Colorado's Maternal, Infant and Early Childhood Home Visiting Program

Needs Assessment 2020

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COLORADO
Center for Health
& Environmental Data
Department of Public Health & Environment

COLORADO
Office of Early Childhood
Division of Community & Family Support

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Statement on Structural Inequity

The Colorado Department of Public Health and Environment acknowledges that long-standing systemic racism, including economic and environmental injustice, has created negative health outcomes. These systems influence a person's health more than individual behaviors and affect marginalized communities, particularly people of color, more than other communities. To realize a future where all Coloradans have the opportunity to thrive, we must be leaders in undoing government policies and practices that have contributed to these inequities.

I. Introduction

The Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families funds the Colorado Maternal, Infant and Early Childhood Home Visiting (CO MIECHV) program. MIECHV's goals include improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting and promoting child development and school readiness. CO MIECHV supports the broader Colorado Home Visiting Program to provide voluntary, evidence-based home visiting services for at-risk pregnant women and families with children through kindergarten entry.

In 2011, CO MIECHV conducted a needs assessment to identify at-risk communities in Colorado with concentrations of premature birth, low birth weight infants, infant mortality, children born to high risk mothers, poverty, crime, domestic violence, high rates of high school dropouts, substance abuse, unemployment and child maltreatment. Using a quintiles of risk approach, 15 Colorado counties were identified as having high concentrations of risk, including six urban counties (Adams, Clear Creek, Denver, Gilpin, Pueblo and Mesa); five rural (Alamosa, Crowley, Lake, Morgan and Otero) and four frontier (Baca, Costilla, Huerfano and Saguache). The 2011 needs assessment informed strategic decision making to focus MIECHV funding and best support families across the state.

CO MIECHV recognizes the importance of an updated needs assessment to provide current information on community needs and inform strategic decision making efforts for strengthening stakeholder collaboration and services for at-risk families. The goal of this needs assessment is to meet federal funding requirements by identifying: 1) communities with high concentrations of risk, 2) quality and capacity of existing programs and 3) capacity for providing substance use disorder treatment and counseling services. Findings from this needs assessment will be used to inform stakeholders about the unmet need for home visiting services, target services to communities with high levels of need and strengthen partnerships and collaboration across early childhood systems.

State Overview

Colorado is a western state, bisected into the Eastern Plains and Western Slope by the Rocky Mountain range. The state has the eighth largest area of landmass in the U.S., and its borders form an almost perfect rectangle, measuring 387 miles by 276 miles. The eastern half of the state consists of grassy plains and rolling prairies, and is known for its agriculture, which is in stark contrast to the mountains that gradually rise westward and give Colorado the highest mean elevation of any state (Figure 1).[1] The metropolitan Front Range (where the plains meet the mountains), extends north to south along the foothills, and includes the capital of Denver, with an elevation of 5,280 ft. which gives the city its nickname of "Mile High City".

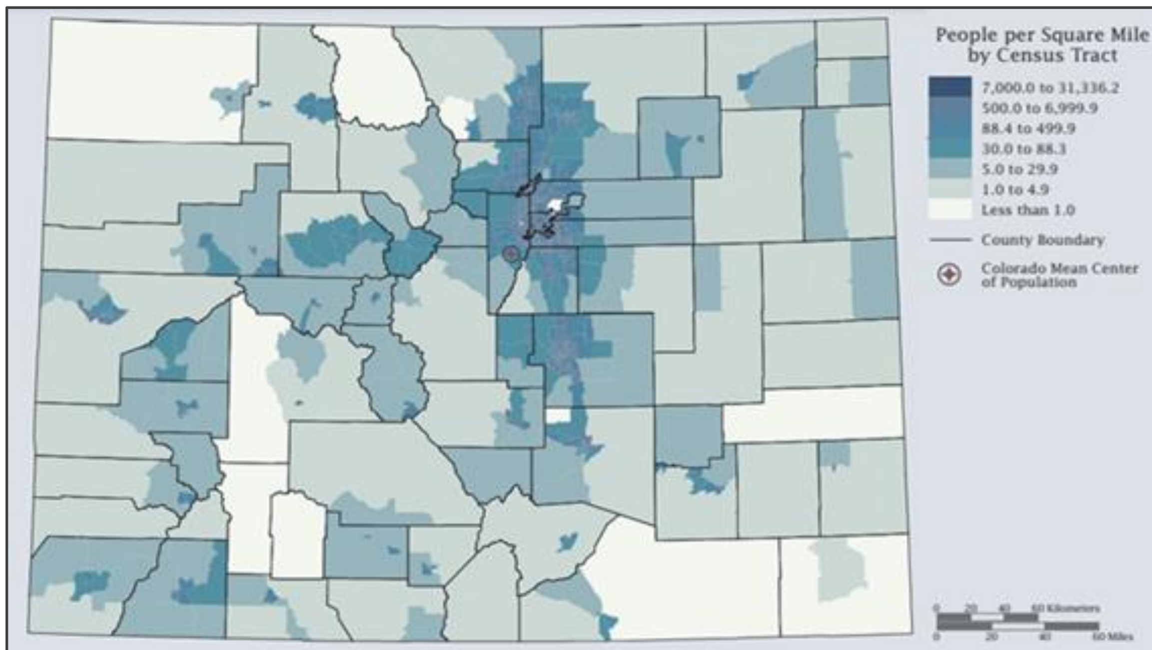
The original inhabitants of the area that is now Colorado included the Apache, Arapaho, Cheyenne and Ute nations and the Pueblo and Shoshone tribes with the Comanche, Kiowa and Navajo tribe territories sometimes extending into the area. There are two federally recognized Tribes in Colorado, the Southern Ute Indian Tribe and Ute Mountain Ute Tribe with reservations in southwestern Colorado.[2]

[1] U.S. Department of the Interior, U.S. Geological Survey. 2020. The national map. Retrieved from: https://viewer.nationalmap.gov/advanced-viewer/.
[2] Colorado Commission of Indian Affairs. 2019. Tribes. https://www.colorado.gov/pacific/ccia/tribes.

Figure 1: Colorado topographic map

Source: U.S. Department of the Interior, U.S. Geological Survey, 2020

Figure 2: Colorado population density by census tract, 2010

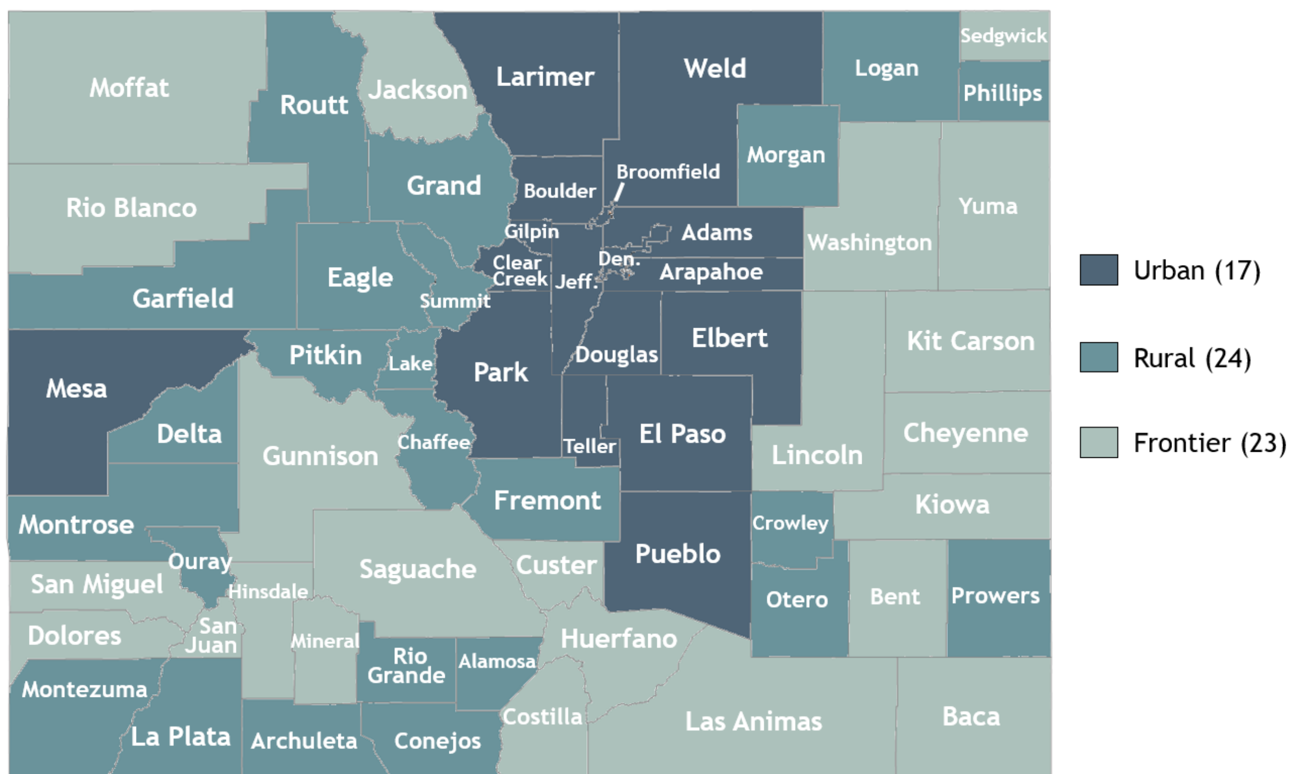


Source: U.S. Census Bureau, 2010

Colorado's vast land mass and 2019 estimated population of 5,758,736 give it a ratio of 55.6 persons per square mile, compared to the U.S. at 86.2.[3] Seventeen urban counties, sixteen along the Front Range and one on the Western Slope, make up 88% of the state's population. The other twelve percent of residents are scattered throughout Colorado's 47 rural and frontier counties (Figure 2).[4] Front Range population centers include the cities of Denver, Aurora, Boulder, Ft. Collins, Greeley, Colorado Springs and Pueblo. The city of Grand Junction, located in Mesa County, is the major metropolitan area on the Western Slope.

Colorado has features similar to many western states with few urban centers and vast rural areas. Additionally, its snowy winters and Rocky Mountain topography, while attractive to residents, create service challenges, making them important considerations when assessing the need for health and human service programs. Of Colorado's 64 counties, 24 are considered rural and 23 frontier, defined as less than six persons per square mile (Figure 3).[5] Colorado has more than one thousand peaks over 10,000 feet high and many Western Slope and mountain counties find themselves geographically isolated by winter weather and mountain passes.

Figure 3: Colorado county designations, 2018



Source: Colorado Rural Health Center, State Office of Rural Health, 2018

[3] U.S. Census Bureau. 2019. Colorado State Profile 2010 Census. https://data.census.gov/cedsci/profile?g=0400000US08#; U.S. Census Bureau. 2019. United States of America Profile. https://data.census.gov/cedsci/profile?g=0100000US.
[4] Based on 2018 U.S. Census Bureau estimates.
[5] Colorado Rural Health Center, State Office of Rural Health. 2018. Colorado: County designations, 2018. Retrieved at: http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2013/10/2018-map.pdf.

II. Identifying Communities with Concentrations of Risk

To determine the most appropriate method to identify communities with high concentrations of risk, the CO MIECHV team assembled a work group of content experts. The group included members of the CO MIECHV evaluation and program team and epidemiologists with expertise in early childhood and maternal and child health content and in needs assessment processes. After reviewing data provided in the simplified method, the work group decided to utilize an independent method to identify at-risk communities. In anticipation of HRSA's Supplemental Information Request for the needs assessment, the CO MIECHV team began reviewing indicators and considering analysis methods and discussing them with stakeholders in 2016, completing a refresh of the original 2011 MIECHV needs assessment in 2017. The indicators included in these assessments provide more detail than those of the simplified method, providing more utility to Colorado's early childhood system and programs, including MCH, Head Start and CAPTA. At the same time, the list of indicators aligns with the five domains of the simplified method (low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime and substance use disorder) and the characteristics described in statute to identify communities with concentrations of risk.[6] Recognizing differences in barriers and challenges for urban, rural and frontier counties, the team decided to compare counties within their designation of population density rather than a state average. The team ultimately decided to select an independent method that was easy to understand for all stakeholders and compared concentrations of risk according to the county's designation.

Phase I: Independent Method

For the first phase of identifying communities at risk, the term "community" refers to the county as most indicators selected were readily available at the county level. In Colorado, with vast areas designated as rural or frontier because of low population densities, most counties do not have enough residents to use zip-code or census-tract level data.

Indicators and Methodology

Federal guidelines required metrics for identifying communities with concentrations of risk based on: 1) premature birth, low-birth-weight infants and infant mortality (including death and neglect) or other indicators of at-risk prenatal, maternal, newborn or child health; 2) poverty; 3) crime; 4) domestic violence; 5) high rates of high school dropouts; 6) substance abuse; 7) unemployment; or 8) child maltreatment. Colorado considered many indicators and gathered data on 35 indicators to narrow down for analysis according to their accuracy, alignment with required metrics and sensitivity to show variation at the county-level. Additionally, criteria included data with the following characteristics: population-based; available at a sub-state or county level; from reliable data sources; collected annually; and modifiable through interventions or programs. Vital records data (data on the entire population) were preferred over population-based survey data (extrapolates results from a sample). Indicators were then categorized based on the age-specific group being assessed (maternal, infant, child, youth and adults). At risk communities were defined as those counties with four or more indicators in the bottom or top quintile (depending on direction).

[6] Social Security Act, Title V, § 511(b)(1)(A).

Colorado data were not available for domestic violence[7] and were excluded from the analysis. Substance abuse indicators were only available at the regional level and the work team decided to use the substance abuse domain score provided by HRSA in the optional simplified method as the indicator for substance use disorder.[8] Along with the required indicators, the work group included three additional indicators: 1) percent of women reporting they experienced three or more stressors during pregnancy (under age 25, not married and without a high school education); 2) child death rate (per 100,000) for children ages 1-14 and 3) percent of children (under age 18) living in poverty.

Thirteen total indicators were included in the analysis:

- Premature births as a percent of total births
- Percentage of low birth weight
- Infant mortality rate
- Percentage of women with three risk factors as defined above
- Child death rate
- Percentage of children in poverty
- Overall child maltreatment rate
- Juvenile crime arrest rate
- Percentage of high school dropouts
- Adult crime rate
- Substance use disorder
- Percentage of unemployment
- Percentage of individuals below the federal poverty level.

Seven of the thirteen indicators concerned maternal, infant and child outcomes: premature birth rate; low birth weight rate; infant mortality rate; maternal risk factors; child death rate; overall child maltreatment rate and substance use disorder. Six indicators concerned socio-demographic risk: percentage of children in poverty, juvenile crime arrest rate, percentage of high school dropouts, adult crime rate, unemployment rate and percentage of individuals below the federal poverty level.

Data were collected for each of Colorado's 64 counties across all thirteen indicators. Counties were grouped according to their designation (urban, rural and frontier). To assure statistical significance, the work group opted to designate the upper quintile (80 percent) of every indicator as a measure of risk. Indicators that were in the upper quintile were flagged red as the "worst" values for a given indicator. Counties in the lower quintile were flagged green as the "best" values for each indicator. The number of red and green flags was tallied for each county and then ranked. A natural cut off point appeared between three and four flags. Counties with four or more red flags were defined as "high risk". Counties with four or more green flags were defined as "low risk" and counties in between were defined as "moderate risk". A similar methodology was used in the original 2011 needs assessment with the exception of the green flags, which were included in the 2020 analysis.

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[7] There are currently no population-based data collected related to domestic violence in Colorado; therefore this indicator was omitted.

[8] Domain scores provided by HRSA were calculated based on z-scores for region-level substance use disorder indicators. Domain scores represent the proportion of standardized indicators that scored over the value of one within the SUD domain, considered at-risk according to HRSA.

Results

Twenty one Colorado counties were identified as having high concentrations of risk, including seven urban counties, eight rural counties and six frontier counties. Table 1 lists counties with high concentrations of risk according to indicator analysis by their county designation. When comparing results to the 2011 MIECHV needs assessment, ten counties moved into the high risk category and four moved out of the high risk category (Baca, Clear Creek, Lake and Morgan). Of those counties that were identified as high risk in 2020 (but not in 2011), two were urban counties (El Paso and Teller), five were rural counties (Conejos, Fremont, Montezuma, Montrose and Prowers) and three were frontier counties (Bent, Dolores, and Las Animas). Additional communities with a high concentration of risk that were not identified at the county level are discussed in Phase II.

Table 1: Counties with high concentrations of risk, 2020

Urban (7 counties)	Rural (8 counties)	Frontier (6 counties)
Adams*	Alamosa*	Bent
Denver*	Conejos	Costilla*
El Paso	Crowley*	Dolores
Gilpin*	Fremont	Huerfano*
Mesa*	Montezuma	Las Animas
Pueblo*	Montrose	Saguache*
Teller	Otero*	
	Prowers	

*Counties identified as high risk in the 2011 MIECHV Needs Assessment; Baca, Clear Creek, Lake County and Morgan County were identified as high risk in 2011, but not in 2020 according to county-level data.

Tables 2, 3 and 4 provide the risk assessment data and the indicators, metrics and data sources used for the analysis. The tables also display the number of high-risk (red) and low-risk (green) flags identified for each county.

Table 2: Urban county risk assessment data, 2020

Level	Infant			Mat.	Child				Adult					Total	
Indicators	Pret. Birth	Low Birth Weight	Infant Mort.	3 Risk Factors**	Child Death Rate (1-14)	Children in Poverty (0-17)	Child Maltreat. (0-17)	Juvenile Crime Arrests	High School Dropouts	Crimes Reported Adults	Unempl. Rate	Individuals <100% FPL	Substance Use Disorder	Overall Risk Summary	
Data Source	Birth cert.	Birth cert.	Birth & death cert.	Birth cert.	Death cert.	US Census Bureau	CDHS	CO Bureau of Invest.	CO Dept. of Edu.	CO Bureau of Invest.	CO Dep. of Labor & Emp.	US Census Bureau	SAMHSA		
Years	2019	2019	15-19	17-19	15-19	2018	2018	2019	18-19	2019	2019	2018	12-16		
Measure	% of total births	% of total births	per 1,000 births	% of total births	per 100,000 children	% of all children	per 1,000 children	per 1,000	% of students	per 1,000 pop	% unemp-loyed	% pop	Simplified method domain score	Red Flags	Green Flags
COLORADO	**9.6**	**9.5**	**4.7**	**3.0**	**15.6**	**12.1**	**9.5**	**11.3**	**2.0**	**57.3**	**2.8**	**9.7**	***		
Adams	9.7	9.8	5.7	4.4	13.5	12.6	12.1	13.8	2.6	123.4	2.9	9.2	0.5	6	0
Arapahoe	9.7	9.6	5.3	2.3	12.4	10.3	6.0	12.3	1.4	27.4	2.7	8.1	0.5	1	1
Boulder	7.3	8.1	3.8	2.7	11.6	6.7	3.6	10.2	0.9	53.9	2.4	9.7	0.8	1	6
Broomfield	7.7	7.9	4.7	1.3	18.3	5.1	2.6	17.2	***	59.0	2.4	4.9	0.5	2	6
Clear Creek	9.0	6.0	*	2.3	0.0	10.2	6.0	10.6	1.0	36.0	2.5	7.2	0.8	1	2
Denver	9.4	10.1	4.6	2.9	13.2	16.7	12.1	7.6	4.5	75.8	2.7	11.7	0.8	5	1
Douglas	9.2	8.9	2.8	0.7	14.8	2.5	5.2	17.0	0.6	35.9	2.4	2.6	0.5	1	6
El Paso	10.9	10.2	5.2	2.7	19.2	13.2	14.7	10.9	2.7	62.8	3.3	9.9	0.0	6	1
Elbert	7.9	8.4	3.8	1.1	50.4	7.2	2.9	12.5	0.9	5.0	2.2	5.0	0.5	1	10
Gilpin	*	11.1	*	0.0	0.0	10.1	14.4	0.7	0.8	149.8	2.3	6.7	0.8	4	6
Jefferson	8.9	8.7	3.9	2.0	11.8	8.0	6.4	13.1	1.3	47.4	2.5	7.0	0.8	1	2
Larimer	9.1	8.6	3.5	2.4	15.4	8.5	5.1	14.2	1.2	49.6	2.4	10.5	0.8	3	2
Mesa	9.6	8.6	4.2	4.2	15.0	19.7	19.9	12.8	2.9	63.2	3.4	14.4	0.3	6	0
Park	11.7	12.0	4.9	2.4	*	12.1	13.7	9.6	0.5	14.6	2.5	8.1	0.0	3	3
Pueblo	9.6	10.4	6.7	5.7	16.7	22.9	4.8	7.1	1.2	75.4	4.1	17.2	0.0	7	3
Teller	14.0	13.6	4.5	3.7	35.9	12.5	8.3	5.4	1.4	40.5	3.1	7.4	0.0	5	2
Weld	9.1	8.5	4.5	3.2	17.7	13.2	11.2	13.5	1.3	41.4	2.5	10.5	0.5	2	0

County names in red indicates high risk (at least 4 red flags for urban counties) designation; county names in green indicates low risk (at least 4 green flags) designation.
Indicator values in the upper quintile (80%) are marked in red; values in the lower quintile (20%) are marked in green. The same values in this table for any given indicator may be in different quintiles due to rounding. Data may appear different from publicly available reports due to rounding and excluded missing/unknown data when applicable.
* Data suppressed due to small numbers
** 3 Risk Factors (age < 25, not married, < high school education, all simultaneously)
*** Data not available: State-level SUD data unavailable; High school dropout rates were collected at the school district level with no data available for the city and county of Broomfield since the 6 districts covering this area are based in other counties.

Table 3: Rural risk assessment data, 2020

Level	Infant			Mat.	Child				Adult					Total	
Indicators	**Pret. Birth**	**Low Birth Weight**	**Infant Mort.**	**3 Risk Factors****	**Child Death Rate (1-14)**	**Children in Poverty (0-17)**	**Child Maltreat. (0-17)**	**Juvenile Crime Arrests**	**High School Dropouts**	**Crimes Reported Adults**	**Unempl. Rate**	**Individuals <100% FPL**	**Substance Use Disorder**	**Overall Risk Summary**	
Data Source	Birth cert.	Birth cert.	Birth & death cert.	Birth cert.	Death cert.	US Census Bureau	CDHS	CO Bureau of Invest.	CO Dept. of Edu.	CO Bureau of Invest.	CO Dep. of Labor & Emp.	US Census Bureau	SAMHSA		
Years	2019	2019	15-19	17-19	15-19	2018	2018	2019	18-19	2019	2019	2018	12-16		
Measure	% of births	% of total births	per 1,000 births	% of total births	per 100,000 children	% of all children	per 1,000 children	per 1,000	% of students	per 1,000 pop	% unemp-loyed	% pop	Simplified method domain score	Red Flags	Green Flags
COLORADO	**9.6**	**9.5**	**4.7**	**3.0**	**15.6**	**12.1**	**9.5**	**11.3**	**2.0**	**57.3**	**2.8**	**9.7**	***		
Alamosa	16.6	15.0	8.1	4.6	30.7	24.3	24.7	6.7	1.7	78.5	3.6	19.1	0.0	6	1
Archuleta	12.6	9.5	*	3.5	*	20.7	8.8	9.9	0.5	36.1	3.2	11.2	0.3	1	0
Chaffee	10.6	9.2	*	1.8	*	13.7	2.2	5.2	1.6	23.6	2.4	10.9	0.0	0	3
Conejos	11.9	9.5	8.6	1.9	58.9	27.5	8.4	4.5	0.9	3.8	3.6	21.4	0.0	5	4
Crowley	*	*	*	5.7	0.0	29.7	11.4	3.9	0.0	23.6	4.3	44.3	0.0	4	4
Delta	11.2	13.1	4.3	2.8	21.3	23.1	13.0	7.2	1.5	40.2	3.3	14.6	0.3	1	0
Eagle	10.6	8.4	5.4	2.9	6.5	8.1	3.5	13.0	2.0	31.8	2.2	6.7	0.3	2	6
Fremont	10.4	8.4	5.7	5.1	33.2	22.1	7.4	9.2	1.7	52.3	4.6	16.5	0.5	4	0
Garfield	10.1	9.8	4.8	4.1	14.2	11.4	7.6	11.9	1.9	50.7	2.7	8.4	0.3	2	0
Grand	9.4	11.8	*	2.1	*	11.7	0.7	3.2	1.1	17.6	2.1	7.9	0.3	0	5
La Plata	6.7	8.2	3.6	3.1	37.3	10.8	4.5	4.6	1.6	37.3	2.5	9.2	0.3	1	5
Lake	6.9	17.2	*	4.2	*	18.5	4.4	8.7	2.5	16.2	2.3	12.6	0.0	2	3
Logan	8.0	4.9	5.3	4.8	*	16.9	29.5	5.3	1.5	76.7	2.4	14.5	0.5	3	2
Montezuma	7.3	5.7	5.9	6.4	26.3	28.8	14.9	8.7	3.0	42.3	4.2	16.3	0.3	6	2
Montrose	7.8	7.0	3.3	5.7	19.7	17.4	20.0	6.9	2.0	54.2	3.1	11.6	0.3	4	3
Morgan	11.0	10.0	3.2	4.7	27.0	15.3	14.1	11.2	1.7	40.1	2.6	12.2	0.5	3	1
Otero	10.3	9.5	4.6	7.0	28.7	29.9	10.8	5.8	0.8	49.0	4.1	20.8	0.0	4	1
Ouray	11.1	11.1	*	*	0.0	11.0	*	10.0	0.0	4.7	2.9	7.5	0.3	1	4
Phillips	10.2	*	*	3.6	*	15.6	7.7	16.7	0.5	15.1	1.6	10.8	0.5	2	3
Pitkin	8.5	9.9	4.2	1.2	*	6.2	1.1	4.8	0.7	28.5	3.1	6.8	0.3	0	4
Prowers	16.8	15.0	3.7	6.0	*	28.6	8.8	3.4	0.4	18.1	2.6	21.6	0.0	5	3
Rio Grande	14.0	12.4	6.5	4.4	*	23.4	14.0	6.4	1.5	52.0	4.1	14.5	0.0	3	1
Routt	10.0	11.3	5.5	1.4	15.3	7.3	7.4	8.1	0.2	41.0	2.2	7.0	0.3	0	5
Summit	10.4	13.8	2.2	3.6	17.0	7.1	1.3	5.4	0.5	58.4	1.8	6.7	0.3	2	5

County names in red indicates high risk (at least 4 red flags for urban counties) designation; county names in green indicates low risk (at least 4 green flags) designation.

Indicator values in the upper quintile (80%) are marked in red; values in the lower quintile (20%) are marked in green. The same values in this table for any given indicator may be in different quintiles due to rounding. Data may appear different from publicly available reports due to rounding and excluded missing/unknown data when applicable.

* Data suppressed due to small numbers

**3 Risk Factors (age < 25, not married, < high school education, all simultaneously)

***Data not available

Table 4: Frontier risk assessment data, 2020

Level	Infant			Mat.	Child				Adult					Total	
Indicators	Pret. Birth	Low Birth Weight	Infant Mort.	3 Risk Factors**	Child Death Rate (1-14)	Children in Poverty (0-17)	Child Maltreat. (0-17)	Juvenile Crime Arrests	High School Dropouts	Crimes Reported Adults	Unempl. Rate	Individuals <100% FPL	Substance Use Disorder	Overall Risk Summary	
Data Source	Birth cert.	Birth cert.	Birth & death cert.	Birth cert.	Death cert.	US Census Bureau	CDHS	CO Bureau of Invest.	CO Dept. of Edu.	CO Bureau of Invest.	CO Dep. of Labor & Emp.	US Census Bureau	SAMHSA		
Years	2019	2019	15-19	17-19	15-19	2018	2018	2019	18-19	2019	2019	2018	12-16		
Measure	% of births	% of total births	per 1,000 births	% of total births	per 100,000 children	% of all children	per 1,000 children	per 1,000	% of students	per 1,000 pop	% unemp-loyed	% pop	Simplified method domain score	Red Flags	Green Flags
COLORADO	**9.6**	**9.5**	**4.7**	**3.0**	**15.6**	**12.1**	**9.5**	**11.3**	**2.0**	**57.3**	**2.8**	**9.7**	***		
Baca	7.8	6.1	0.0	2.4	0.0	29.3	1.3	2.4	1.5	14.7	1.7	19.4	0.0	2	7
Bent	11.9	15.3	*	2.4	0.0	30.4	24.9	7.4	3.8	58.6	2.9	33.9	0.0	5	2
Cheyenne	27.3	*	0.0	0.0	0.0	20.4	6.5	14.3	0.8	10.7	1.6	12.6	0.5	3	4
Costilla	20.0	18.9	*	2.9	0.0	36.9	19.3	*	1.9	0.0	3.9	25.2	0.0	5	3
Custer	15.4	15.4	*	*	*	24.9	16.6	13.2	0.5	41.4	3.0	12.0	0.0	1	1
Dolores	40.0	40.0	42.3	*	*	16.5	11.7	4.8	2.5	17.4	3.0	12.8	0.3	4	2
Gunnison	7.2	8.0	8.6	1.8	*	10.4	12.3	8.7	0.9	30.5	2.1	10.4	0.3	1	3
Hinsdale	*	*	0.0	0.0	0.0	17.0	*	*	0.0	12.4	3.7	8.6	0.3	0	5
Huerfano	10.0	7.5	*	3.7	*	37.4	27.4	7.3	0.5	49.4	5.7	21.7	0.0	6	1
Jackson	*	25.0	0.0	*	*	20.0	*	*	2.4	2.2	2.3	13.4	0.3	2	2
Kiowa	17.6	*	0.0	*	0.0	19.2	3.3	*	0.0	23.3	1.6	13.8	0.0	1	6
Kit Carson	7.8	5.8	*	6.8	0.0	20.1	20.3	7.8	0.8	41.7	1.7	12.6	0.5	3	3
Las Animas	5.2	10.3	6.4	7.5	82.1	26.6	24.8	4.9	1.7	59.8	3.9	19.2	0.0	6	2
Lincoln	9.4	6.3	*	3.3	0.0	21.0	16.6	*	0.5	9.6	2.3	16.2	0.5	1	2
Mineral	*	*	0.0	0.0	0.0	15.9	*	*	0.0	0.0	2.3	9.3	0.0	0	8
Moffat	4.6	6.6	3.5	2.9	29.9	16.7	3.4	11.9	3.0	57.9	3.4	12.3	0.3	3	2
Rio Blanco	12.5	12.5	0.0	3.1	0.0	12.0	23.7	16.3	0.2	11.3	3.7	10.8	0.3	3	5
Saguache	12.5	*	*	4.0	50.6	37.0	12.6	8.8	3.9	17.4	4.0	24.6	0.0	6	1
San Juan	*	*	0.0	0.0	0.0	20.4	*	*	0.0	20.9	3.0	14.4	0.3	0	4
San Miguel	*	*	*	*	0.0	9.8	1.8	7.3	0.3	14.5	2.8	8.6	0.3	0	4
Sedgwick	*	*	0.0	*	0.0	25.9	21.5	*	1.4	0.9	2.0	14.9	0.5	1	3
Washington	8.2	8.2	*	2.7	*	19.6	21.1	13.1	0.7	37.4	2.0	13.7	0.5	1	0
Yuma	2.9	3.7	*	2.7	37.4	16.6	10.1	4.3	0.7	14.5	1.6	12.1	0.5	2	4

County names in red indicates high risk (at least 4 red flags for urban counties) designation; county names in green indicates low risk (at least 4 green flags) designation.
Indicator values in the upper quintile (80%) are marked in red; values in the lower quintile (20%) are marked in green. The same values in this table for any given indicator may be in different quintiles due to rounding. Data may appear different from publicly available reports due to rounding and excluded missing/unknown data when applicable.
* Data suppressed due to small numbers
**3 Risk Factors (age < 25, not married, < high school education, all simultaneously)
***Data not available

Phase II: Additional Communities at Risk

The work team recognized that other communities with high concentrations of risk may not have been identified using county-level data. Two counties previously categorized as at risk and currently receiving MIECHV services were not identified as having high concentrations of risk at the county level: Clear Creek County and Morgan County. Clear Creek is served by one local implementing agency with MIECHV funds and due to its small population (9,663 in 2018),[9] data suppression made it impossible to utilize sub-county-level data to assess risk in different areas of the county. In FY18-19, MIECHV funds supported 20 households in Clear Creek and Gilpin counties with a funded caseload of 12 in FY19-20. Morgan County is supported by one MIECHV-funded local implementing agency with a funded caseload of 40 in FY19-20. As discussed below, subpopulations within Morgan County may face higher concentrations of risk with unknown long-term consequences of high rates of COVID-19.

During stakeholder engagement and collaboration with other program staff in early childhood, child welfare and maternal and child health, Black and African American Coloradans were also identified as a community that systematically faces higher concentrations of risk. According to this feedback and findings from other needs assessments, the work team investigated concentrations of risk for Black and African American communities across the state. Given the relatively small number of Blacks and African Americans in most Colorado counties, the disparities and inequities faced are often diluted in county averages. While Black and African American Coloradans are being identified as a community for the purposes of this needs assessment, the work team recognizes that Black and African American identities are complex and multidimensional with limitations in interpreting data to accurately reflect or represent them.[10]

Morgan County

Three indicators at the county level were flagged for Morgan County as being high risk: child maltreatment, juvenile arrests and substance use (Table 3). Seven of thirteen indicators for Morgan County were higher than the state average. Based on information about potentially vulnerable subpopulations in Morgan County that may be concentrated in more urban areas, the work group decided to review additional data that were not included in Phase I to assess the county's concentration of risk.

Morgan County's economy and workforce is heavily reliant on agriculture and manufacturing. Nearly one in five jobs is in manufacturing (19.8%) and 10.7% are in agriculture.[11] As a top producer of corn and cattle in the state, agriculture accounts for an estimated 49% of Morgan County's base industries[12] and ranks fourth across counties in the value of agricultural products sold.[13] The county has a large proportion of Hispanic/Latino residents (36.5%) and approximately 13.6% are foreign born compared

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[9] Colorado Department of Local Affairs. (2020). 2018 population estimate; Population forecasts 1 year increments, 2000-2050 data. Retrieved from: https://demography.dola.colorado.gov/population/population-totals-counties/#population-totals-for-colorado-counties.

[10] Some Coloradans may not identify with race categories provided and data are not always collected uniformly with some incorporating ethnicity into the same field and others keeping them separate or allowing for participants to select all categories or only one. Source: Colorado Department of Public Health and Environment, Office of Health Equity. Racial and ethnic data: Consideration for collection and reporting. Retrieved from: https://drive.google.com/file/d/1UCO5fb9JdxX6l2i8ZnNfHkAzt3zqmj7I/view.

[11] Colorado Department of Local Affairs. (2020). Colorado demographic profiles: Morgan County, Employment by Industry, 2018. Retrieved from: https://gis.dola.colorado.gov/apps/ProfileDashboard2/.

[12] Estimate of economic activity that brings in outside dollars; Ibid.

[13] Census of Agriculture. (2017). County profile 2017: Morgan county Colorado. Retrieved from: https://www.nass.usda.gov/Publications/AgCensus/2017/Online_Resources/County_Profiles/Colorado/index.php.

to 9.8% statewide.[14] Over one in four households speak a language other than English at home (26.6%) compared to 17% in Colorado.[15] In 2005, Fort Morgan became a secondary migration area for the resettlement of Somali refugees to work for the county's largest employer, a meat processing plant, with over 1,000 Somali refugees resettled in Fort Morgan by 2013.[16]

In May 2020, Morgan County had the highest rate of coronavirus disease 2019 (COVID-19) cases across the state[17] and has since moved to the third highest rate of all counties at 2,588 per 100,000 behind Logan (3,984) and Mineral (2,618) County.[18] Over one quarter of all cases in Morgan County are from three outbreaks in meat and food processing plants.[19] The largest of these outbreaks was at the meat packaging plant that brought Somali refugees to the area. The employer reports, in addition to immediate impacts to physical and mental health and the economy, the pandemic has the potential of long-lasting negative impacts for individuals and communities. The pandemic has been associated with mental health challenges, such as increased anxiety and depressive disorder, substance use and suicidal ideation with racial/ethnic minorities and essential workers reporting disproportionately worse outcomes.[20] Given the high percentages of Morgan County residents who are essential workers in agriculture and manufacturing and foreign-born residents, there is cause for concern on the potential disproportionate impact of communities in Morgan County.

According to the number of high risk flags identified at the county level in combination with large immigrant populations and agricultural/manufacturing workforce and high COVID-19 case rates, the CO MIECHV team believes Morgan County has a high concentration of risk.

Black and African American Communities

The conditions in which people grow, work, learn and play have a greater impact on health outcomes than individual behaviors. These factors impact a person's experiences throughout their life and lead to inequitable health outcomes. Historic and systemic racism, including environmental and economic injustice, systematically impact communities of color. Black and African American Coloradans continue to be exposed to additional harm and experience significant inequities in health outcomes across the state. Data analyzed across health outcomes by CDPHE's Office of Health Equity demonstrate, when compared to white Coloradans, Black and African American Coloradans have a significantly lower life expectancy with significantly more Black/African Americans living below poverty and experiencing food insecurity. Black and African American Coloradans experience statistically higher rates of infant mortality and HIV as well as higher prevalence of low-birth-weight births, women facing three or more stressors during pregnancy, childhood asthma and diabetes.[21]

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[14] U.S. Census Bureau. (2020). Quick facts, Morgan County; Colorado, 2019 estimates. Retrieved from: https://www.census.gov/quickfacts/fact/table/morgancountycolorado,CO/PST045219.

[15] Ibid.

[16] Colorado Encyclopedia. (2020). Morgan county. Retrieved from: https://coloradoencyclopedia.org/article/morgan-county#page-title.

[17] Paul, J. (2020). The Colorado county with the highest coronavirus infection rate is now on the Eastern Plains. The Colorado Sun. Retrieved from: https://coloradosun.com/2020/05/07/morgan-county-colorado-coronavirus-outbreak/.

[18] Colorado Department of Public Health and Environment. (2020). Colorado COVID-19 data. Accessed on 9/28/2020: https://covid19.colorado.gov/data.

[19] Calculated based on CDPHE outbreak and case data; CDPHE. (2020). Outbreak data. Accessed on 9/28/2020: https://covid19.colorado.gov/covid19-outbreak-data.

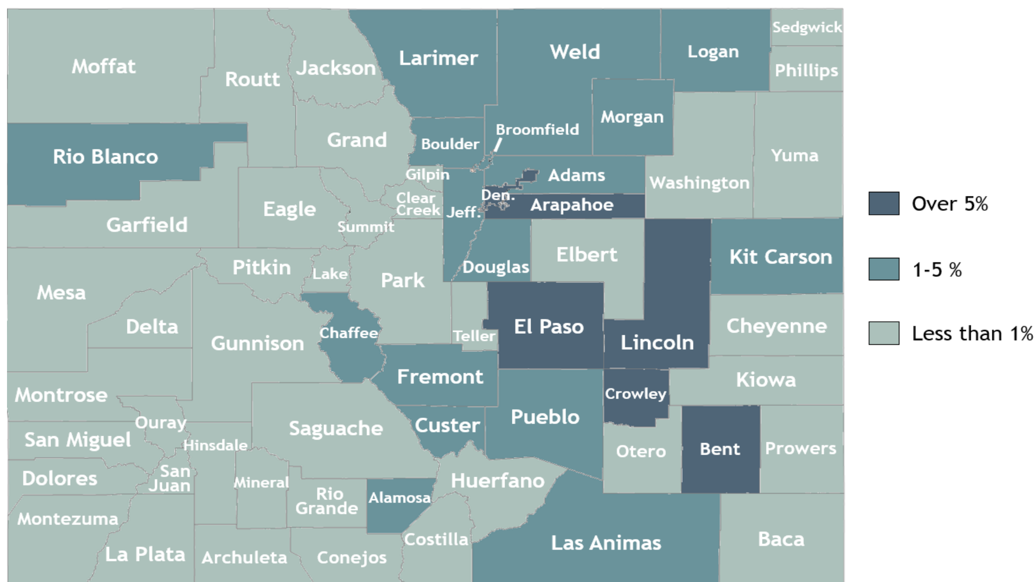
[20] Czeisler, M.É., Lane, R.I., Petrosky, E. et al. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1.

[21] Data range from 2013-2017; Colorado Department of Public Health and Environment, Office of Health Equity. (2019). Health inequities impacting Colorado communities of color: Black/African American Coloradans. Retrieved from: https://drive.google.com/file/d/1b4pO8xIxvohqNTFn0_jkuqA634RT0xDl/view.

Using 2008-2013 data on maternal mortality in Colorado, the Maternal Mortality Review Committee found statistically significant inequities in maternal mortality prevalence among Black/African American women (9.7%) compared to all Black/African American women giving birth (5.4%).[22]

Based on recommendations from experts in MCH and early childhood as well as stakeholders and the known inequities experienced in Black and African American communities in Colorado, the work group decided to review additional data for Black and African American Coloradans. The State Demography Office's 2018 population forecast estimates the Black and African American population in Colorado at 239,940 (4.2%).[23] Arapahoe and Denver counties have the highest percentages of Coloradans identifying as non-Hispanic Black or African American (Figure 4).[24]

Figure 4: Non-Hispanic Black/African American population forecasts by county, 2018



Source: Colorado Department of Local Affairs, 2018

County-level estimates were unattainable for Black and African American Coloradans due to the small sample broken out by each county; therefore, the work group decided to analyze risk at the state level. Two indicators used during Phase I were not available for Black and African American Coloradans, the rate of child maltreatment and substance use disorder. Because of the size of this community, the data were compared to other urban counties to assess risk. Two out of three of the counties with the highest percentage of Black or African American residents are urban counties and the Black and African American population size is comparable to that of other urban counties. The same methodology in Phase I was used to assess concentrations of risk for Black and African American Coloradans. Across eleven indicators, nine were identified as high risk for Black/African American Coloradans, more than any urban county (Table 5). While Black and African American Coloradans live in different areas of the state, as a community, they experience high concentrations of risk.

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[22] Colorado Department of Public Health and Environment. (2017). Understanding maternal deaths in Colorado: An analysis of mortality from 2008-2013. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/PF_Maternal_Mortality_Colorado-12-01-17.pdf.

[23] Does not include individuals that identify as Hispanic; Colorado Department of Local Affairs. 2018. Race Forecast data. Retrieved from: https://demography.dola.colorado.gov/population/data/.

[24] Ibid.

Table 5: Black/African American Coloradan risk assessment data, 2020

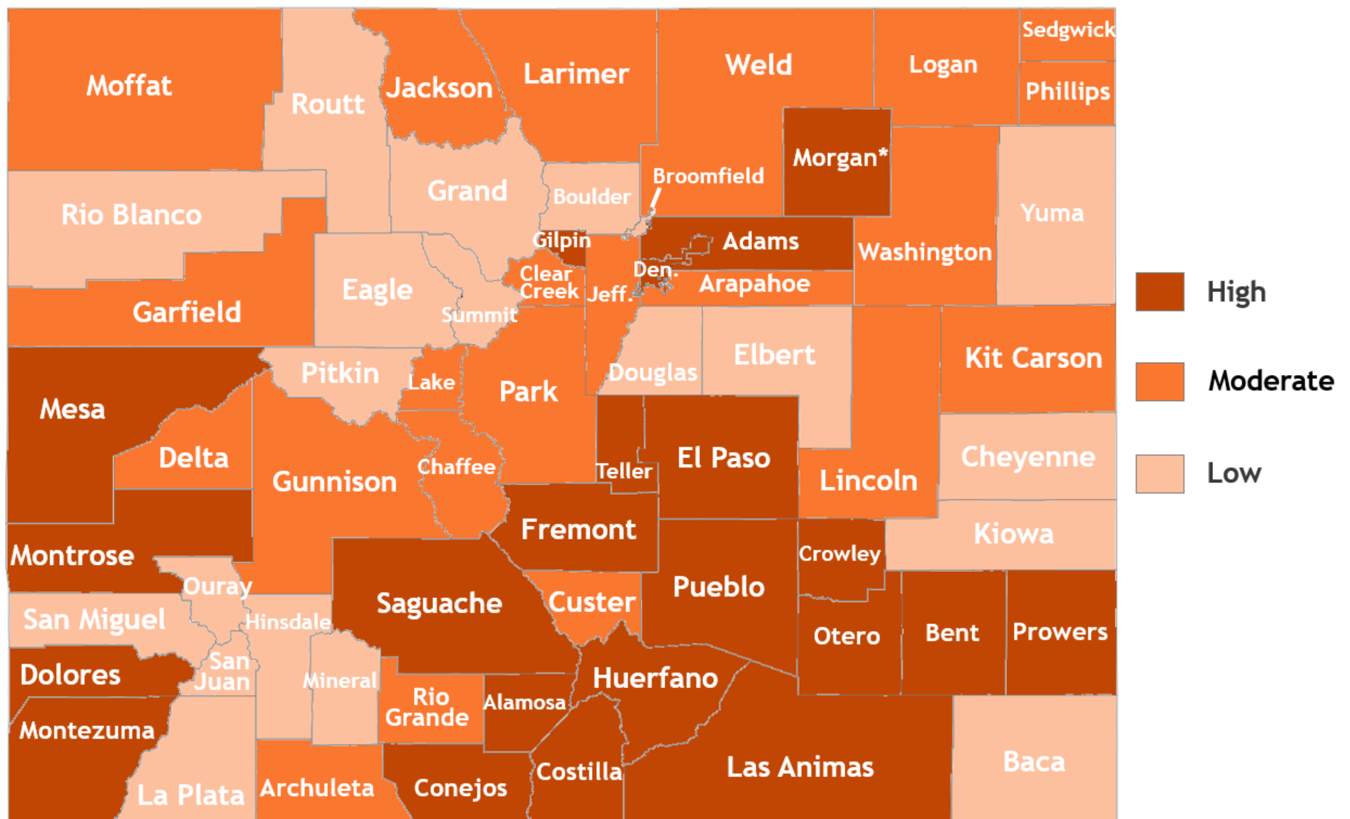
Level	Infant			Mat.	Child				Adult					Total	
Indicators	**Pret. Birth**	**Low Birth Weight**	**Infant Mort.**	**3 Risk Factors****	**Child Death Rate (1-14)**	**Children in Poverty (0-17)**	**Child Maltreat. (0-17)**	**Juvenile Crime Arrests**	**High School Dropouts**	**Crimes Reported Adults**	**Unempl. Rate**	**Individuals <100% FPL**	**Substance Use Disorder**		
Data Source	Birth cert.	Birth cert.	Birth & death cert.	Birth cert.	Death cert.	US Census Bureau	CDHS	CO Bureau of Invest.	CO Dept. of Edu.	CO Bureau of Invest.	CO Dep. of Labor & Emp.	US Census Bureau	SAMHSA	**Overall Risk**	
Years	2019	2019	15-19	17-19	15-19	2018	2018	2019	18-19	2019	2019	2018	12-16	**Summary**	
Measure	% of total births	% of total births	per 1,000 births	% of total births	per 100,000 children	% of all children	per 1,000 children	per 1,000	% of students	per 1,000 pop	% unemp-loyed	% pop	Simplified method domain score	Red Flags	Green Flags
COLORADO	**9.6**	**9.5**	**4.7**	**3.0**	**15.6**	**12.1**	**9.5**	**11.3**	**2.0**	**57.3**	**2.8**	**9.7**	***		
Black/ AA	12.5	14.0	9.8	3.7	23.1	16.7		13.6	3.0	4.3	3.6	18.0		9	1
Adams	9.7	9.8	5.7	4.4	13.5	12.6	12.1	13.8	2.6	123.4	2.9	9.2	0.5	6	0
Arapahoe	9.7	9.6	5.3	2.3	12.4	10.3	6.0	12.3	1.4	27.4	2.7	8.1	0.5	1	1
Boulder	7.3	8.1	3.8	2.7	11.6	6.7	3.6	10.2	0.9	53.9	2.4	9.7	0.8	1	6
Broomfield	7.7	7.9	4.7	1.3	18.3	5.1	2.6	17.2	***	59.0	2.4	4.9	0.5	2	6
Clear Creek	9.0	6.0	*	2.3	0.0	10.2	6.0	10.6	1.0	36.0	2.5	7.2	0.8	1	2
Denver	9.4	10.1	4.6	2.9	13.2	16.7	12.1	7.6	4.5	75.8	2.7	11.7	0.8	5	1
Douglas	9.2	8.9	2.8	0.7	14.8	2.5	5.2	17.0	0.6	35.9	2.4	2.6	0.5	1	6
El Paso	10.9	10.2	5.2	2.7	19.2	13.2	14.7	10.9	2.7	62.8	3.3	9.9	0.0	6	1
Elbert	7.9	8.4	3.8	1.1	50.4	7.2	2.9	12.5	0.9	5.0	2.2	5.0	0.5	1	10
Gilpin	*	11.1	*	0.0	0.0	10.1	14.4	0.7	0.8	149.8	2.3	6.7	0.8	4	6
Jefferson	8.9	8.7	3.9	2.0	11.8	8.0	6.4	13.1	1.3	47.4	2.5	7.0	0.8	1	2
Larimer	9.1	8.6	3.5	2.4	15.4	8.5	5.1	14.2	1.2	49.6	2.4	10.5	0.8	3	2
Mesa	9.6	8.6	4.2	4.2	15.0	19.7	19.9	12.8	2.9	63.2	3.4	14.4	0.3	6	0
Park	11.7	12.0	4.9	2.4	*	12.1	13.7	9.6	0.5	14.6	2.5	8.1	0.0	3	3
Pueblo	9.6	10.4	6.7	5.7	16.7	22.9	4.8	7.1	1.2	75.4	4.1	17.2	0.0	7	3
Teller	14.0	13.6	4.5	3.7	35.9	12.5	8.3	5.4	1.4	40.5	3.1	7.4	0.0	5	2
Weld	9.1	8.5	4.5	3.2	17.7	13.2	11.2	13.5	1.3	41.4	2.5	10.5	0.5	2	0

County names in red indicates high risk (at least 4 red flags for urban counties) designation; county names in green indicates low risk (at least 4 green flags) designation.
Indicator values in the upper quintile (80%) are marked in red; values in the lower quintile (20%) are marked in green. The same values in this table for any given indicator may be in different quintiles due to rounding. Data may appear different from publicly available reports due to rounding and excluded missing/unknown data when applicable.
* Data suppressed due to small numbers
**3 Risk Factors (age < 25, not married, < high school education, all simultaneously)
***Data not available.

Communities at Risk

According to Phase I and II of the needs assessment, 23 communities were identified as having high concentrations of risk. These communities include 22 counties (Figure 5) plus Black/African American Coloradans. Twenty-two counties were identified as having moderate concentrations of risk (six urban, eight rural and eight frontier counties) and 20 were identified as having low concentrations of risk (four urban, seven rural and nine frontier).

Figure 5: Counties by concentration of risk, 2020



*Note: Morgan County was determined to have high concentrations of risk in Phase II

III. Identifying Quality and Capacity of Existing Programs

Overview

Colorado's state government and other stakeholders place a great value on early childhood home visitation. For purposes of this assessment, "early childhood home visitation" is defined as programs using home visiting as a primary intervention strategy for providing services to pregnant women and/or children from birth to kindergarten entry. Using this definition, Colorado supports seven home visiting models: Home Instruction for Parents of Preschool Youngsters (HIPPY), Parents as Teachers (PAT), Nurse-Family Partnership (NFP), SafeCare Colorado, HealthySteps, Healthy Families America (HFA) and Early Head Start Home Based Option (EHS-HBO).

The services offered and where the models are located differ by county. Some Colorado counties, like Denver County, provide many options for families across a fairly small geographic area. Other counties, especially Grand County's rural landscape and Hinsdale County's frontier area, only offer one option for select families interested in home visiting.

Colorado's MIECHV-designated high-risk counties differ widely in their home visiting model offerings (Table 6). Sometimes these differences are based on the population of the county, with urban counties providing the most options and rural and frontier counties offering fewer. Sometimes the differences are based on state geographic location, as is seen in Clear Creek County and Gilpin County's mountainous terrain.

One of Colorado's home visiting models, Nurse-Family Partnership, offers services in all counties. However, given the restrictive eligibility criteria, many families in counties with only NFP offered have no options for home visitation. As cited by Colorado's Child Fatality Prevention System's 2020 Annual Legislative Report,[25] "not a single county in Colorado…has home visiting programs to meet the overall needs of families in the county."

Table 6: Home visiting programs by county

County	HIPPY	PAT	NFP	SafeCare CO	Healthy Steps	HFA	Early Head Start
Adams	X	X	X	X	X		
Alamosa	X	X	X	X	X		X
Arapahoe	X	X	X	X	X		
Archuleta			X	X			
Baca			X	X			
Bent		X	X	X			
Boulder		X	X				X
Broomfield		X	X				
Chaffee			X	X			X
Cheyenne			X	X			
Clear Creek		X	X				
Conejos	X	X	X	X			
Costilla	X	X	X	X			
Crowley	X	X	X	X			
Custer			X	X			

[25] Child Fatality Prevention Systems: 2020 Legislative Report. (2020). CFPS recommendations to prevent child death. Retrieved from: www.colorado.gov/pacific/cdhs/child-fatality-reviews.

County	HIPPY	PAT	NFP	SafeCare CO	Healthy Steps	HFA	Early Head Start
Delta		X	X				
Denver	X	X	X	X	X		X
Dolores		X	X	X			
Douglas		X	X				
Eagle			X			X	X
El Paso		X	X	X			
Elbert			X				
Fremont		X	X				X
Garfield			X			X	
Gilpin		X	X				
Grand			X				
Gunnison			X				
Hinsdale			X				
Huerfano		X	X	X			
Jackson			X				
Jefferson	X	X	X	X	X		X
Kiowa			X	X			
Kit Carson			X				
La Plata		X	X	X			
Lake			X				X
Larimer		X	X				X
Las Animas		X	X	X			
Lincoln			X				
Logan			X	X			
Mesa		X	X	X	X		X
Mineral	X	X	X	X			
Moffat			X	X			
Montezuma		X	X	X			
Montrose		X	X				
Morgan		X	X	X	X		
Otero	X	X	X	X			X
Ouray		X	X				
Park		X	X				
Phillips			X	X			
Pitkin			X			X	
Prowers			X	X			
Pueblo	X	X	X	X	X		
Rio Blanco			X	X			
Rio Grande	X	X	X	X			
Routt		X	X	X			
Saguache	X	X	X	X			
San Juan			X	X			
San Miguel		X	X				
Sedgwick			X	X			
Summit		X	X				X
Teller		X	X				X
Washington			X	X			
Weld	X	X	X	X			
Yuma			X	X			X

To understand home visiting options in Colorado, a guide to each model is listed in Table 7 (summarized from Colorado's Preschool Development Grant 2019 Needs Assessment).[26]

Table 7: Colorado home visiting model guide

Model	Program Summary	Ages Served	Home Visitor Requirements
HIPPY	Parent-driven school readiness	Three to five years	Peers trained and often recruited from communities they serve
PAT	Empowering parents in their roles as their children's first teachers	Prenatal to kindergarten entry	Trained parent educators
NFP	Community health nursing program that empowers first-time moms to transform their lives and create better futures for themselves and their babies	Prenatal to two years	Nurse licensure
SafeCare CO	Helping parents manage challenging behaviors and identify household hazards	Birth to five years	Trained parent support providers
Healthy Steps	Pediatric clinical program that fosters positive parenting and promotes children's early development	Birth to three years	Trained professionals (i.e., Master's-level social workers, psychologists, nurses, early childhood educators)
Healthy Families America	Promoting child well-being and preventing the abuse and neglect of children by delivering home visiting services that empower families and communities	Prenatal to three years	Trained family support specialists

[26] Colorado Shines Brighter: Opportunities for Colorado's Early Childhood System. (2019). Family and community supports. Retrieved from: http://coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=Colorado-Shines-Brighter&lang=en.

EHS-HBO	A two-generation initiative aimed at enhancing the development of infants and toddlers while strengthening families	Prenatal to three years	Trained child development professionals

Child First, a therapeutic, evidence-based model working with very vulnerable young children and families, is planned to launch in Colorado in 2021. Using braided funding mechanisms, state intermediary Invest in Kids anticipates delivering services through several statewide applicants to families in the range of prenatal mothers through children five years old.

Funding

Home visiting programs in the state use a variety of funding streams to meet the needs of families served, the community at large and the organization. Colorado's MIECHV grant (for FY2020-2021, the award is $7,702,429) is used to fund programmatic and administrative costs for the awardee (Colorado Department of Human Services, Office of Early Childhood), data/evaluation/continuous quality improvement (Colorado Department of Public Health and Environment), 16 local implementing agencies and two state program-model intermediaries (Invest in Kids and Parent Possible). Colorado MIECHV consists of three models (HIPPY, PAT and NFP) administered in 12 counties around the state. HIPPY receives MIECHV funding for services in five counties (Adams, Denver, Pueblo, Crowley and Otero), and PAT provides MIECHV-funded services in all 12 high-risk counties.

NFP is available to families in every Colorado county. Using Colorado's Tobacco Master Settlement Agreement as the main funding stream for the Nurse Home Visitor Program, NFP is slated to receive $25,184,132[27] to provide services in all 64 counties. Only two of those counties receive MIECHV funds for NFP (Denver and Adams). While NFP is the highest-funded home visiting model in Colorado, funding from MIECHV, cash funds allocated through the state legislature and Medicaid reimbursements do not cover all expenses related to hiring, training, evaluation and service provision. The state intermediary, Invest in Kids, and local implementing agencies must supplement funding through grants and fundraising.

State dollars also fund two additional home visiting models: SafeCare Colorado and HealthySteps. SafeCare Colorado provides home visitation services in 39 counties and two tribes (Ute Mountain Ute and Southern Ute). For 2018-2019, SafeCare Colorado received $5,483,230 from the state general fund, and in 2019-2020, the amount increased to $5,521,422. However, due to the state economic shortfall caused by COVID-19 and the subsequent mandatory budget cuts, SafeCare Colorado's general fund contribution is $5,100,566 for 2020-2021. The state general fund is also used for six of 14 HealthySteps sites, with a state contribution of $571,946 for 2020-2021.

Finally, two evidence-based models in Colorado are supported through other funding streams. Early Head Start-Home Based Option provides services in 11 counties, using funding from the national Office of Head Start, Administration for Children and Families. While no state funding is used to fund Early Head Start's home-based services, the Colorado Department of Human Services, Office of Early Childhood, receives a small amount of federal funding to house the state Head Start Collaboration

[27] Colorado House Bill 20-1360: Long Bill 2021. (2020). Operating agency budgets: human services. Retrieved from: https://leg.colorado.gov/sites/default/files/documents/2020A/bills/2020a_hum_act.pdf.

Office. Healthy Families America, serving three counties, is funded largely through foundations, private donations and local government.

Capacity

Colorado's home visitation models serve over 10,000 families each year.[28] Before the pandemic caused by COVID-19 and the resulting economic shortfall, many models were in the beginning or even final stages of expanding services, either by serving additional counties, increasing caseload or both. While widespread expansion may be on hold for a few years, many models, their state intermediaries and state funders are looking to the future and are anxious to restart planning efforts to bring voluntary home visiting to more Colorado families in more parts of the state.

One such effort is Colorado's Home Visiting Investment Task Force, which is a stakeholder group approved by the Governor's Office Early Childhood Leadership Commission. This task force will develop a five-year vision and strategy for the home visiting landscape and includes input from the home visiting model intermediaries and site leadership, Head Start, the Governor's Office, Department of Public Health and Environment, Department of Health Care Policy and Financing, Department of Education, county human services departments, county public health departments, pediatricians, family resource centers, early childhood councils, philanthropy and families who participate in home visiting.

Table 8: Colorado Home Visiting Coalition: Our impact

Model	Families & Children Served Statewide[29] (2018)	MIECHV Only (2018)	Significant Outcomes
HIPPY	985	453	Gains in school readiness; higher achievement in school; increased parental involvement
PAT	2,493	1,284	Gains in percentile scores on school readiness tests; increased mastery in subtest areas of colors, letters, numbers/counting, size comparisons, and shapes; more supportive parenting
NFP	4,576[30]	702	Improved pregnancy outcomes through increased preventive health practices; improved child health and development; improved family economic self-sufficiency
SafeCare Colorado	1,805	N/A	Reduction in child welfare cases; reduction of hazards in the home; improved safety in the home; increased use of new parenting skills

[28] As reported by model to the Colorado Home Visiting Coalition. Retrieved from: https://cohomevisiting.org/our-impact.

[29] As reported by model to the Colorado Home Visiting Coalition. Retrieved from: https://cohomevisiting.org/our-impact.
[30] Invest in Kids: 2018-2019 Annual Report. (2019). Retrieved from https://www.iik.org/media/1795/final-annual-report-18-19.pdf.

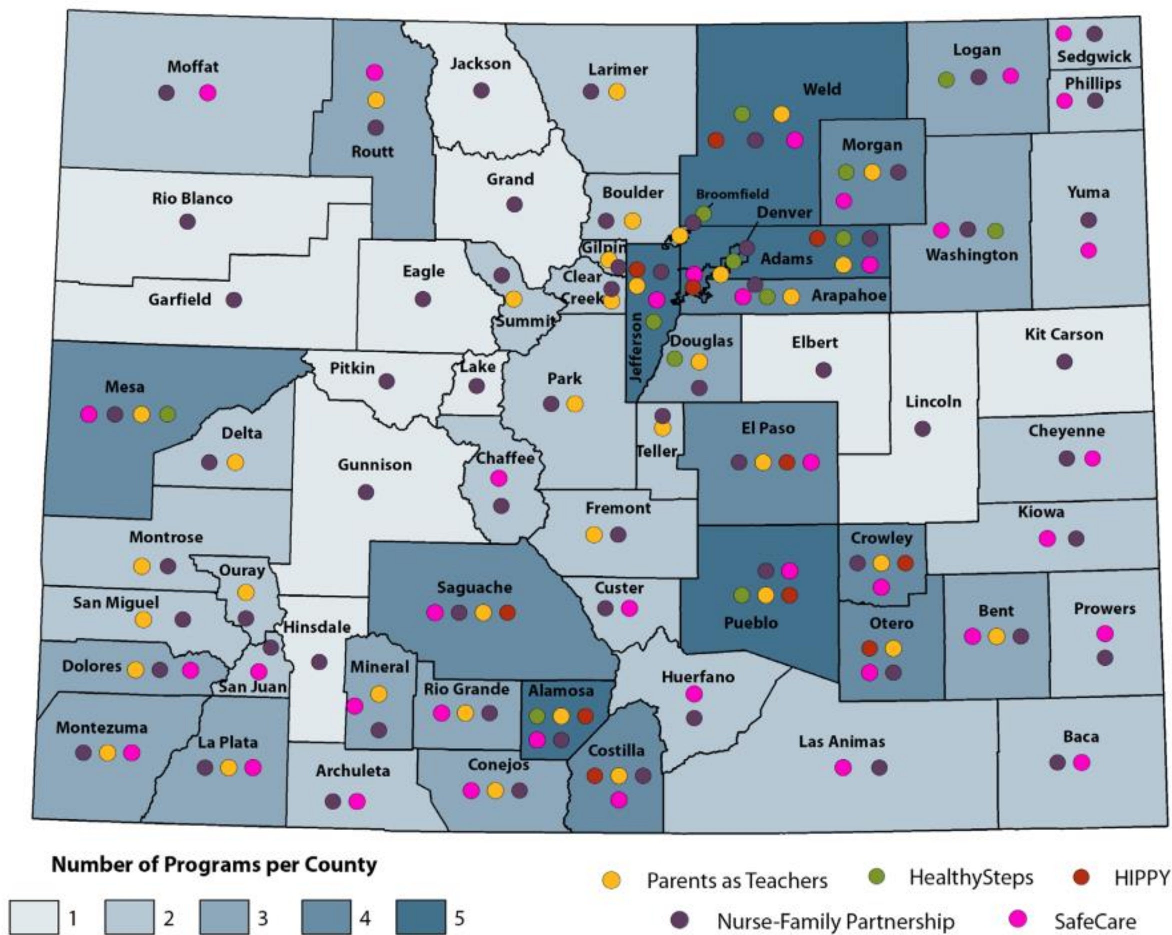
Healthy Steps	1,889	N/A	Reduction in cost of future maternal and child mental health interventions; improved child safety; more secure child-parent attachment
Healthy Families America	77	N/A	Increase in positive parenting practices; improvement in child health; reduction in juvenile delinquency, family violence, crime and child maltreatment; improvement in child development and school readiness
EHS-HBO	648	N/A	Fewer child welfare encounters; reduction in attention problems and experience with bullying; higher educational attainment for parents

Barriers and Gaps

Colorado faces similar challenges to other states in terms of home visitation service delivery. From a geographic standpoint, CO MIECHV provides HIPPY, PAT and NFP services in six urban counties, four rural counties and two frontier counties. As seen from the 2019 home visitation density map below (Figure 6),[31] programs tend to be more heavily concentrated along Colorado's I-25 corridor, running through the central part of the state. This region includes the Denver metro area, Colorado Springs and Pueblo. Home visiting programs in these areas usually have more access to public transportation, both for home visitors and their families, walkable public outdoor spaces, community colleges and trade schools as well as increased family support program options.

[31] Colorado Shines Brighter: Opportunities for Colorado's Early Childhood System. (2019). Family and community supports. Retrieved from: http://coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=Colorado-Shines-Brighter&lang=en.

Figure 6: Home visitation program density map by county, 2019



In Colorado's rural and frontier counties, residents and home visitation programs may face more day-to-day challenges than their urban counterpoints, at least in terms of enrolling families and access to services. In Colorado's Eastern Plains and Western Slope, the lightest blue shading indicates only one home visiting program offering, which is NFP in all cases. Due to NFP's limited program eligibility criteria, families with multiple and/or older children will not qualify for voluntary home visiting in those regions.

Even in rural and frontier counties with more than one program offering, transportation is often a tremendous barrier. For example, families living in Saguache, Costilla and Alamosa counties in Colorado's San Luis Valley have little to no public transportation option.[32] Limited transportation options may reduce opportunities for families to learn about home visiting offerings in their area from places like social service offices, parent-teacher events, child care facilities, higher education institutions and clinical settings. Further, the San Luis Valley experiences a rate of homelessness much higher than the state average. Families eligible for MIECHV services may not reside in a place

[32] San Luis Valley Citizens' Academy. (2017). The transit alliance. Retrieved from: http://www.transitalliance.org/wp-content/uploads/SLV_Report.pdf.

conducive to home visiting and coupled with no available transportation to meet a home visitor outside of a residential setting, may leave families unable to participate.[33]

In all MIECHV counties, low salaries for home visitors are often cited as a barrier to service delivery, especially in PAT and HIPPY programs. Home visitor supervisors frequently attribute low wages as a top reason for staff attrition, and as home visitors gain experience in working with families, careers with higher wages may become more attractive.[34] While state administration works throughout each program year to encourage the highest wages possible for home visitors and supervisors, factors like constantly rising fringe and costs of program overhead (including rent) make this difficult for program budgets to sustain. Additionally, while CO MIECHV has been able to maintain program budgets at a steady level for the last several years, Colorado's overall award has experienced a yearly decrease since federal fiscal year 2016-2017.

Colorado's Preschool Development Grant 2019 Needs Assessment identified the following barriers in home visitation service delivery[35]:

- **Workforce**: Program administrators identified difficulties filling home visitor positions with qualified staff and cited often lengthy family waiting lists with not enough team depth to serve them.
- **Culturally responsive services**: While Colorado uses a culturally responsive framework as its statewide approach to prevention programs, families and providers experienced bias and lack of language services (bilingual staff, translation and interpretation services), highlighting the need for service provider training.
- **Parent schedules**: Families cited lack of stable housing or alternate meeting location availability along with daily work schedules as reasons for not enrolling in or withdrawing from home visiting programs.
- **Familiarity and perceptions**: Family reported unawareness about voluntary home visiting and even when families were familiar with programs, they were worried about confidentiality concerns.

[33]Colorado Coalition for the Homeless. (2018). Homeless point in time study. Retrieved from: https://www.coloradocoalition.org/sites/default/files/2018-10/2018%20PIT%20Report%20-%20Sheltered.pdf.
[34]Discussion from state PAT and HIPPY supervisor meetings, as evidenced by CO MIECHV state lead Rebecca Dunn.
[35]Colorado Shines Brighter: Opportunities for Colorado's Early Childhood System. (2019). Family and community supports. Retrieved from: http://coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=Colorado-Shines-Brighter&lang=en.

IV. Capacity for Providing Substance Use Disorder Treatment and Counseling Services

Publicly-funded behavioral health services in Colorado are predominantly managed by two state agencies, the Colorado Department of Human Services Office of Behavioral Health (OBH) and the Department of Health Care Policy and Financing (HCPF). OBH is the designated Single State Authority for substance use disorder (SUD) prevention and treatment, supporting community-based SUD services for low-income adults and youth who are ineligible for Medicaid.[36] HCPF is the single state agency to administer Colorado's Medicaid program and is responsible for SUD services to Medicaid clients. Additional programs and funding are provided through other state agencies, such as behavioral health services for children, youth and families involved in child welfare and the juvenile justice systems. Services are paid using state cash fund dollars, federal grant dollars, state and federal Medicaid dollars, local government dollars, client fees, private insurance funds as well as private donations and grants. As in most states, treatment systems are complex in Colorado and gaps between data collection systems make it challenging to quantify SUD treatment needs and the state's capacity to meet that need. OBH is in the final stages of completing a comprehensive behavioral health needs assessment (with an anticipated release date late in October 2020), but data were not available in time for this report's submission.

However, several data sources were utilized to inform this review of SUD treatment capacity in Colorado, including:

- 2017 Needs Assessment conducted by the Keystone Policy Center (2017 COPIN)
- 2015 Needs Assessment conducted by the Western Interstate Commission for Higher Education (2015 COPIN)
- 2020 Licensing and Designation Database and Electronic Records System Data (LADDERS)
- 2019 Drug and Alcohol Coordinated Data System admissions data (DACODS)
- 2018 National Survey on Drug Use and Health (NSDUH)
- 2019 Colorado Health Access Survey (CHAS)
- 2019 National Survey of Substance Abuse Treatment Services (N-SSATS)
- 2019 Treatment Episode Data Sets (TEDS)

Families eligible for MIECHV services in Colorado must be pregnant or have a child under age six and reside in a MIECHV-served county (12 counties served under FY19-20 MIECHV contracts). Approximately 7% of Colorado MIECHV families in FY18-19 reported needing substance use treatment or had a history of substance abuse in their household. Home visitors may provide SUD treatment service information/referrals to enrollees for themselves or other family members if the need is identified. Though data on privately-funded SUD treatment services are not systematically reported in Colorado, the overwhelming majority of MIECHV families would qualify for state-funded programs either through Medicaid (58% of MIECHV-enrolled adults in FY18-19) or income requirements (98% of MIECHV families at 300% FPL or below in FY18-19). While some sub-population SUD treatment service data are available and reported for pregnant mothers and women with one or more dependent children, disaggregating data according to the child's age was not possible. Therefore, this section provides information on treatment services across the state rather than just focusing on current MIECHV service areas and populations to determine capacity for meeting substance use disorder needs for MIECHV enrollees and their family members.

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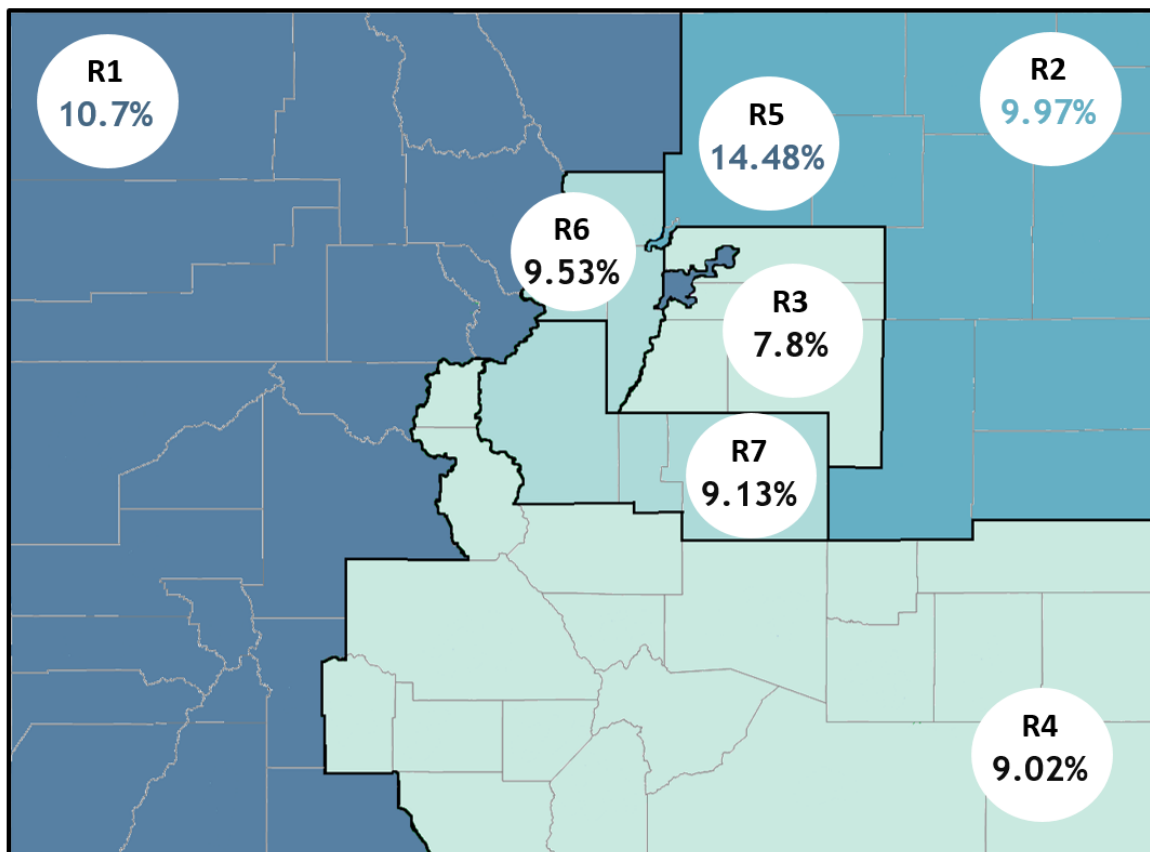
[36] To qualify for OBH-funded treatment services, individuals must have an income less than 300% of the federal poverty level and cannot be eligible for Medicaid.

Substance Use Disorder in Colorado

According to the 2018 National Survey on Drug Use and Health (NSDUH), an estimated 533,000 Coloradans 12 years and older (11.3%) were dependent on or misused alcohol and/or drugs in the past year.[37] Small area estimates from 2016-2018 NSDUH sub-state data present higher annual average percentages of SUD in Denver (region 5), western Colorado (region 1), and northeast Colorado (region 2) as displayed in Figure 7.[38] Substance use prevalence varied by type of substance in each region with surveys suggesting that regions 1 and 5 had comparatively higher alcohol use disorder prevalence in the past year; regions 1, 5 and 6 more illicit drug use disorder and regions 1 and 7, higher percentages of pain reliever use disorder (Table 9).

Figure 7: SUD prevalence by region, 2016-2018



Note: Blue percentages are higher than SUD estimates across the state (9.85%) for ages 12 and older, with darker shades denoting higher prevalence of substance use disorder.
Source: National Survey on Drug Use and Health, 2016-2018

[37] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). National survey on drug use and health, 2017 and 2018. Retrieved from: https://nsduhweb.rti.org/respweb/homepage.cfm.

[38] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). National survey on drug use and health sub-state tables, 2016-2018. Retrieved from: https://nsduhweb.rti.org/respweb/homepage.cfm.

Table 9: Sub-state SUD prevalence, 2016-2018

Region	Substance Use Disorder	Alcohol Use Disorder	Illicit Drug Use Disorder	Pain Reliever Use Disorder
Colorado	9.85%	7.18%	4.03%	0.69%
Region 1	**10.70%**	**7.74%**	**4.25%**	**0.73%**
Region 2	**9.97%**	7.02%	3.80%	**0.70%**
Region 3	7.80%	6.03%	3.27%	0.67%
Region 4	9.02%	6.57%	3.68%	0.67%
Region 5	**14.48%**	**10.50%**	**5.33%**	**0.70%**
Region 6	9.53%	6.73%	**4.25%**	0.66%
Region 7	9.13%	6.53%	**4.05%**	**0.74%**

Note: **Bolded** figures are higher than statewide prevalence for 12 years and older.
Source: National Survey on Drug Use and Health, 2016-2018

Treatment and Counseling Services

Publicly-funded, licensed substance use treatment centers offer a variety of substance use services, including assessment, detoxification, DUI education and therapy, case management, outpatient services, medication assisted treatment and residential treatment. Most facilities have special programs or groups for specific populations, including justice-involved populations, youth, women, men, pregnant or postpartum women, Spanish-speaking populations, LGBTQ+, veterans and active military as well as clients with co-occurring mental and substance use disorders.

MIECHV families in Colorado seeking SUD treatment services can access the Licensing and Designation Database and Electronic Reporting System (LADDERS), the directory for OBH licensed providers. As of September 14th, 2020, 616 substance use treatment facilities were licensed through OBH.[39] Appendix A provides maps of providers according to license type and level of care. Services provide three broad levels of care according to the American Society of Addiction Medicine (ASAM) including Level I (outpatient services), Level II (intensive outpatient/partial hospitalization services) and Level III (residential and inpatient services).[40] Most providers are licensed for outpatient services (92%), almost half for intensive outpatient or partial hospitalization (43%) and only 16% are licensed at the highest levels of care for clinically and medically managed residential and detox treatment. One quarter of providers are licensed to offer gender responsive treatment services, which require specialized services and environments to meet women's needs (e.g. child care, transportation, women-only therapeutic environments, priority admission for pregnant women).

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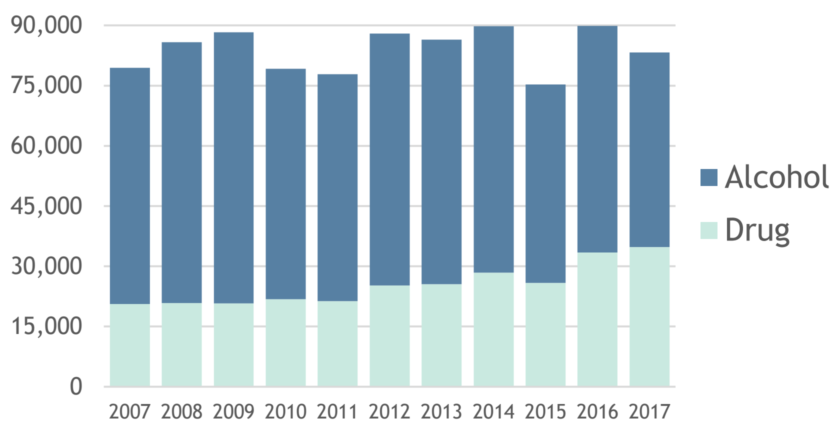
[39] Colorado Department of Human Services, Office of Behavioral Health. (2020). Licensing and designation database and electronic reporting system data. Accessed on 9.14.2020.

[40] For more information on levels of care, see Appendix A. Service and license definitions are provided in the Code of Colorado Regulations: Colorado Department of Human Services. (2013). Code of Colorado regulations, 2 CCR 502-1. Retrieved from: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=5432.

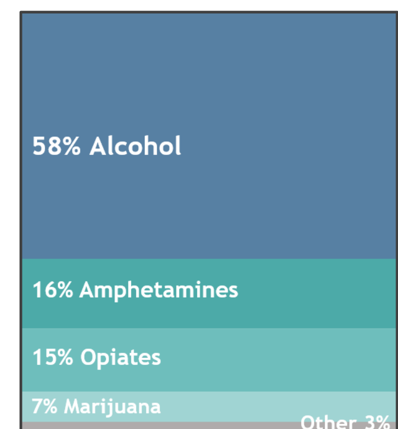
Quantifying individuals receiving treatment in Colorado is challenging due to various data collection systems at different agencies and privately-funded programs that do not require a license[41] and are not required to report data to the state. Approximately 54,318 individuals received publicly-funded substance use treatment and/or withdrawal management services through OBH in fiscal year 2018-2019.[42] Administrative data reported in the 2017 Treatment Episode Data Set (TEDS) included 83,293 SUD treatment admissions in Colorado.[43] The 2017 TEDS demonstrated that statewide admissions over the past ten years have remained fairly consistent between 75,000 and 90,000 per year (Figure 8). Four substance groups accounted for 97% of treatment admissions by primary substance reported at admission in 2017: alcohol (58%), methamphetamine/amphetamines (16%), opiates (15%) and marijuana (7%). While alcohol remains the leading substance for which people have sought treatment, methamphetamine and opioid admissions have increased over the past ten years (see Figure 12 in Appendix A). According to DACODS, 30% of all SUD treatment and withdrawal admissions at OBH-licensed facilities in 2019 (N=81,828) were women and 35% of female admissions had dependent children compared to 20% of male admissions.[44] Nearly one quarter (24%) of all treatment and withdrawal admissions had dependent children.

Figure 8: Alcohol and drug treatment admissions



Source: TEDS, 2017

Figure 9: Treatment admissions by substance



Source: TEDS, 2017

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[41] Licensed substance use treatment programs in Colorado may include outpatient counseling, residential treatment, withdrawal management, intensive outpatient services, and opioid treatment programs. They do not include private substance use treatment programs that do not accept public funding.

[42] Concrete numbers may be difficult to report due to varying data systems and reporting requirements for state agencies and programs. Public data do not necessarily include buprenorphine treatment through an independent, waivered medical practitioner or naltrexone treatment not affiliated with a SUD treatment facility; Colorado Department of Human Services, Office of Behavioral Health. (2019). Office of Behavioral Health fact sheet. Retrieved from: https://drive.google.com/file/d/1ugz5_2Jg6MrOz0AG1l4US9p3FZsRpqp8/view.

[43] Facilities required to report to TEDS include state-licensed facilities, methadone facilities and community-based juvenile and adult justice treatment programs (not institutionally based). 'Admissions' do not represent individuals as individuals may be admitted into the same program or different programs throughout the year; Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2019). Treatment Episode Data Set (TEDS): 2017; admissions to and discharges from publicly-funded substance use treatment. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[44] CDHS, Office of Behavioral Health. (2019). Drug and Alcohol Coordinated Data System data.

Gaps in Services

In addition to the complexities of measuring treatment capacity, quantifying the need to identify gaps in services is also challenging. Though 9.85% of Coloradans were identified as needing substance use treatment in the past year (as defined by the 2018 NSDUH) only 5.4% of those with a NSDUH-defined SUD reported receiving treatment in the past year.[45] Defining need based on NSDUH SUD criteria or diagnosis criteria alone may overestimate need. According to a Technical Advisory Group established by the U.S. Department of Health and Human Services and the Human Services Research Institute, as many as half of these individuals may recover without receiving treatment.[46] Nearly 95% of 2018 survey participants at the national level meeting NSDUH SUD criteria that did not receive services did not believe they needed treatment for their substance use.[47] Of those who perceived needing services but did not receive them, 40.7% nationwide made an effort to get treatment.[48] Some individuals may not seek services due to skepticism of treatment, tolerance of SUD risks and burdens or utilization of other coping mechanisms. Additionally, some individuals may utilize treatment services without meeting clinical SUD criteria because they rely on the support for ongoing recovery.[49] Perceived or unmet need may be a helpful estimate to determine need among those who are ready and want to seek treatment, but it may exclude individuals in need of treatment that do not recognize or are unwilling to report a need for services. According to the 2019 Colorado Health Access Survey (CHAS), 95,000 Coloradans 18 and older (2.3%) self-reported needing SUD services, but not receiving them in the past year.[50] The gaps between needing services, perceived need of services and receiving treatment, provide important context to assessing capacity and need for treatment services in the state.

Need assessments conducted on substance use services in Colorado in 2015[51] and 2017[52] utilized available secondary quantitative data and primary qualitative data including stakeholder surveys, interviews and focus groups. The 2017 Colorado Populations in Need (COPIN) study concluded that "Stakeholders across Colorado emphasized that when it comes to SUD services, the gaps and needs are significant and varied and nearly every population is underserved."[53] Despite this finding, both studies found key gaps according to service type, region and subpopulation.

Service type gaps

Gaps in residential and detoxification services were identified by stakeholders in the 2017 COPIN across the state. Stakeholders stressed that more residential services (at each intensity level) were

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45 Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). National survey on drug use and health, 2017 and 2018. Retrieved from: https://nsduhweb.rti.org/respweb/homepage.cfm.

46 U.S. Department of Health and Human Services [HHS]. (2019). Needs assessment methodologies in determining treatment capacity for substance use disorders: Final report. Retrieved from: https://aspe.hhs.gov/system/files/pdf/262436/SUDNetCap.pdf.

47 Substance Abuse and Mental Health Services Administration [SAMHSA]. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: SAMHSA. Retrieved from https://www.samhsa.gov/data/.

48 Ibid.

49 HHS. (2019). Needs assessment methodologies.

50 Colorado Health Institute. (2019). Colorado Health Access Survey Data 2009-2019. Retrieved from: https://www.coloradohealthinstitute.org/data.

51 Western Interstate Commission for Higher Education, Mental Health Program. (2015). Needs analysis: Current status, strategic positioning, and future planning. Colorado Department of Human Services Office of Behavioral Health. Retrieved from: https://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/OBH-Needs-Analysis-Report2015-pdf.

52 Keystone Policy Center. (2017). Bridging the divide: Addressing Colorado's substance use disorder needs. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/Keystone-SUD-final%203.27%20rev%20with%20one%20pages_2.pdf.

53 Ibid, pg 2.

needed. In 2017, the Colorado Health Foundation estimated that residential and inpatient SUD treatment facilities could serve up to 5,256 people with a 15-day inpatient stay and 15,525 people with a 30-day residential stay annually, which they concluded was inadequate to meet need.[54] Nearly half of all treatment facilities in Colorado are currently only licensed for outpatient services and very few facilities are licensed to offer services at all three ASAM levels of care.[55]

Generally, more clinically managed, social detox services were identified as a need by 2017 COPIN participants. Additionally, a medical component to detox services to avoid sending detox patients to emergency departments when there are medical complications that cannot be addressed in a social detox are needed. Stakeholders also highlighted gaps in supportive and transitional services, e.g. for justice-involved patients. According to a needs assessment conducted specifically on opioids, increased access to medication-assisted treatment services is needed, especially for rural communities that must travel long distances to reach services.[56]

Regional gaps

LADDERS data demonstrates that five counties do not have any SUD treatment providers licensed through OBH: Dolores, Hinsdale, Jackson, Mineral and San Juan. Twenty three counties (36%) have facilities with licenses representing all three ASAM Levels. Most counties only have licensed facilities for ASAM Level I or licenses for ASAM Level I and II. Only one county, Clear Creek, had Level I and III licenses and no facilities licensed at Level II. Figure 10 has a breakdown of licensed ASAM levels available in each county. Less than a quarter of counties have a facility licensed for opioid treatment or MAT services. While most counties have a facility licensed for gender responsive treatment, facilities may not currently offer these services.[57] Unsurprisingly, urban counties have more varied services compared to rural and frontier communities that may not have access to residential or detox services. Half of the counties receiving MIECHV services have access to all three levels of care (Adams, Alamosa, Denver, Mesa, Pueblo and Otero). Five counties have access to two levels of care (Clear Creek, Costilla, Crowley, Morgan and Saguache) and one (Gilpin) only has outpatient services. Though limited by data systems, the 2015 COPIN calculated penetration rates (estimated proportion of individuals that received SUD treatment services).These rough estimates indicated that western Colorado may have had greater unmet SUD treatment needs and the southeast may be better served relative to other regions.[58]

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[54] Colorado Health Institute. (2017). Exploring options for residential and inpatient treatment of substance use disorder in health first Colorado: A report to the General Assembly in response to House Bill 17-1351. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report_0.pdf.

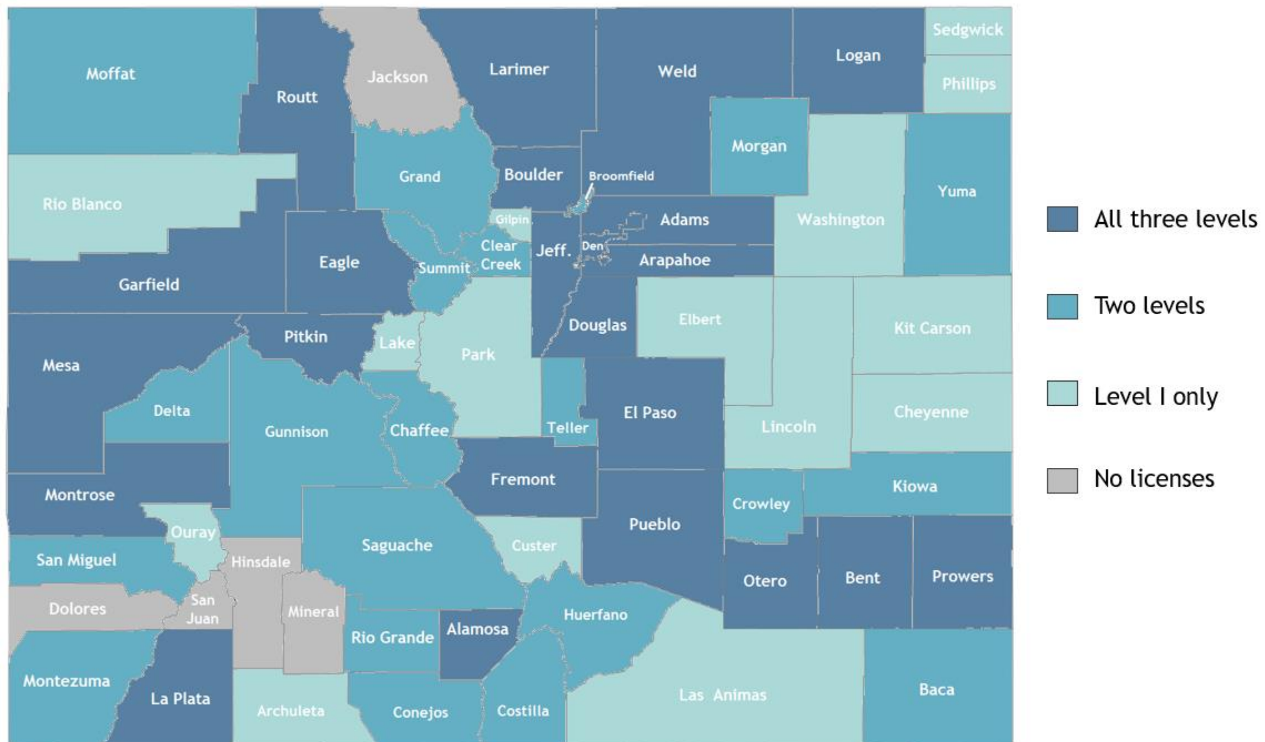
[55] CDHS, OBH. (2020). LADDERS data.

[56] Colorado Health Institute. (2017). Needs assessment for the SAMHSA state targeted response to the opioid crisis grant. Retrieved from: https://drive.google.com/file/d/0B_Qu7DlYJwx7d0FuVzdwVFp0bVU/view.

[57] The Tough as a Mother campaign vetted specialized SUD treatment services for women and though the data may not include newer licenses, it potentially provides a more accurate picture of which services are offered specifically for women: https://www.toughasamother.org/find-help.

[58] Definitive rates of unmet need could not be calculated due to the lack of comparable data between OBH and HCPF service counts. Findings are based on themes identified between separate penetration rates for OBH and HCPF funded programs. Data could not be unduplicated between programs and HCPF data combined mental health and SUD data, making it impossible to quantify SUD services across both programs.

Figure 10: County access to licensed SUD treatment providers by ASAM Levels



Source: LADDERS, 2020

Subpopulation gaps

The 2017 COPIN concluded that all populations across Colorado are underserved. However, several subpopulations were identified in both studies as underserved with gaps in specialized or targeted treatment services needed to support them.

- Location: Rural and frontier Communities experience unique challenges. Services may be farther away, difficult to reach and may not be able to offer the same range of services as urban centers. Detox services in rural areas are particularly difficult to sustain with a limited number of patients. Generally, rural counties have higher rates of opioid prescriptions with the southeastern counties of Pueblo, Huerfano, Costilla and Las Animas reporting the highest opioid prescription rates in the state as well as the highest rates of opioid overdose.[59]

- Age: Adolescents experience gaps in detox services, inpatient and outpatient treatment options, residential care, longer-term sober living and supportive housing and in-home providers for multi-generational substance use. Stakeholders explained that many services were only available for youth associated with the criminal justice system. In both the 2015 and 2017 assessments, adolescents with co-occurring disorders were identified as an underserved group. Seniors were also identified across most regions as having unique challenges in 2017, according to isolation, stigma, access and comorbidity.

[59] Colorado Health Institute. (2017). Needs assessment for the SAMSHA state targeted response.

- Gender and sexual orientation*:* Stakeholders reported that pregnant, postpartum and parenting women receive more funding and services compared to other populations in 2017. As with all populations, stakeholders still felt they were underserved and noted they may experience additional stigma and guilt associated with being a mother. Stakeholders reported that adult men and women are not usually a target population, resulting in a lack of gender-specific services. According to the 2019 CHAS, adult men were more likely to report needing SUD services and not receiving them in the past year than women in Colorado (3% compared to 1%). The Colorado Health Institute explains this may be due to higher rates of usage among men and the stigma women feel or fear surrounding child welfare if they have children.[60] COPIN 2017 participants reported that LGBTQ populations are underserved, especially LGBTQ youth, who are in need of targeted and inclusive services.

- Race, ethnicity, and culture: People of color were reported as underserved across most regions. Stakeholders identified needs for bilingual and bicultural products and services to better support non-English speaking, immigrant and refugee populations. Gaps were identified in culturally specific treatment, including peer support and traditional healing methods for native and tribal populations. No significant differences were found in those unable to attain services in the 2019 CHAS between participants identifying as white non-Hispanic and Hispanic/Latino, though sample sizes limited the ability to compare access according to other groups. Penetration rates analyzed in 2015 did not find major differences for OBH SUD services among white non-Hispanic and minority groups.

- Income and insurance*:* Low-income and individuals with no/insufficient insurance experience gaps in services according to affordability if they do not qualify for services. They may be unable to afford copayments or deductibles required and stakeholders reported they may lose benefits before accessing services and resources needed for long-term sobriety. Participants in 2017 also highlighted that Medicaid does not cover residential treatment, except for pregnant women, which has limited funding. Low income (participants at or below 200% of the federal poverty line) and uninsured Coloradans were more likely to report needing care and not receiving it according to the 2019 CHAS.

- Housing*:* People experiencing homelessness or insecure housing were identified as needing additional support and services, especially for those with co-occurring disorders. Stakeholders reported that shelters needed medications and recovery supports for treatment.

- Trauma*:* Veterans and active military patients need additional support to access services, with an identified need for trauma-informed care that recognizes drivers of substance use in post-traumatic stress disorder and brain trauma. While some services are available through the Department of Veterans Affairs, stakeholders noted that patients may not be able to access all services and may be reluctant to utilize them. Other populations with a history of trauma could benefit from provider training in trauma-informed care, such as domestic violence survivors.

[60] Colorado Health Institute. (2020). Going without: Many Coloradans not getting needed treatment for substance use disorder. Retrieved from: https://www.coloradohealthinstitute.org/research/going-without.

- Co-occurring disorders: Patients with co-occurring mental health and substance use disorders were identified in both needs assessments as a significantly underserved population. Stakeholders highlighted major gaps in coordination of services between mental health, substance use and physical health concerns. Stakeholders reported that patients with co-occurring disorders can be left with no options for treatment as they may be denied mental health treatment if using substances, but cannot stop using if the underlying mental health condition is not addressed.

- Criminal justice: Individuals with criminal justice-involvement need additional services, especially in jails and prisons. Stakeholders noted the need for medication-assisted treatment, especially for inmates with co-occurring disorders. Relapse rates are high among recently released individuals with gaps in transitional services and support to provide ongoing care.

Barriers to Receipt of Services

Barriers to receipt of substance use disorder treatment and counseling services in Colorado fall into a few broad categories. Barriers may be experienced disproportionately by different subpopulations as described in the previous section.

Affordability

Cost and insurance coverage are major concerns for people seeking SUD services. Nearly half of CHAS 2019 participants said they did not receive needed SUD services because of the cost of treatment (47.7%), while 52.1% of insured Coloradans reported they did not get needed treatment because they did not believe their insurance would cover SUD services.

Access

Transportation was identified as a top barrier for receiving services in the 2015 and 2017 COPIN assessments, especially for rural and frontier communities and adolescents or those without their own transportation. Gaps in service types may impact access to treatment and additional services to meet specific individuals' needs may inhibit access, such as child care availability. According to the 2019 National Survey of Substance Abuse Treatment Services (N-SSATS), only 5.6% of outpatient treatment facilities in Colorado provide child care and 31.6% of outpatient services have transportation assistance.[61] Nearly one third of CHAS 2019 participants (32.9%) said they did not get services because they had a difficult time getting an appointment.

Stigma, education and privacy

In the 2017 COPIN, stigma and lack of education were identified as key barriers to treatment. Individuals living in small communities may feel less comfortable accessing services due to privacy concerns and fear that their communities will judge them if they seek services. Community de-stigmatization of SUD was identified as a need since the lack of recognition of SUD as a chronic disease outside of the health system is a barrier to care and recovery. The 2019 CHAS revealed that 72.8% of those not receiving SUD services reported feeling uncomfortable speaking with a health

[61] Substance Abuse and Mental Health Services Administration. (2020). National Survey of Substance Abuse Treatment Services (N-SSATS): 2019. Data on substance abuse treatment facilities. Rockville, MD: SAMHSA. Retrieved from: https://www.samhsa.gov/data/data-we-collect/n-ssats-national-survey-substance-abuse-treatment-services.

professional and 72.4% reported concern over what would happen if someone found out they had a problem.

Provider challenges
Workforce challenges were identified as key barriers for delivering SUD services in both COPIN assessments, including high turnover rates, staff shortages, inadequate compensation and insufficient training. Providers and stakeholders reported needed training for trauma-informed care, medication-assisted treatment and treatment for adolescents. In 2015, workforce shortages and challenges were identified as a likely contributor to service gaps experienced across the state. Providers are also limited according to funding available and requirements and restrictions of those funding streams. Providers felt overburdened with administrative duties for each funding stream or payer with varying data collection and reporting requirements. Providers may be contracting with as many as twelve different state agencies or divisions/programs within the same agency. Funding is also often tied to specific populations. COPIN 2017 participants reported that the scope of funding is often too restrictive, making it difficult for communities to target resources according to need.

Action and Collaboration

As discussed, Colorado is working on multi-faceted behavioral health reforms to improve service delivery in the state. House Bill 19-1287 mandated the creation of a statewide, online registry for behavioral health capacity, which is scheduled to go live in January 2021. This centralized tracking registry will capture SUD treatment provider capacity daily, including available SUD treatment beds and which programs are accepting new clients. The registry should help efficiently place Coloradans seeking treatment and to maximize available resources.

The Behavioral Health Task Force was created through a 2019 executive order to evaluate the behavioral health system and develop a strategic plan to reform the system. The taskforce has 25 members and four subcommittees, including the state safety net, children's behavioral health, long-term competency and COVID-19 related issues. The taskforce brings together representatives from local and state government, criminal justice experts, advocacy groups, behavioral health experts and consumers. The Office of Behavioral Health is also completing a comprehensive Populations in Need study to assess current behavioral health programs, capacity and need. Based on the 148 recommendations from the taskforce and PIN study findings, the taskforce is developing the strategic plan, which is scheduled to be released in fall 2020. There are currently strategic plans in place for statewide SUD prevention[62] and recovery[63] services, but not treatment services.

Behavioral Health Task Force recommendations fell into six pillars similar to gaps identified in previous needs assessments, including improving access, affordability, workforce and support, accountability, consumer and local guidance and whole person care. Whole person care recommendations surround challenges to receive support outside of behavioral health services including housing or food assistance or across different mental, substance and physical health needs.

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[62] Colorado Department of Human Services Office of Behavioral Health, Colorado Health Institute. (2018). Putting prevention science to work: CO statewide plan for primary prevention of substance abuse 2019-2024.
[63] Colorado Department of Human Services, Colorado Health Institute, Mental Health Colorado, Colorado Consortium. (2019). Colorado statewide strategic plan for substance use disorder recovery: 2020-2025.

Prioritized recommendations include increasing training for services outside of the behavioral health field and improved care coordination between services.[64]

One of the recommendations passed by the Behavioral Health Task Force is to create a behavioral health administration to lead and promote the state's behavioral health priorities and be accountable for the delivery of services across the state. This administration would help streamline the complex system currently in place. Colorado has over ten state agencies with behavioral health funding/programs and providers often have separate contracts across multiple agencies or within the same agency. The behavioral health administration would help streamline this system to minimize data and administrative burden on providers and improve communication across funding streams and programs. Another task force recommendation that could be particularly helpful for MIECHV families in need of SUD services surrounds the creation of care coordination entities that would offer regional support for care navigation for behavioral health services. The vision of this system would be for anyone to be able to contact their local or regional entity to get information and help navigate the system and get connected or placed within the right program for them. See Appendix B for more information on the current state system and proposed changes.

Separate from the Behavioral Health Task Force, the state has a Substance Abuse Trend and Response Task Force through the Attorney General's office that examines substance use trends to inform SUD policies and services. The taskforce brings together representatives of state and local government, SUD treatment providers, public health officials, legislators, child advocates, law enforcement officers, judges and prosecutors.

Several state and pilot programs provide additional services to support pregnant and parenting women and parents with young children. The Special Connections program[65] provides residential SUD treatment for women during pregnancy and for one year after birth on the Front Range. The program includes five providers with 16 beds in Greeley, 16 beds in Pueblo and 48 beds in the Denver-metro area. Unlike most residential treatment, Special Connections programs utilize a two-generation approach and allow parenting women receiving residential treatment to house children with them (accepted ages ranging from 0-12 years). As with most programs, these services are limited; enrollees wait an average of 8-12 weeks for short-term programs with an average 20-30 women on the waitlist at any given time[66] and acute need in Colorado Springs and Denver. CDHS awarded Illuminate Colorado with funding to implement a mobile child care pilot program in 2020 to meet the immediate needs of caregivers accessing SUD treatment. The project is piloting a mobile child care unit in the Denver-metro area and in the San Luis Valley to serve children ages 0-24 months.[67] In 2020, OBH launched the Tough as a Mother campaign to reduce stigma as a treatment barrier and connect mothers with dependent children to SUD treatment services in their community.

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[64] Colorado Behavioral Health Task Force, Colorado Department of Human Services. (2020). A report on the remedy for behavioral health reform: Putting people first. Draft Report. Retrieved from: https://drive.google.com/drive/folders/1W1QPnR1tuGMJ4PDwXvmr5MY4ZtlHU8mN.

[65] Information and data on the Special Connections program were gathered during informal interviews with program managers at HCPF and OBH.

[66] Mental Health Colorado and Illuminate Colorado. (2019). Behavioral health supports for high-risk families: HB19-1193 fact sheet. Retrieved from: https://static1.squarespace.com/static/55766d41e4b0c4045c59aafb/t/5c86d58f08522971b6d5c3a1/1552340368438/HB19-1193+Fact+Sheet+3_6.pdf.

[67] Illuminate Colorado. (2019). *Illuminate Colorado to receive $630,000 contract for innovative child care pilot at addiction treatment services program*. Retrieved from: https://www.illuminatecolorado.org/news/childcarepilot.

While some of these initiatives are still underway or still in the planning stages, they provide a path towards meaningful changes to meet the needs of Coloradans. The development of the taskforce provided an opportunity to break down silos between programs and stakeholders and improve services. A prioritized solution under the strategic plan identifies an opportunity for state and local advisory groups that would bring together stakeholders to inform and guide system and service improvements moving forward. This large shift will help streamline efforts to improve services along the continuum of SUD care to Coloradans. MIECHV enrollees may especially benefit from the proposed care coordination entities, Special Connections and mobile child care units, especially if these programs can be expanded in more regions and for more parents. This needs assessment provided additional collaboration opportunities, which strengthened ties between the MIECHV state evaluation and program team with the Office of Behavioral Health and HCPF. Our team plans to leverage these relationships to continue discussions on how to best serve MIECHV enrollees and their families to meet their SUD needs along the continuum of care.

V. Coordination with Title V MCH Block Grant, Head Start, and CAPTA Needs Assessments

Over the course of the last two years, Colorado engaged in a number of needs assessment efforts focused on early childhood that either connected directly to or informed the current MIECHV needs assessment. Additionally, most of these assessments examining the needs, resources and services at the state and local level also shared some of the same stakeholders across groups. The CO MIECHV team is in a unique position with the program team located in the state human services department and the evaluation team housed in the Center for Health and Environmental Data at the public health department. Public health departments are charged with functions that directly support needs assessments. The Centers for Disease Control and Prevention established guidance for strengthening public health systems and promoting best practices. This includes the "Ten Essential Public Health Services" which relate directly to needs assessments for the state and communities. Two of these are particularly salient: "1) Assess and monitor population health status, factors that influence health, and community needs and assets and, 2) Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it."[68] The partnership across these two state departments, human services and public health, promoted stakeholder engagement and collaboration in early childhood, maternal and child health, child welfare and behavioral health while planning and implementing the MIECHV needs assessment.

The CO MIECHV team has close partnerships and overlaps with Title V Maternal and Child Health (MCH) at CDPHE. The manager of the CO MIECHV evaluation team also leads the MCH Epidemiology unit at CDPHE that headed the **Title V MCH Block Grant Needs Assessment**. Also, the MIECHV evaluation manager met regularly with the MCH program staff, especially the Needs Assessment project manager, starting in 2018 and continuing through 2020, to identify and share common datasets and analyses. The MCH framework's[69] priorities, identified through quantitative and qualitative data collection and analyses, align well with home visiting's two-generation (2Gen) supports by increasing or improving: prosocial connection, access to supports, social emotional well-being, economic mobility and positive child and youth development. Findings that informed MCH's decision to include racial equity as a strategic anchor for programming and the priority of reducing racial inequities supported the CO MIECHV team's decision to analyze concentrations of risk in Black and African American communities during this needs assessment.

Collaboration with Colorado Head Start for the MIECHV needs assessment as well as the **2019 Colorado Birth Through Five Needs Assessment**[70] funded through the Preschool Development Grant (PDG B-5) informed overlaps and gaps in home visiting services as well as barriers to accessing services. The MIECHV evaluation manager represented the CO MIECHV data perspectives on the stakeholder group guiding the PDG efforts, sharing data and methods. The **Colorado Head Start 2019 Program Information Report** also informed the identification of service gaps and overlap. Through funding from Title II of CAPTA, the Office of Early Childhood engaged a postdoctoral fellow from the

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[68] Centers for Disease Control and Prevention. (2020). 10 Essential Public Health Services. Retrieved September 20, 2020 from, https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.

[69] Colorado Department of Public Health and Environment (2020). *Maternal and Child Health Programs*. Retrieved September 20, 2020 from https://drive.google.com/file/d/14Zuuw4Kk28jP2-60E2lKPxMUJ35kS1q2/view.

[70] Colorado Department of Human Services, Office of Early Childhood and Colorado Health Institute. (2019). *Colorado shines brighter opportunities for Colorado's early childhood system: The Colorado birth through five needs assessment*. Retrieved from: https://dcfs.my.salesforce.com/sfc/p/#410000012srR/a/4N000000AGxx/QPNqI9n15kNbYRhObm7zKcWoPajUElvqWkrdaeSJdHY.

Society for Research in Child Development who worked closely with the MIECHV data team to understand and align MIECHV-related indicators. The fellow completed an update to Colorado's **Child Maltreatment Framework for Action**[71] as well as County Prevention Maps. The project's purpose was to identify a short list of actionable indicators that counties and community planners could address to reduce the number of children exposed to child maltreatment and to promote child, family and community well-being. The project was conceptualized in partnership with researchers at the University of Texas System, Population Health (Dorothy Mandell and Molly O'Neil) as the methodology closely aligned with their Maltreatment Risk in Communities 2016 project.[72] Counties classified as having elevated risk for child maltreatment demonstrated overlap with MIECHV communities, especially in rural areas. Similar findings in access to services echo throughout these needs assessments: there are not enough services to meet the needs of Colorado families, with rural areas facing unique barriers for accessing services and inability to meet demand due to funding limitations.

In addition to needs assessment findings and data from the Title V MCH Block Grant, Head Start and Title II of the CAPTA, the CO MIECHV team also utilized findings from the Preschool Development Grant and Office of Behavioral Health needs assessments as a foundation for the MIECHV needs assessment. In anticipation of the MIECHV Needs Assessment SIR as well as feedback about community-level changes from county residents and agencies, Colorado refreshed the original 2010 MIECHV Needs assessment with available data in 2017. Home visiting stakeholder meetings with state intermediaries and program and evaluation staff were held to review and reflect on initial indicators and findings from the data gathered in the 2017 pre-assessment. Assessment reviews and stakeholder engagement through meetings and informal interviews gathered through this process contributed to the selection of indicators, identification of service gaps and interpretation of results.

As discussed previously, collaboration with the Office of Behavioral Health at CDHS helped inform the SUD treatment service section of this report. This included two needs assessments as well as data gathered from behavioral health program staff. The CO MIECHV evaluation team collaborated with CDHS Office of Early Childhood and Division of Child Welfare in the development of the Child Maltreatment Prevention Framework for Action's Prevention Measurement Guide project under CAPTA Title II funding. The guide includes population-level indicators of risk and protective factors for child maltreatment. Collaboration on this guide helped inform the selection of indicators and data sources for this needs assessment according to data available at the county or census-tract level.

While the CO MIECHV team members previously had strong relationships and ties with many of the stakeholders and programs engaged, this needs assessment provided additional opportunities for collaboration and connections. Team members participate on the Colorado Early Childhood Leadership Commission's (ECLC) Data Committee.[73] Additionally, the MCH, Head Start and CAPTA programs are represented on the ECLC. Selected indicators from the original 2010 MIECHV Needs Assessment as well as the 2017 pre assessment helped the ECLC determine baseline data as well as performance indicators for the three "Areas of Opportunity" for the state's early childhood system.

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[71] Colorado Department of Human Services, Office of Early Childhood. (2020). *Colorado Child Maltreatment Framework for Action*. Retrieved from: https://co4kids.org/sites/default/files/toolkits/CDHS_MaltreatmentPrevention_MeasureGuide_06192020_Digital.pdf.
[72] The University of Texas System, Office of Population Health. (n.d.). *Maltreatment Risk in Communities*. https://www.utsystem.edu/offices/population-health/overview/maltreatment-risk-communities-2016.
[73] The ECLC is Colorado's federally-authorized state advisory council for early childhood. http://www.earlychildhoodcolorado.org.

The current 2020 Needs Assessment data will be shared through this group to determine progress, set new goals and identify areas of overlap. Additionally, the Needs Assessment will inform the Home Visiting Investment Task Force in developing a five-year strategy to expand resources to support a full home visiting continuum for families across Colorado. The CO MIECHV team plans to use these new and strengthened partnerships to improve state-level coordination of early childhood and maternal and child health service efforts. The CO MIECHV team plans to connect more regularly with partners and identify areas for collaboration moving forward. The team will also work to incorporate information on services and program changes across programs that will impact Colorado families into the monthly CO MIECHV newsletter to encourage regular collaboration and keep home visitors informed.

VI. Conclusion

Over the past two years, the CO MIECHV team has worked with stakeholders and partners in early childhood, maternal and child health, child welfare and behavioral health while planning and implementing the MIECHV needs assessment. The goal of this needs assessment was to identify 1) communities with high concentrations of risk, 2) the quality and capacity of existing programs and 3) the capacity for providing substance use disorder treatment and counseling services.

Using the quintiles of risk approach with additional data provided in a second phase of analysis, twenty two counties were identified as being “high risk” and findings suggest that Black and African American Coloradans across the state, as a community, face high concentrations of risk. While Colorado has six evidence-based home visiting models, more funding is needed to meet the need for home visiting services statewide. Currently, no county is able to meet the need for services, with the impacts of COVID-19 further impeding programs’ ability to serve families. At least one home visiting model is available in every county, however rural and frontier communities face unique challenges to access services with transportation barriers and fewer models and programs offered in their region. Several counties only have one model available and families may not qualify for services because of the program’s strict eligibility requirements.

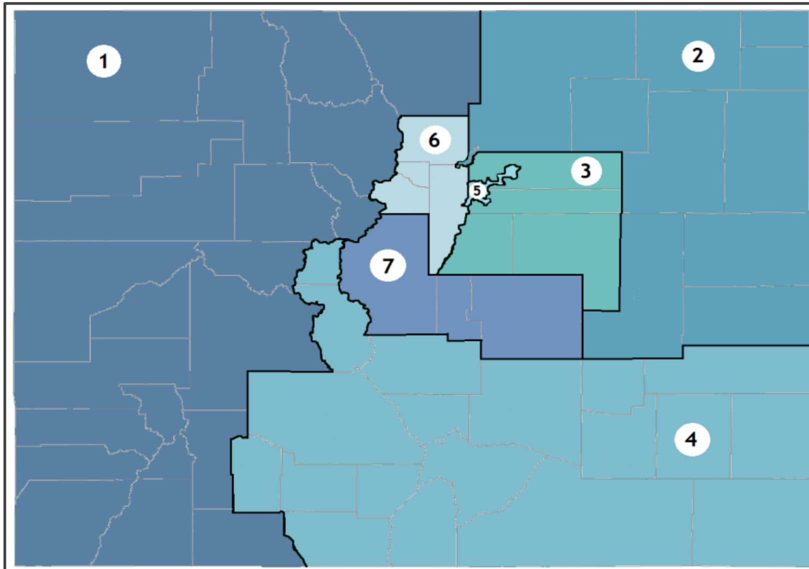
Colorado has over 600 licensed substance use treatment facilities. As with home visiting services, SUD services are not sufficient to meet the need in any region or for any subpopulation. Some groups may face additional challenges, barriers and stigma. Structural changes in the state behavioral health system are underway to help streamline SUD services and better support Coloradans. In addition to these plans, there are several promising pilots currently underway that may help MIECHV families access SUD treatment services, including a mobile child care unit and residential treatment services specifically for women with young children.

Findings from this needs assessment will be used to inform stakeholders about the unmet need for home visiting services and target services to communities with high levels of need. Results will be shared with stakeholders and provide an opportunity to strengthen partnerships and collaboration across early childhood systems in Colorado.

Appendix A: SUD Treatment Section Maps and Figures

NSDUH provides sub-state SUD data estimates for Colorado based on 2016-2018 data by OBH planning areas. Due to sample size constraints, certain planning areas were combined to create seven regions as displayed in Figure 11 with counties in each region listed below the map.[74]

Figure 11: Regional map for SUD treatment services



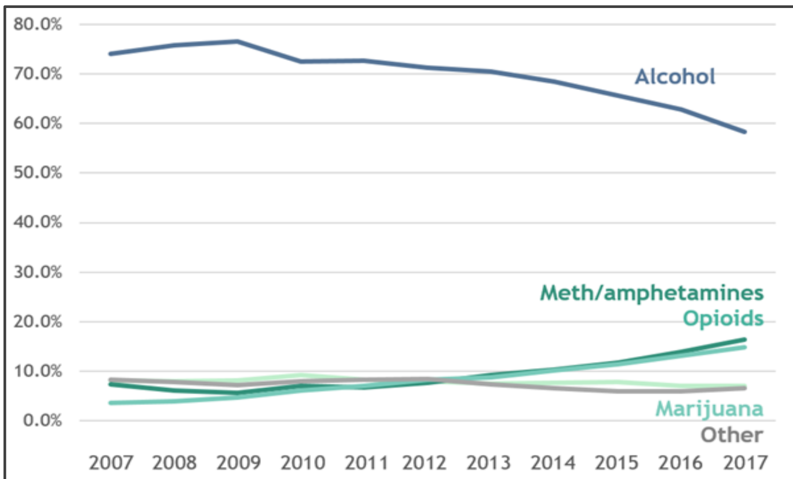
Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Archuleta Delta Dolores Eagle Garfield Grand Gunnison Hinsdale Jackson La Plata Larimer Mesa Moffat Montezuma Montrose Ouray Pitkin Rio Blanco Routt San Juan San Miguel Summit	Broomfield Cheyenne Kit Carson Lincoln Logan Morgan Phillips Sedgwick Washington Weld Yuma	Adams Arapahoe Douglas Elbert	Alamosa Baca Bent Chaffee Conejos Costilla Crowley Custer Fremont Huerfano Kiowa Lake Las Animas Mineral Otero Prowers Pueblo Rio Grande Saguache	Denver	Boulder Clear Creek Gilpin Jefferson	El Paso Park Teller

Source: National Survey on Drug Use and Health 2016-2018

[74] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). National survey on drug use and health, 2017 and 2018. Retrieved from: https://nsduhweb.rti.org/respweb/homepage.cfm.

Figure 12 is based on TEDS 2017 data, showing Colorado SUD admissions from 2007 to 2017 according to the primary substance reported at admission.[75]

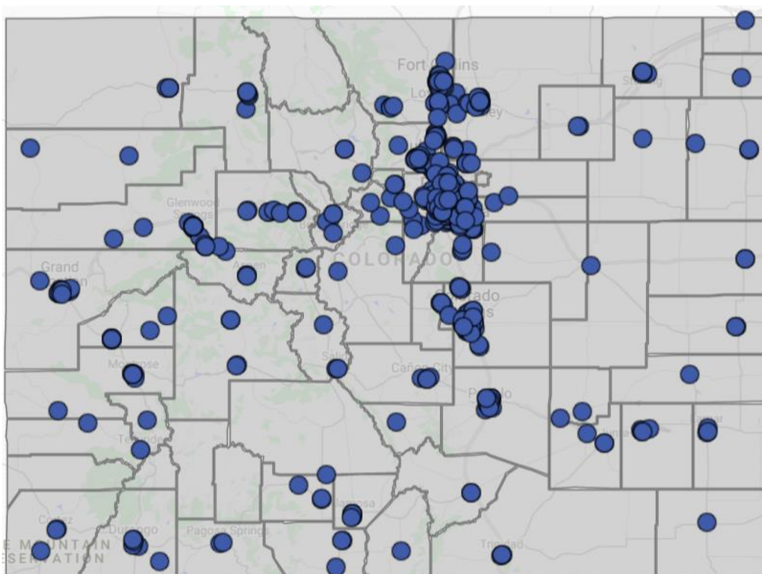
Figure 12: Proportion of Colorado treatment admissions by primary substance, 2017



Source: Treatment Episode Data Set, 2017

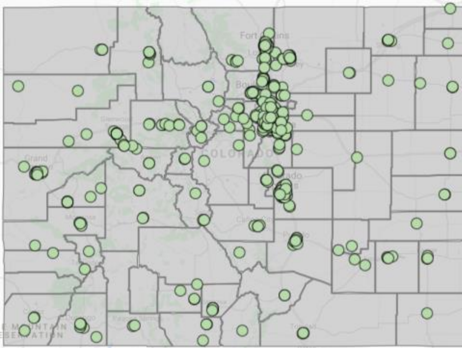
As of September 14, 2020, 616 SUD treatment providers were licensed through the Office of Behavioral Health in Colorado. Five counties did not have any licensed providers: Dolores, Hinsdale, Jackson, Mineral, and San Juan. The six maps below break these providers down according to treatment license type and level of care. Though the providers may have current licenses, they may not be offering those specific services.

Figure 13: Colorado SUD treatment center locations, 2020

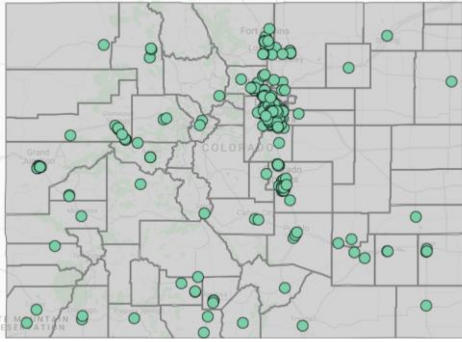


Note: Grey lines represent counties and dots represent a licensed SUD treatment provider
Source: LADDERS, data exported September 14, 2020

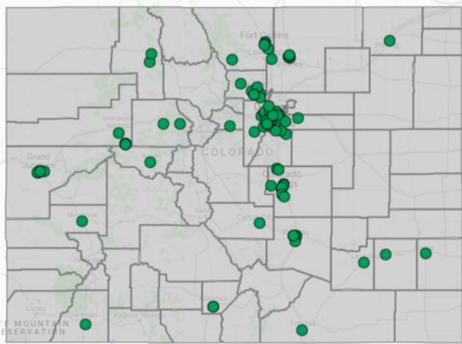
[75] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2019). Treatment Episode Data Set (TEDS): 2017; admissions to and discharges from publicly-funded substance use treatment. Rockville, MD: Substance Abuse and Mental Health Services Administration.



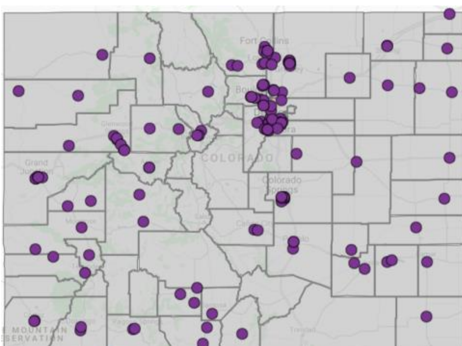
Outpatient Treatment Services (ASAM Level I)
Most licensed SUD treatment providers across the state are licensed to offer outpatient services (92%), defined as ASAM Level I. All 59 counties with a licensed SUD treatment provider have at least one outpatient program in their county.



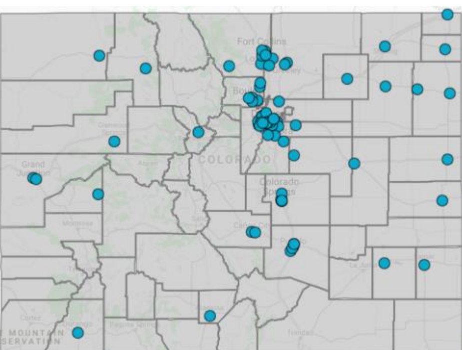
Intensive Outpatient and Partial Hospitalization Treatment Services (ASAM Level II)
Less than half of licensed programs (43%) have Level II care, including intensive outpatient and/or day treatment (partial hospitalization). 43 counties have at least one SUD provider licensed to provide level two care. In addition to the five counties without any SUD treatment facilities, Archuleta, Cheyenne, Clear Creek, Custer, Elbert, Gilpin, Kit Carson, Lake, Las Animas, Lincoln, Ouray, Park, Phillips, Rio Blanco, Sedgwick and Washington counties do not have ASAM Level II services.



Inpatient and Residential Treatment Services (ASAM Level III)
Only 16% of providers are licensed for ASAM Level III residential and inpatient services, which include: Clinically managed low-, medium- and high-intensity residential services, clinically managed residential detox, medically monitored intensive residential treatment and medically monitored inpatient detoxification. 24 counties have at least one provider that is licensed for Level III services.



Gender Responsive Treatment Services
About one in four providers are licensed for gender responsive treatment services (25%) across 50 counties. The license does not guarantee the program is able to offer specialized services for women. However, vetted services are available through the Tough as a Mother campaign.



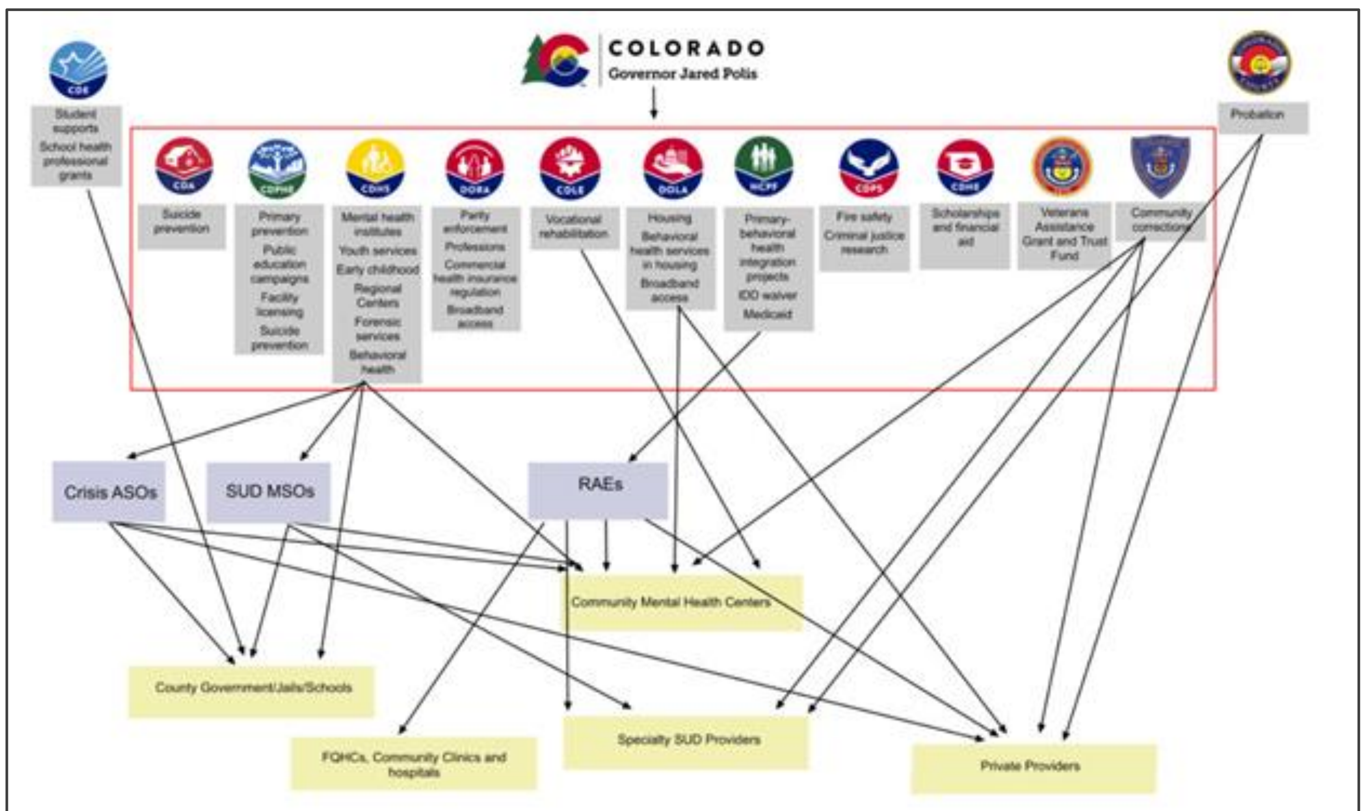
Opioid and MAT Treatment Providers
Most opioid and MAT treatment providers are located in urban centers across the state. Very few providers have a license for opioid or MAT treatment. They are located in 13 counties: Adams, Alamosa, Arapahoe, Boulder, Denver, El Paso, Jefferson, La Plata, Larimer, Mesa, Prowers, Pueblo and Weld. The map to the left shows facilities that have an opioid or MAT treatment license or offer MAT as an additional service.

Appendix B: Current and Proposed Behavioral Health Systems of Care in Colorado

Colorado's current behavioral health system is quite complex. The state has over 10 agencies with behavioral health funding/programs as depicted in Figure 14.[76] Providers often have separate contracts across multiple agencies or within the same agency. Agencies have different data collection and reporting systems, which creates a large administrative burden for providers. Colorado's Behavioral Health Task Force passed the recommendation to create a Behavioral Health Administration with a State Stakeholder Advisory Board to streamline Colorado's continuum of care as shown in Figure 15.[77]

Another recommendation proposed by the Colorado Behavioral Task Force is to create care coordination entities to merge existing regional intermediaries and improve behavioral health service delivery to Coloradans as displayed in the Figure 16.[78]

Figure 14: Current state-level behavioral health system



Source: Colorado Behavioral Health Task Force, 2020.

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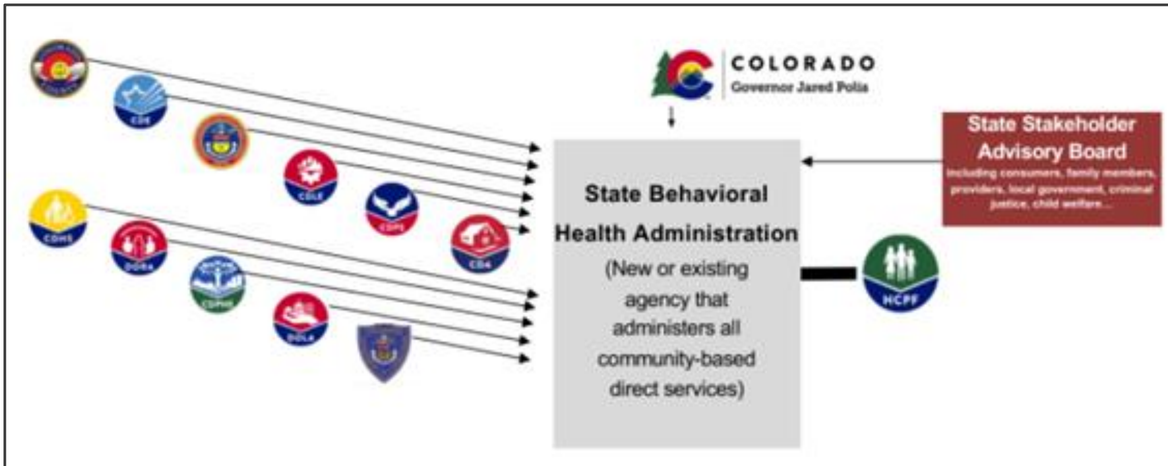
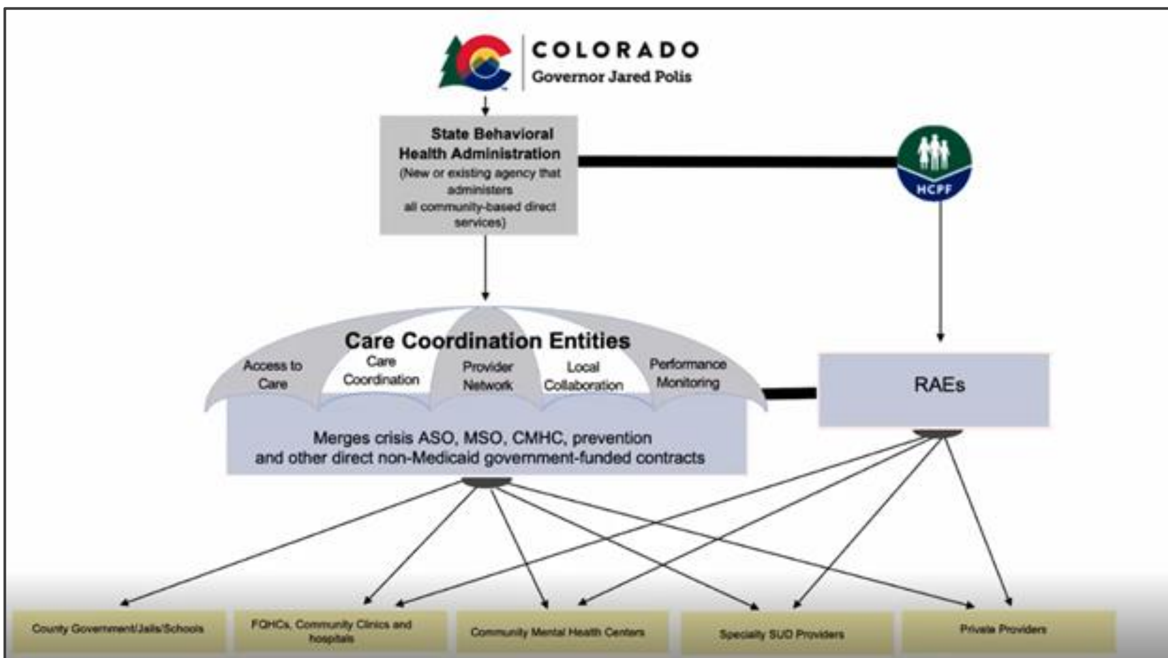
[76] Colorado Behavioral Health Task Force, Colorado Department of Human Services. (2020). July 30th 2020 meeting slides. Retrieved from: https://drive.google.com/file/d/1cG21FCDDWrf7APsjlnhFWsul9kQS8pdC/view.
[77] Colorado Behavioral Health Task Force, Colorado Department of Human Services. (2020). August 27th 2020 meeting slides. Retrieved from: https://drive.google.com/file/d/1VwAkEqCpzgmQya8v3evRqGWsWNOeZjUE/view.
[78] Colorado Behavioral Health Task Force, Colorado Department of Human Services. (2020). August 14th 2020 meeting slides. Retrieved from: https://drive.google.com/file/d/1jbnP3xLbzT96PRaK9yHmvRLeAPR8_9th/view.

Figure 15: Proposed state-level behavioral health system



Source: Colorado Behavioral Health Task Force, 2020

Figure 16: Proposed care coordination entities system



Source: Colorado Behavioral Health Task Force, 2020