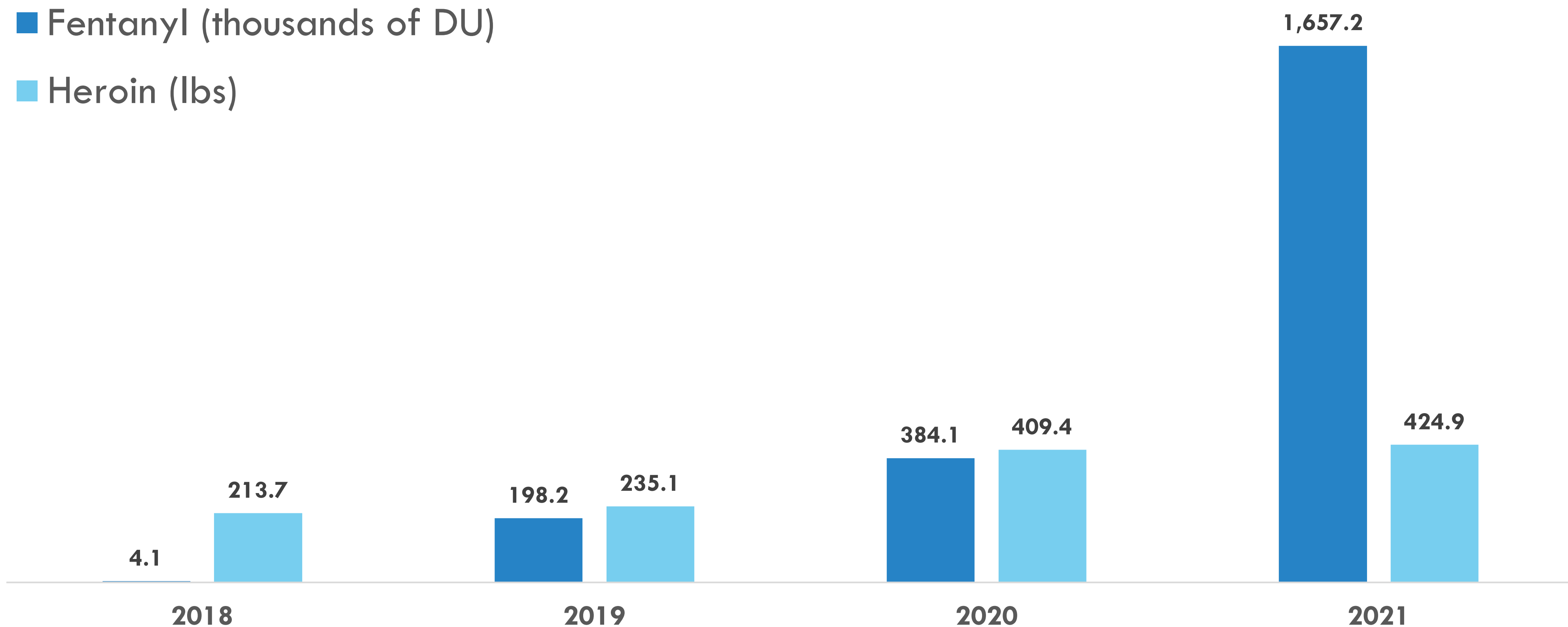
- High **administrative burden** to provide services, especially for grant funded programs with strict guidelines and reporting requirements, as well as working with Medicaid and insurances to cover services.
- **Medicaid and private insurance** cover mental and behavioral health supports at different rates than physical health, many times less than the actual cost of service. Some services that support recovery, such as navigation, are not currently covered. Coverage for inpatient SUD treatment is limited and there are gaps in coverage for individuals reentering the community from the justice system. Insurance and administrative burdens limit the ability to access culturally appropriate services.
- **Cost** of care is expensive, self-pay is a barrier for many, medications to treat OUD are expensive, and Medicaid does not currently cover the costs of services such as treating those in the criminal justice system
- **Navigation** to appropriate services is a challenge in the mental and behavioral health system. This touches each area in the continuum from prevention through recovery. Navigation is hard for the justice involved population. It can be challenging to know where to refer individuals and the specific requirements of entry.
- Many individuals seeking care face **long wait lists** for services, this was particularly noted for mental health support and SUD treatment for individuals on Medicaid, and acute and crisis services. Many times, programs require sobriety to access support, and waitlists to access sometimes don't align when an individual is ready to become sober. Some programs have limited hours of operation that don't align with an individual's schedule (such as open in the evenings or on weekends).
- There is a general **shortage of service providers** across the continuum. The region is missing upstream (meaning prevention and early intervention), full wraparound services to prevent individuals reaching crisis levels, there are not enough harm reduction providers, syringe disposal sites, and organizations distributing naloxone. Services are lacking for high acuity patients including inpatient, residential, long-term care, etc., especially with medically assisted detox. Often, the only options for people are the emergency department or jail. There is a lack of step-down services post-crisis and minimal bridge support. There is a general lack of youth-specific providers. There is a lack of testing and testing, treatment, and peer supports for juveniles specifically with SUD. Virtual services don't work for all populations.

Respondents Identified the Following Regarding General Equity Challenges:

- Services for **non-English or English-learning** individuals are limited. Services across the continuum and supporting materials are rarely offered in languages other than English.
- Many **providers do not identify similarly to the individuals they're serving** whether racially, ethnically, sexual orientation, gender expression, or other identities. There is a **shortage of bilingual and bicultural** providers.
- Many support services are grounded in the White dominant, Western culture. **Culturally appropriate** and responsive services are lacking. There is limited support for grassroots, community-informed efforts, many of which may be more culturally appropriate. It is difficult for these small programs to become "evidence based" and can be hard for small, grassroots programs to market services and reach community members in need.
- **Geographically**, many services are lacking or inaccessible to the mountain communities, and there are **limited resources available to undocumented individuals**.
- The mental and behavioral health system rarely addresses **socioeconomic challenges**. Transportation to and from services are challenging for many individuals, especially for youth, individuals in the mountain regions, the justice involved population, and the unhoused community. Many of these individuals also face **housing challenges**, lacking ongoing, supportive housing. There are restrictions for individuals with drug-related criminal histories, housing contamination due to drug use is a problem, and some sober living homes are not accepting of individuals on MAT.

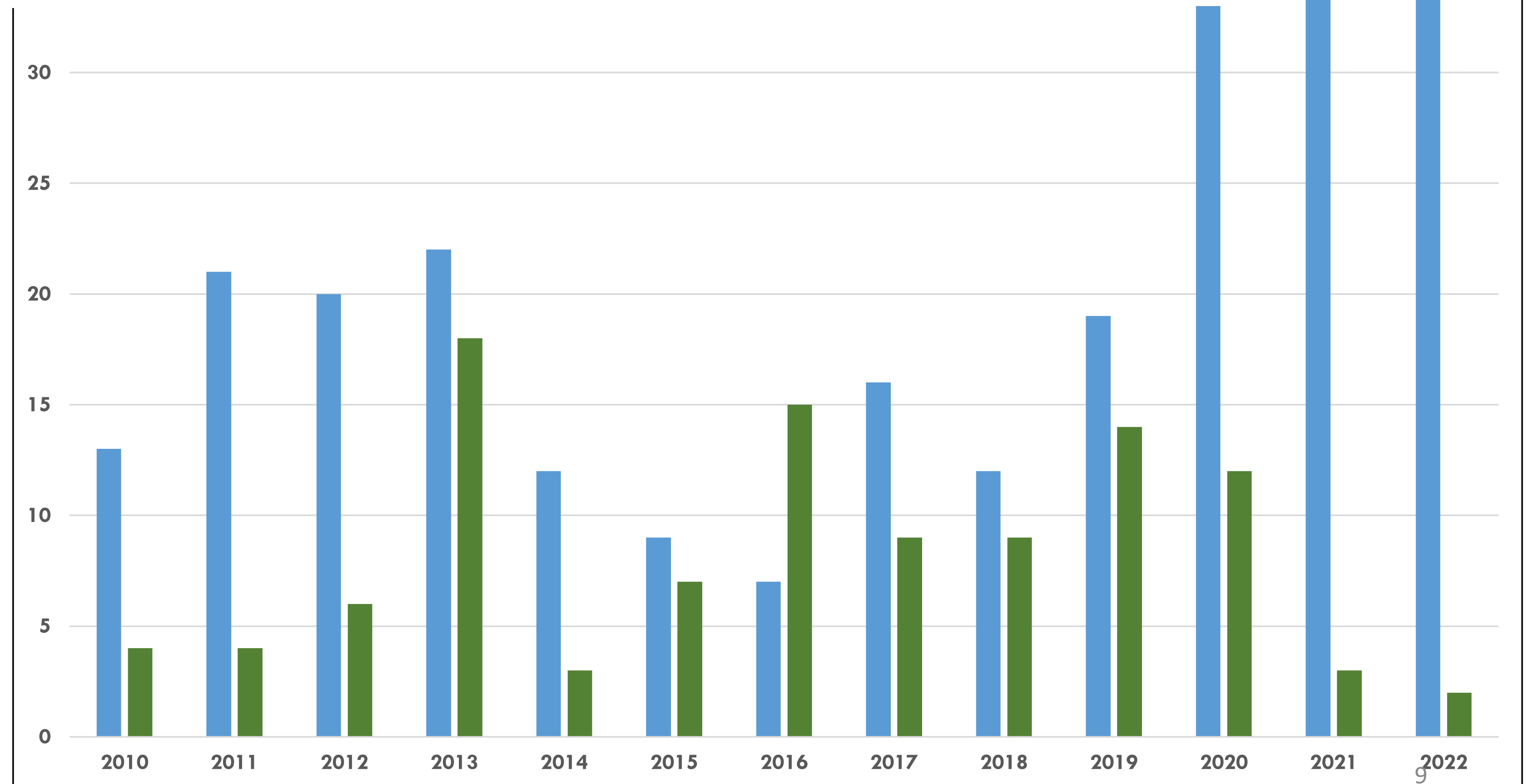
Quantitative Data

Fentanyl drug seizures in Colorado are increasing at higher rates than heroin



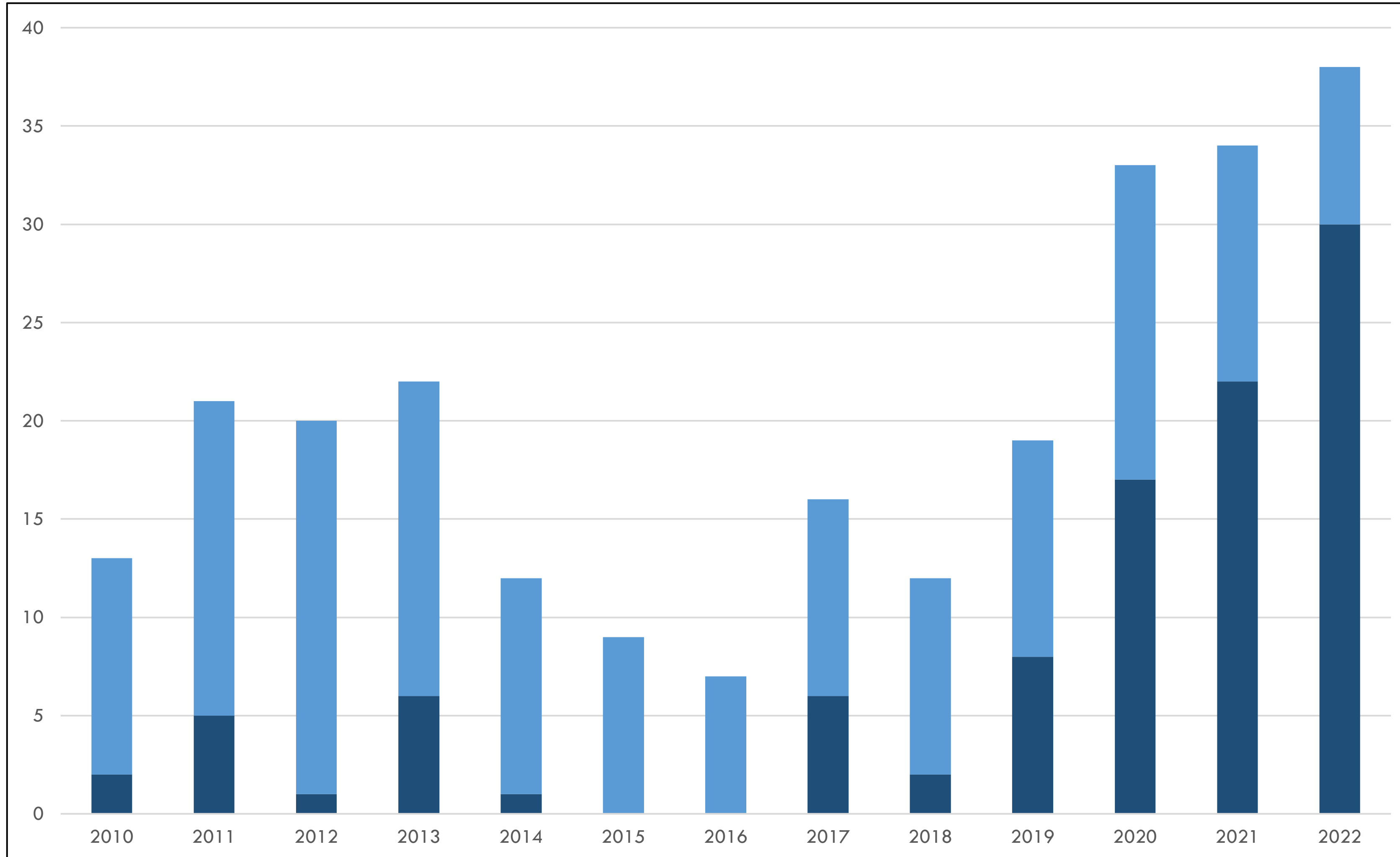
Source: Boulder County Drug Task Force

Deaths associated with **analgesics*** are increasing while deaths related to **heroin** are decreasing

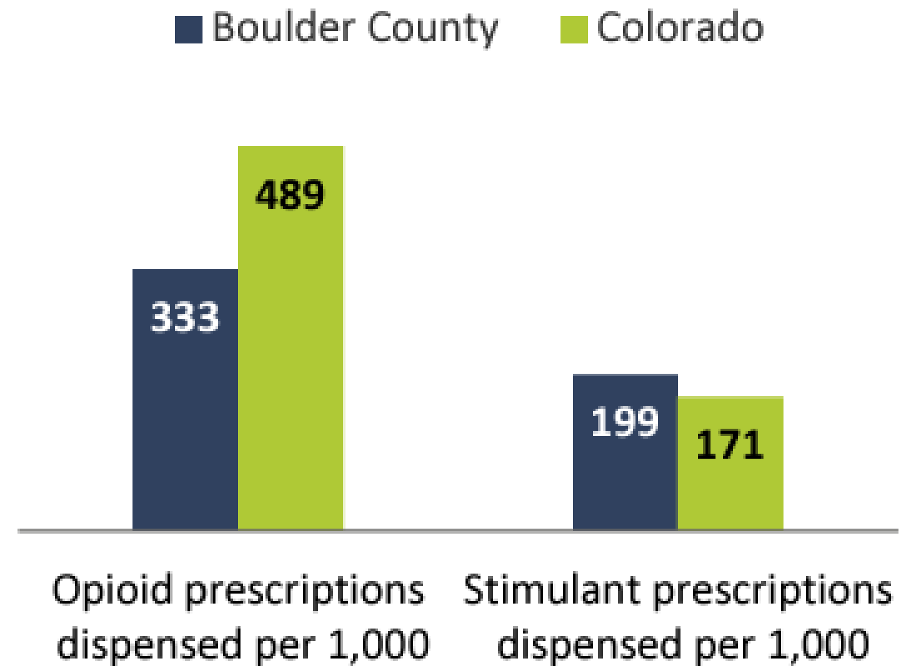


**refers to non-heroin opioids such as those prescribed or obtained illicitly*

Analgesic deaths **mentioning fentanyl** are increasing while deaths **without the mention of fentanyl** are decreasing



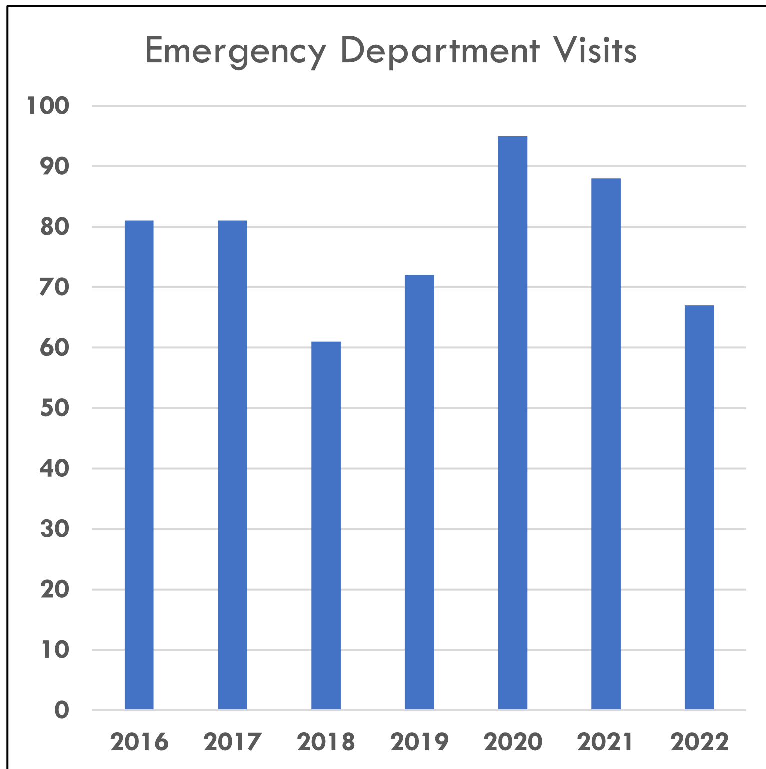
Boulder County's opioid prescription rate is lower than the **state's**

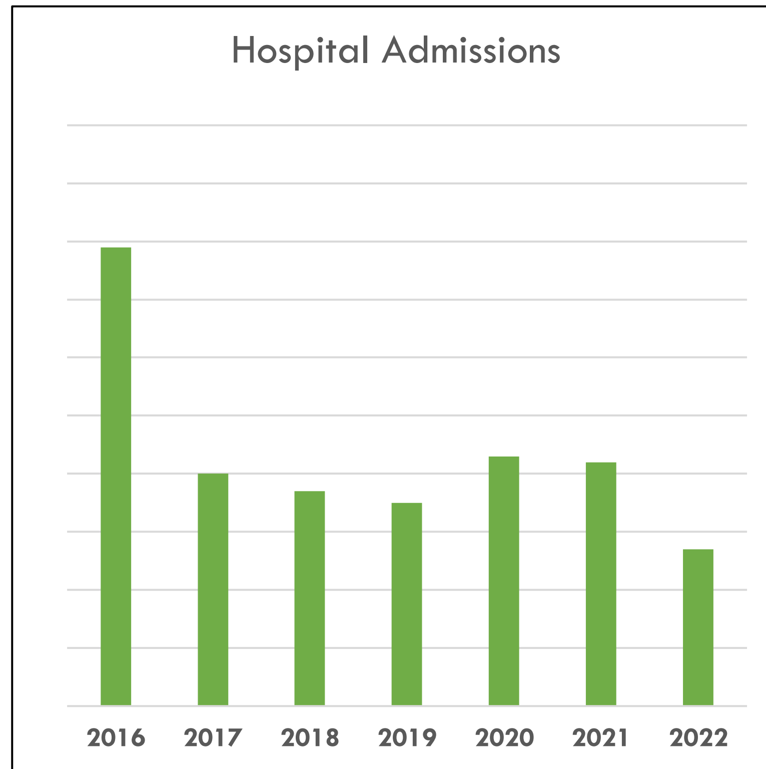


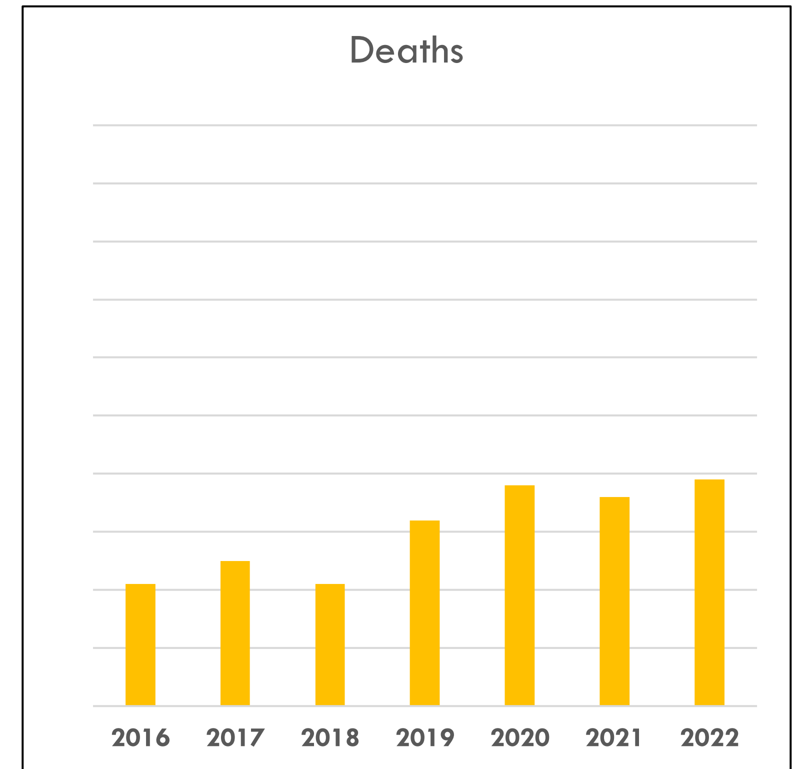
Source: Boulder County Public Health Community Health Assessment, 2023

Implications: Paired with the mortality data above, Boulder County's opioid concerns may be more related to illicit analgesics (such as counterfeit pills) rather than prescribing practices or heroin.

In recent years, there's been a decrease in **emergency department** visits and **hospital admissions**, while **deaths** have remained relatively static

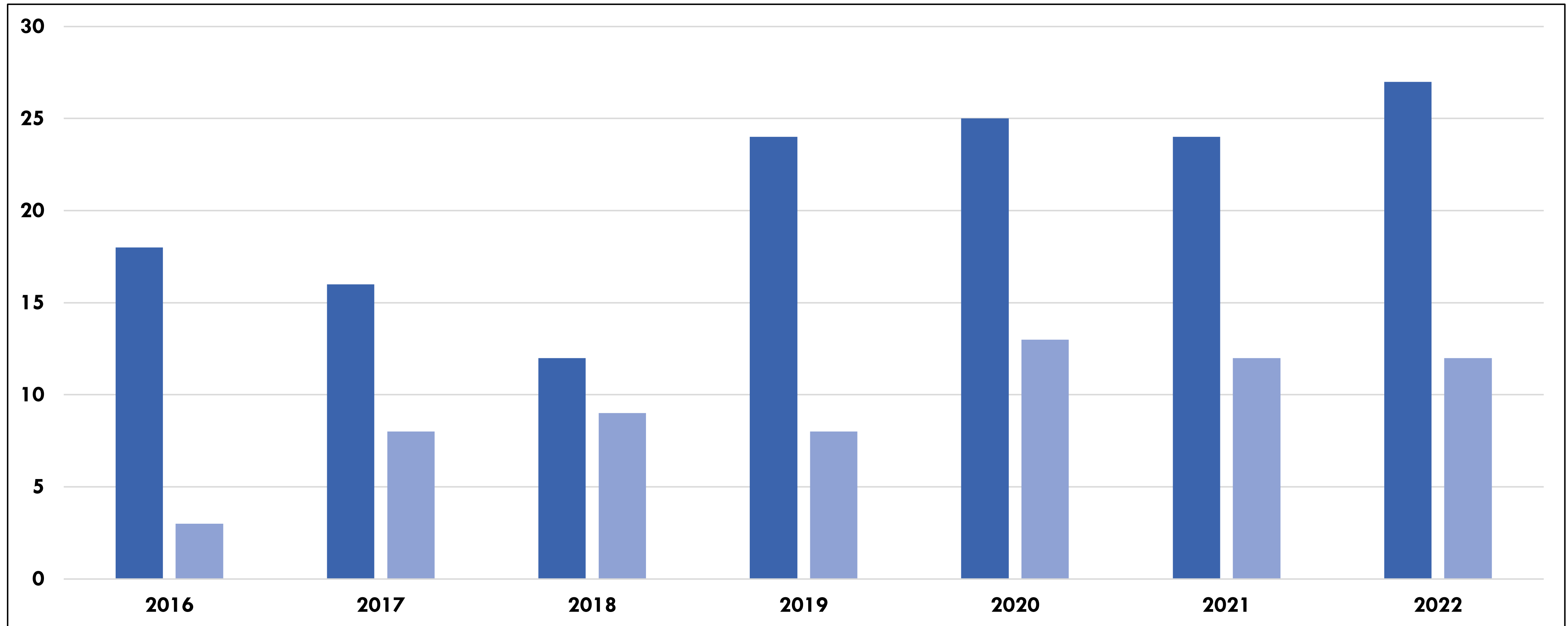






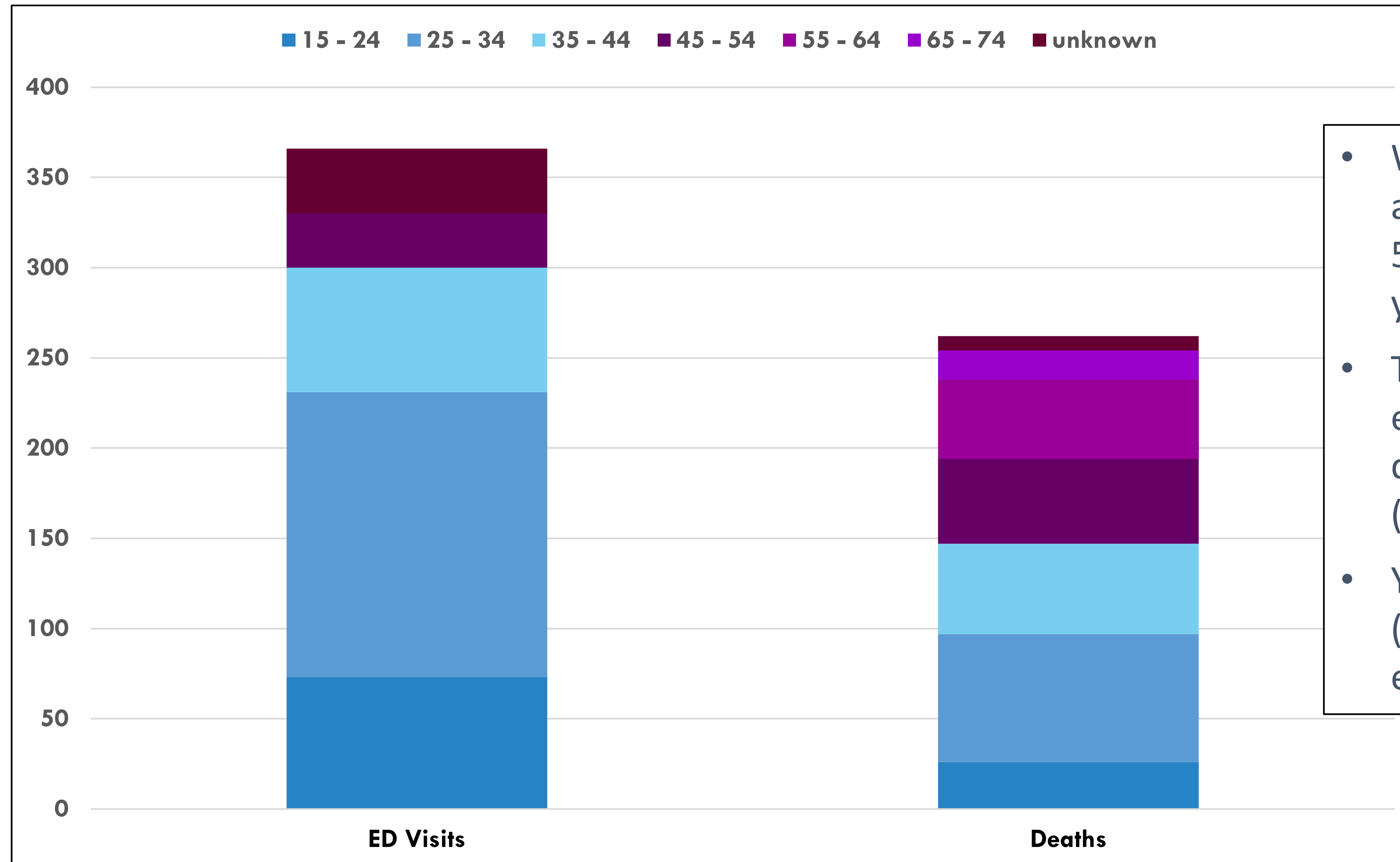
Source: Colorado Department of Public Health and Environment

Males are significantly more impacted in overdose deaths than females



Source: CDPHE Vital Statistics Program

Greater **age diversity** in deaths than emergency department visits

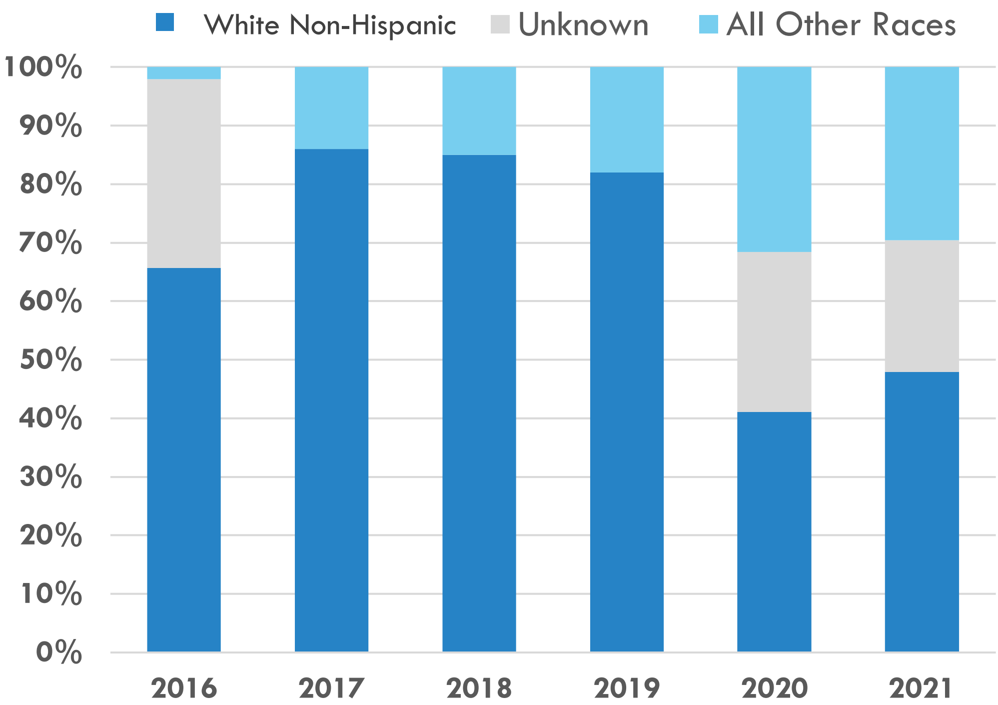


- While 82% of overdose ED visits were among those younger than 45, only 56% of deaths were among those younger than 45.
- The largest age group for both emergency department visits and deaths were those 25 – 34 years old (43% of ED visits and 27% of deaths)
- Younger people may be more likely (compared to older) to go to the emergency department

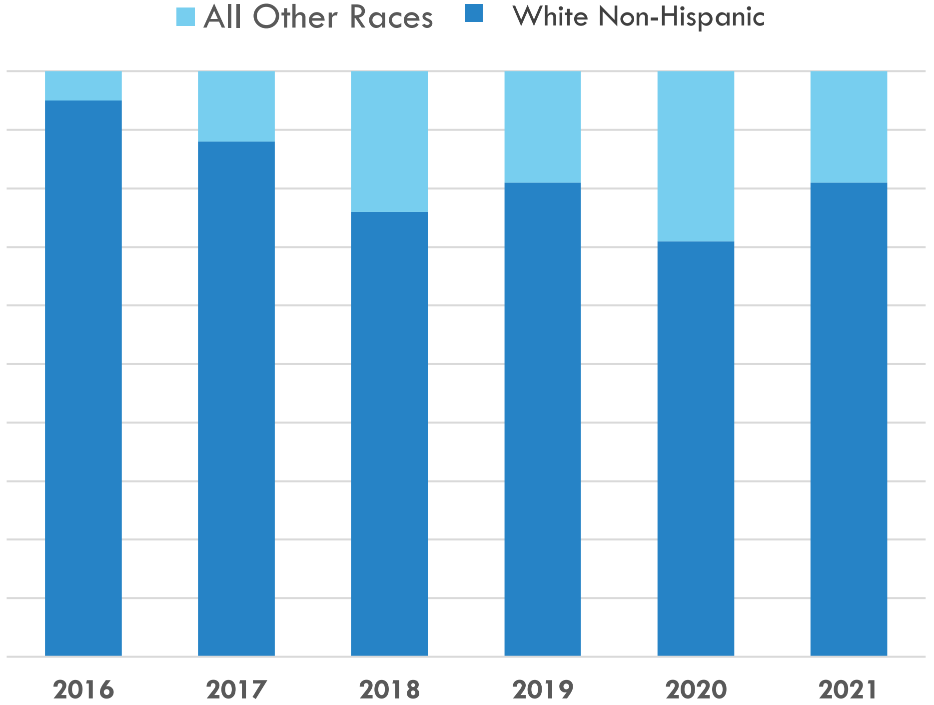
2017 - 2022

Recent data start to show a shift in **racialized impact**, although further data are needed to identify trends*

Emergency Department Visits



Deaths



**Awaiting 2022 and 2023 data, demographic tracking also changed after 2021 making comparison to past years more challenging*

Source: CDPHE

There is a Health Provider Shortage in the rural **mountain region**

This map represents the number of SUD treatment services encounters available to resident males and females ages 18 and above who are experiencing an episode of SUD. Census block groups that are not blue fall below an estimated provider capacity of eight visits per person affected by SUD and may receive formal designation as a SUD-Health Provider Shortage Area

Source: CDPHE & Health Management Associates

RAE Region 6* has the highest number of Medicaid providers billing for behavioral health services^ compared to the other RAEs.

Region	# of Medicaid Members in 2018/19	# of Medicaid Providers Billing Behavioral Health Services	Medicaid Provider Rate per 1,000
Region 1	228,169	1,249	5.5
Region 2	103,709	316	3.0
Region 3	343,404	1,940	5.6
Region 4	152,471	415	2.7
Region 5	246,674	1,427	5.8
Region 6	176,466	1,227	7.0
Region 7	222,226	882	4.0
Colorado*	1,557,421	7,456	4.8

** Includes Boulder, Gilpin, Clear Creek, Jefferson, and Broomfield Counties*

^ Behavioral health services include substance use and mental health

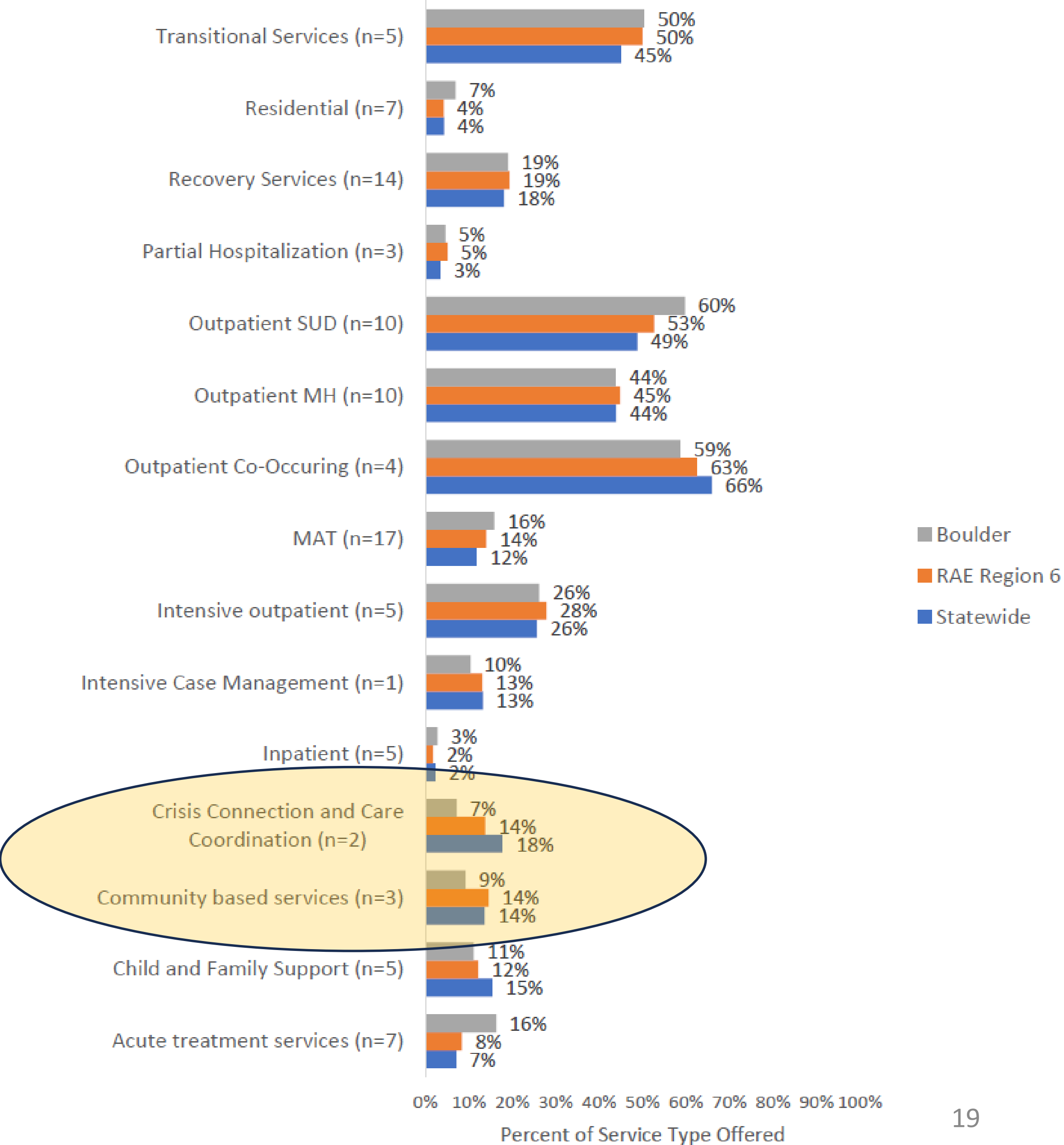
Source: Health Management Associates

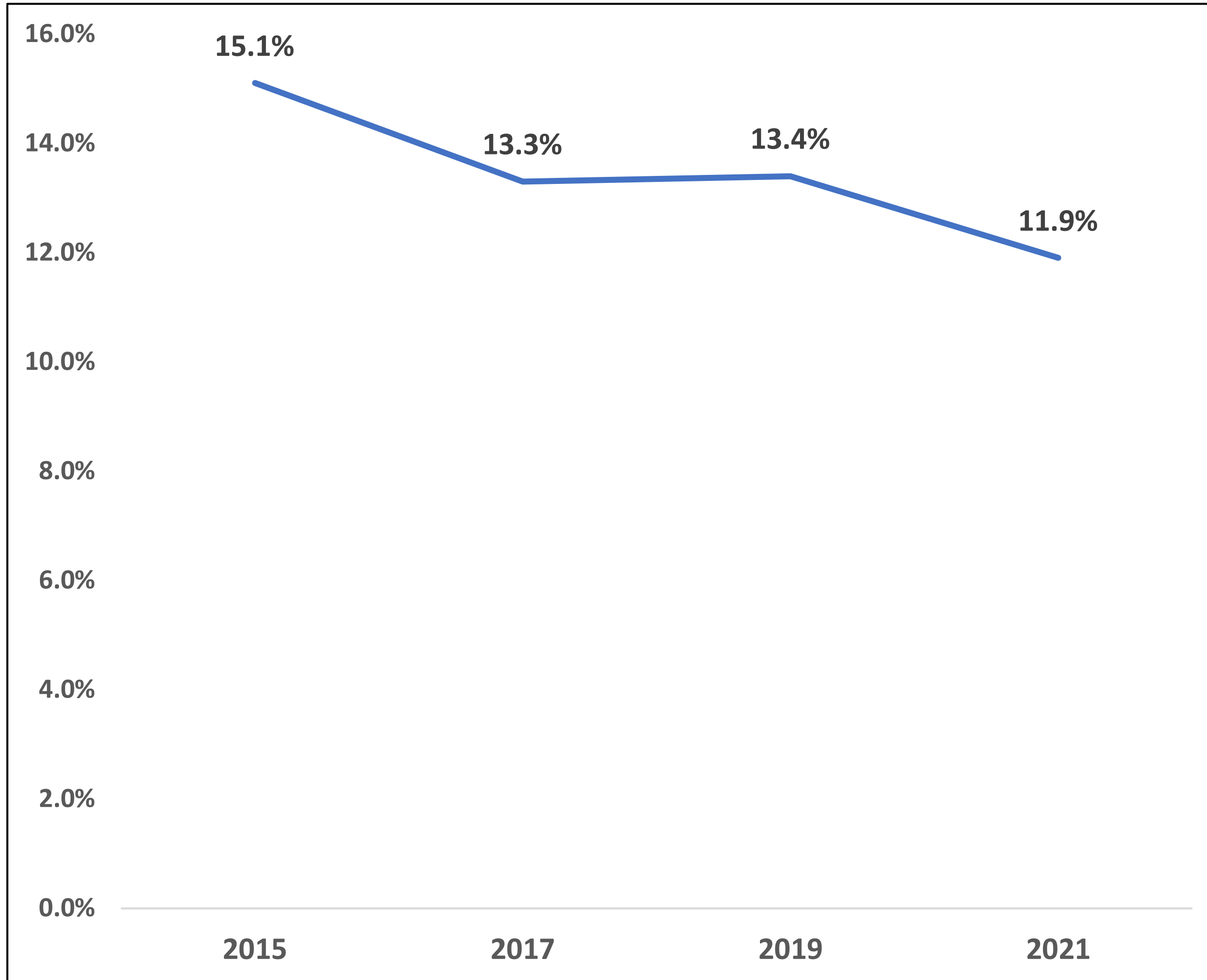
Boulder County's **behavioral health workforce** (rate of disciplines per 1,000 residents) is higher for mental health professionals while only on-par or slightly less than the RAE and statewide for substance use-specific professionals

	Boulder County (Count)	Boulder County	RAE Region 6	Statewide
Licensed Professional Counselor	694	2.15	1.37	0.94
Licensed Clinical Social Worker	360	1.12	0.81	0.68
Psychologists	216	0.67	0.39	0.32
Marriage and family therapists	70	0.22	0.14	0.12
Psychiatrist	60	0.19	0.11	0.10
Certified Addiction Counselor III	31	0.10	0.09	0.08
Certified Addiction Counselor II	25	0.08	0.08	0.07
Licensed Addiction Counselor	22	0.07	0.05	0.04
Certified Addiction Counselor I	12	0.04	0.04	0.06
Master of Social Work	-	0.00	0.00	0.00
Compact Advanced Practice Nurse	-	0.00	0.00	0.00
Advanced Practice Nurse	4	0.01	0.01	0.01
Physician Assistant	3	0.01	0.00	0.00
	1,497.0	**4.64**	**3.07**	**2.44**

Orange font indicates a ratio below RAE 6 or the State ratio. Green font indicates a ratio above RAE 6 or the State. Note: This data does not account for providers who may be working outside of Colorado and delivering services via telehealth. Source: CDPHE Colorado Health Systems Directory, Primary Care Office, March 2020.

Boulder County is above the RAE and state in many behavioral health services, however, is drastically less in provision of **crisis connection and care coordination**, and **community based services**, which may impact priority populations are greater levels

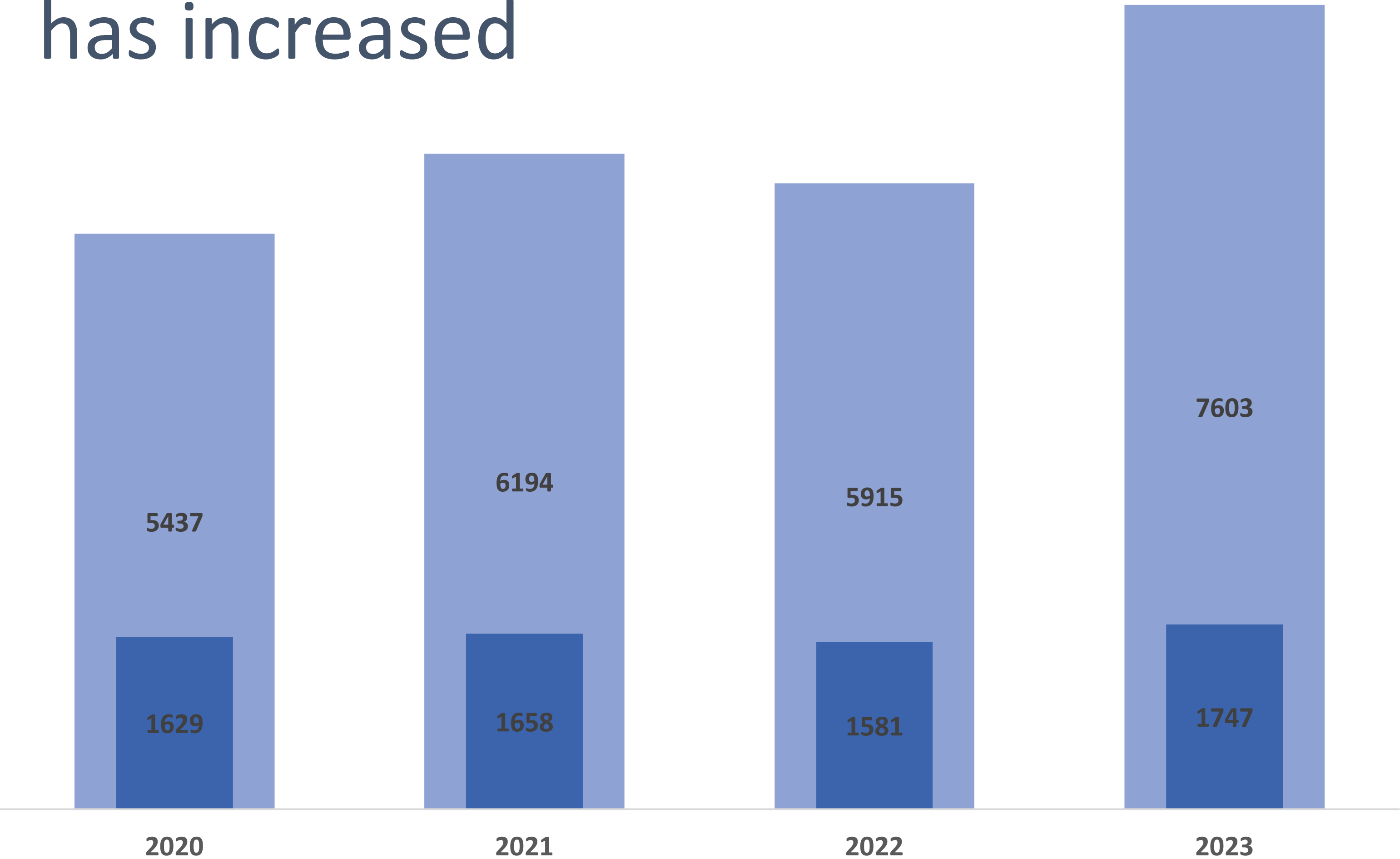




Source: Healthy Kids Colorado Survey

There has been a decline in the **percentage of high school students who have taken a prescription drug without a doctor's prescription one or more times during their life**

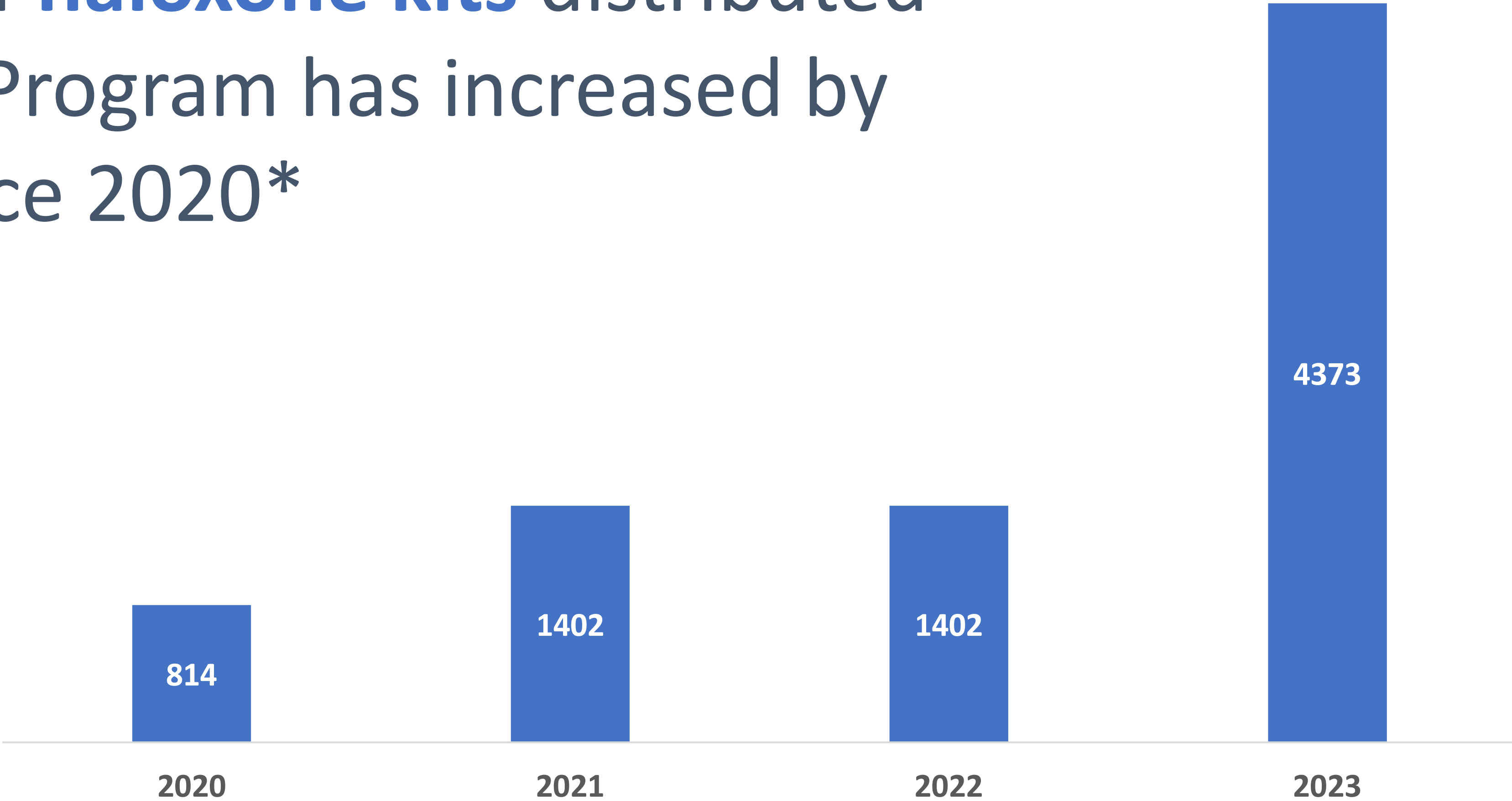
While **unique individuals** seeking harm reduction services has remained relatively stable, the number of **total separate encounters** has increased



2020 Avg: 3.3 encounters/individual
2023 Avg: 4.4 encounters/individual

Source: BCPH The Works Program

The number of **naloxone kits** distributed by the Works Program has increased by over 430% since 2020*



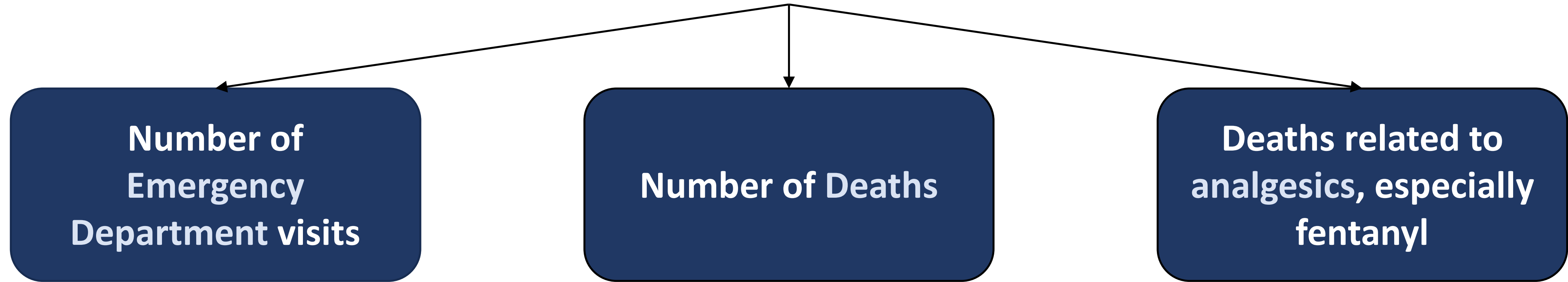
** More information is needed here as far as causality*

Source: BCPH The Works Program

Establishing Priorities

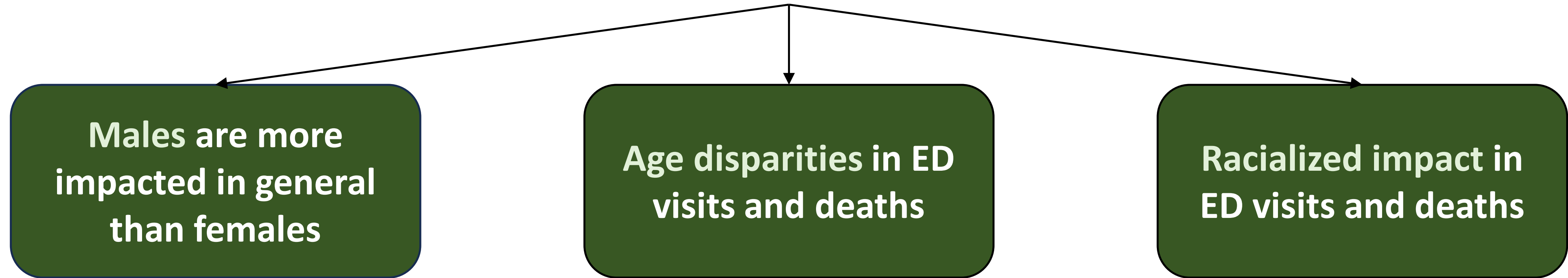
Identify the areas or indicators that you feel are the most harmful to the community, or areas where allocating Opioid Settlement funds would have the greatest impact

If you wanted to impact these data indicators…



…you might set priorities from these core abatement strategies or related approved uses:

- Funding media campaigns to **prevent opioid misuse.**
- Increased **availability and distribution of naloxone** and other drugs that treat overdoses…
- Expand **availability of treatment for OUD** and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("MAT") approved by the U.S. Food and Drug Administration.
- Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate **follow-up care through a bridge clinic** or similar approach.



…you might prioritize these core abatement strategies or related approved uses:

- **School-based or youth-focused programs** or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
- Support **stigma reduction** efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
- Ensure that **health care providers are screening for OUD** and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
- Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a **focus on youth and young adults** when transition from misuse to opioid disorder is common.

Based on qualitative data, you might prioritize these core abatement strategies or related approved uses:

- Offer home-based wrap-around services to persons with OUD and any co- occurring SUD/MH conditions, including, but not limited to, **parent skills training**.
- Expand services such as **navigators** and on-call teams to begin MAT in hospital emergency departments.
- Expand **warm hand-off services** to transition to recovery services.
- **Hire or train behavioral health workers** to provide or expand any of the services or supports listed above.
- Create or support **culturally appropriate services** and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
- Provide or support **transportation** to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
- Provide **access to housing** for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

Or, do you feel like you need more information?
…you might prioritize:

- Monitoring, surveillance, **data collection and evaluation of programs and strategies** described in this opioid abatement strategy list.
- A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to **track, share or visualize key opioid- or health-related indicators** and supports as identified through collaborative statewide, regional, local or community processes.