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State Opioid Response Grant: 2022 – 2023 Annual Report

Peer Recovery Coach Program

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Contents

HIGHLIGHTS

The Substance Abuse and Mental Health Services Administration (SAMHSA) first awarded the State Opioid Response (SOR) grant to the Colorado Department of Human Services, Office of Behavioral Health (OBH) in 2018. This grant was renewed in 2020 and 2022. The department shifted to become the Behavioral Health Administration (BHA) in 2021. As part of this discretionary grant, funding was provided for positions across the state for professional peers to support individuals with substance use disorders (SUD) as they access treatment. Peers (also known as peer navigators, peer recovery coaches, and peer support specialists) are persons with lived experience with SUD who provide referrals to a variety of services including medication for opioid use disorder (MOUD) and other treatment and recovery support, as well as to services and resources that support the whole person, such as housing, employment, transportation, and more. Based on evaluation data, including referral tracking and interviews with peers, their supervisors, and grant staff, this report details how peers support clients with SUD and describes successes and opportunities to improve the program.

SUCCESSES OF PEER PROGRAM	CHALLENGES & OPPORTUNITIES FOR PROGRAMMATIC IMPROVEMENT
❖ Peers were effective at connecting clients to treatment resources. Data collected between October 2022 – September 2023 shows: • Peers gave 730 referrals to medication for opioid use disorder treatment. • Peers also gave 4,615 referrals to other treatment and recovery resources and 1,574 referrals to support groups. ❖ Peers conducted 32 naloxone trainings, distributed 809 naloxone kits, conducted 16 trainings on fentanyl test strips, and distributed 826 test strips (since tracking began on May 1, 2023).	❖ Many peers struggled with low compensation including pay, benefits, and access to training. ❖ Interviewees widely wanted more peers staffed across the state and public directories of certified peers. ❖ Peers reported sometimes encountering stigma related to their lived experience with community resources and even staff at their organizations. ❖ Many peer supervisors wanted more guidance on how to support peers, including training, written materials, and opportunities to connect with grant staff.

BACKGROUND

The Substance Abuse and Mental Health Services Administration (SAMHSA)[1] first awarded the State Opioid Response (SOR) grant to the Colorado Department of Human Services, Office of Behavioral Health (OBH) in 2018. This grant was renewed in 2020 and 2022. The department shifted to become the Behavioral Health Administration (BHA) in 2021. As part of this grant, funding was provided for positions across the state for professional peers to support individuals with substance use disorders and a statewide peer supervisor to provide support and training to these peers. Peers, also known as peer navigators, peer recovery coaches, and peer support specialists, are persons with lived experience who provide referrals to a variety of services including medication for opioid use disorder (MOUD) and other treatment and recovery supports, as well as to services and resources that support the whole person such as housing, employment, transportation, and more. Based on their lived experience with SUD, peers also provide an array of socio-emotional support to an individual seeking recovery.

PURPOSE OF EVALUATION

BHA contracted with The Evaluation Center (TEC), University of Colorado Denver, to conduct an evaluation of SOR funded programs including the peer program. The evaluation was primarily intended to be utilization-focused and formative in nature. The focus of the program evaluation was to:

- Assess the role of peers and understand how their role is integrated into their communities and statewide opioid response efforts,
- Learn how to best support a peer workforce (e.g., supervision, compensation), and
- Understand their impact and reach in referring clients to appropriate treatment and recovery services.

As part of this evaluation, 20 interviews were conducted during the fifth year of the program. An online tracking tool was developed to support data collection and assessment of the impact and reach of peers. This tool has been updated throughout the five years of the peer program to fulfill the reporting requirements of the grant, as well as to address the evolving work of peers. Detailed information on data collection and analysis methods is included in Appendix A.

TYPES OF PEERS FUNDED THROUGH SOR

Under this grant, several different types of peers were funded, each with different contexts to their work.

COMMUNITY-BASED PEERS

The community-based peers were housed within treatment organizations across the state. Their role allowed them to provide referrals to not only their treatment center but to any treatment or community

[1] See Appendix B for acronym definitions.

resource most appropriate or accessible to a client. Additionally, these peers provided an array of other types of referrals and services to support an individual seeking recovery.

CRIMINAL JUSTICE PEERS

The criminal justice peers were housed within treatment organizations or community organizations that had a working relationship with individuals re-entering their communities after being incarcerated. These peers were frequently integrated with or worked closely with the Work & Gain Education & Employment Skills (WAGEES) program. Like the community-based peers, these peers also connected clients to a variety of treatment and community resources needed by an individual in recovery.

PEERS AT ROCKY MOUNTAIN CRISIS PARTNERS

In addition to the community-based and the criminal justice peers, the SOR grant supports three positions at Rocky Mountain Crisis Partners (RMCP). RMCP operates the state crisis line in Colorado and provides a variety of crisis intervention, support, and referral services to Coloradans free of charge.

One of the SOR funded positions is an Opioid Response Coordinator, who oversees the RMCP opioid follow-up program. For callers who are identified as using opioids, the program offers a month of follow-up call support to discuss and explore treatment resources, to set goals around substance use, and to provide social support. Individuals in the other two SOR funded positions provide the telephone follow-up services and help take in-coming calls related to substance use. In 2020 this service was also extended to callers who are identified as using stimulants.

KEY FINDINGS

IMPLEMENTING A SUCCESSFUL PEER PROGRAM

HOW PEERS WORK WITH CLIENTS AND COMMUNITY AGENCIES

Peers play a vital role in their community by supporting individuals who are struggling with substance use disorders. These peers, often in recovery themselves, offer a unique blend of empathy, understanding, and guidance based on their lived experience that professional counselors may not always provide. They act as relatable role models, offering hope and demonstrating that recovery is possible. Peers provide one-on-one support, helping individuals set and achieve their recovery goals, navigate treatment options, and access community resources. They also serve as a source of emotional support, providing a listening ear during difficult moments and fostering a sense of belonging. By sharing their lived experiences and providing ongoing encouragement, peers empower their clients to build resilience, maintain sobriety, and lead healthier, more fulfilling lives, contributing positively to the overall well-being of the community. One peer supervisor said, "Peers are an essential part of the recovery process."

Peers have a unique, non-clinical role. Their professional code of ethics[2],[3]allows them to develop a supportive relationship with a client in which they can provide unique perspectives, share their lived experiences, and support individuals through their own path to recovery. Peers' support include a variety of activities including running support groups, attending court dates with clients, providing information on treatment modalities, creating awareness and helping destigmatize recovery services through community outreach, conducting and supporting harm reduction activities, and helping connect clients to community resources that can provide further stability as the client is seeking recovery from substance use disorder. One peer described how they researched resources in the community as well as connecting with clients, "The first thing I did was get connected with the resources in my area, the teen houses, the sober houses, the halfway houses, different businesses, and the day shelters. Then after that I got established by going to parks, visiting these day shelters that I already had connections with and just talking to people on their level and meeting them where they're at."

Consistent with previous evaluation findings, peers and their supervisors suggested that a statewide directory or database of peers (any certified peer, not just SOR-funded peers) would be a useful resource for many treatment providers and for individuals seeking help. Elements that would be helpful to include in a database or directory would be:

- Peer name and contact information
- Geographic location
- Focus (e.g., mental health, SUD, OUD)

[2] Advocates for Recovery Colorado. (August, 2019) Colorado Peer Navigator Training.

[3] Substance Abuse and Mental Health Services Administration. (2015, December). Core Competencies for Peer Workers in Behavioral Health Services. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

- Descriptors of lived experience (e.g., experience in prison, experience with child protective services)

Pueblo County has already developed a peer database resource,[4] which was cited by those working in Pueblo as exceptionally helpful in supporting clients.

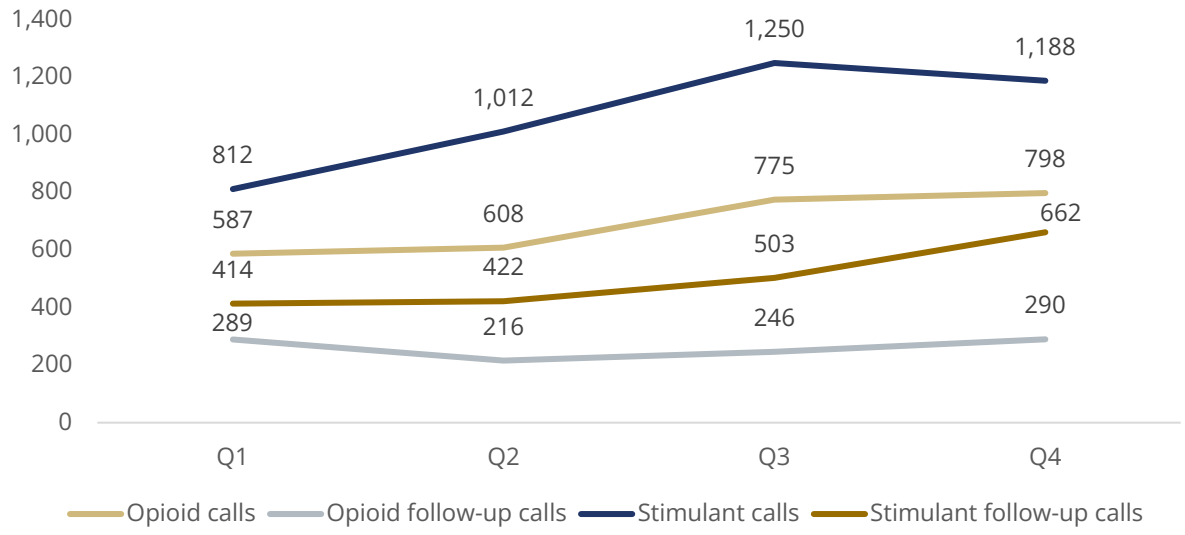
IMPACT AND REACH OF PEERS

Rocky Mountain Crisis Partner Peer Impact and Reach

Consistently, the peers staffed at RMCP received more calls from individuals identified as using stimulants compared to those using opioids. Exhibit 1 details the number of calls received at RMCP by quarter as well as how many follow-up calls were placed to provide ongoing support to individuals with SUD.

Between October 2022 – September 2023, RMCP received 2,768 incoming calls from individuals who identified as using opioids and conducted 1,041 follow-up calls to support these individuals. During this same period, RMCP received 4,262 incoming calls from individuals who identified as using stimulants and conducted 2,001 follow-up calls to support these individuals.

Exhibit 1. Calls and follow-up calls to RMCP by quarter year five



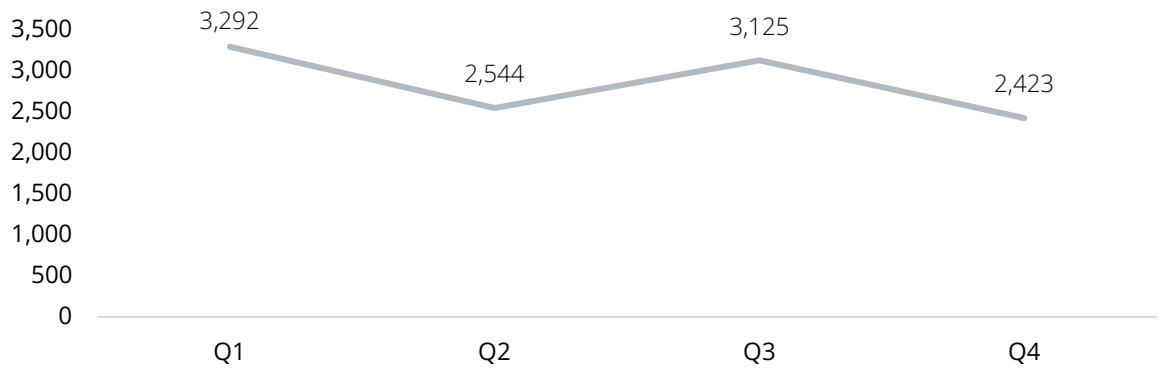
Community-Based and Criminal Justice Peer Impact and Reach

During the fifth year of the SOR-funded peer program, peers that submitted data through the peer tracking tool reported having 11,384 client contacts.[5] Exhibit 2 details the client contacts that peers reported during each quarter.

[4] https://county.pueblo.org/public-health-department/peer-support-database

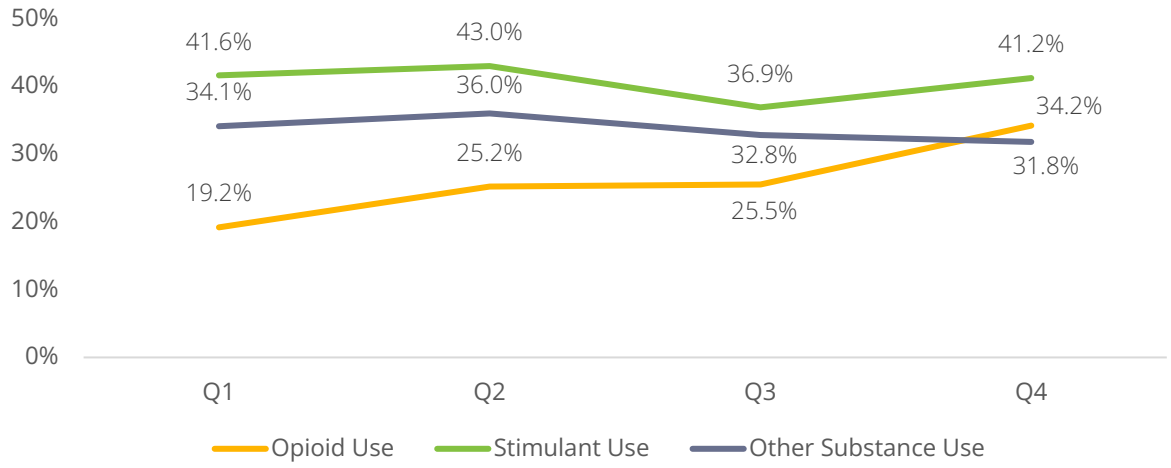
[5] "Client contacts" refers to the number of instances a peer connects with clients. Since clients likely are contacted multiple times, this number describes overall case-load and not unique persons.

Exhibit 2. Reported client contacts by quarter[6] in year five



Similar to the RMCP peers, the community-based and criminal justice peers reported more clients were struggling with stimulant use compared to other substances. Exhibit 3 details peers' clients' substance use type by quarter. In their reports, peers were able to select the substance(s) identified by their clients - specifically, opioid, stimulant, and/or other substance use. Peers were able to select multiple substances and thus percentages equal more than 100%.

Exhibit 3. Reported client substance use by quarter year five*



*Q1 and Q3 do not add up to 100% due to missing data

During the fifth year of the program, peers provided over 33,000 referrals and services for 11,384 client records. This represents a program average of just over 60 referrals to MAT/MOUD per month and over 2,750 total referrals or services provided each month between October 2022 - September 2023. Exhibit 4 outlines the frequency of all service and referral types provided by peers as reported in the online data collection and tracking tool. During their work supporting a client, peers frequently reported providing more than one type of referral to a client. This detailed look into peer referral data can

[6] Quarters follow program year. Quarter 1 includes October – December. Quarter 2 includes January – March. Quarter 3 includes April – June. Quarter 4 includes July – September.

provide insights to the types of supports Coloradans suffering with SUD need in addition to treatment and recovery resources. Exhibit 5 details the top five most frequent referrals or services provided by peers.

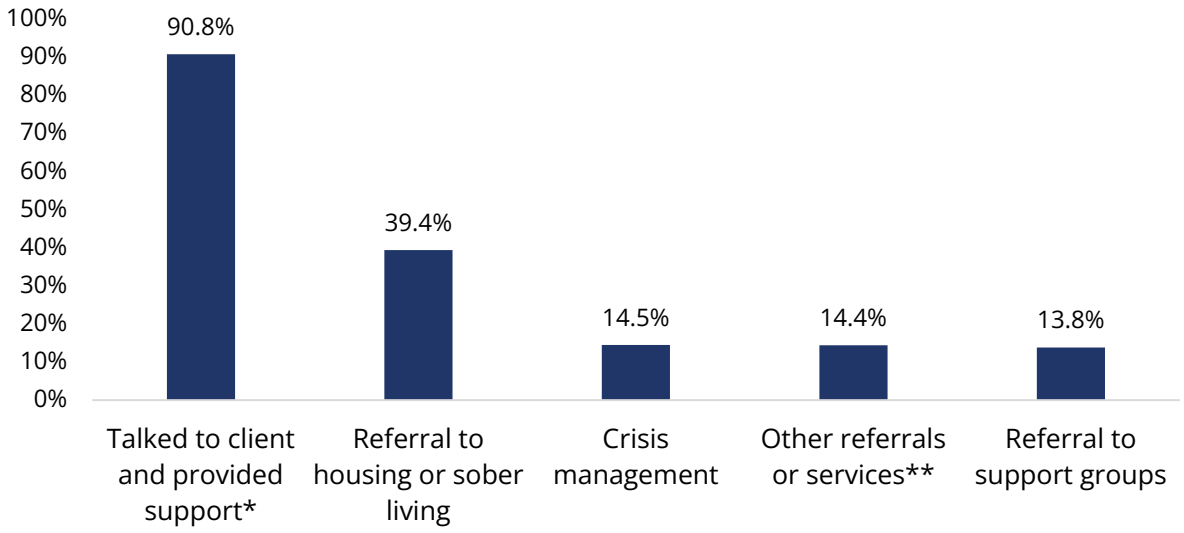
Exhibit 4. Type of referrals and services provided by peers during year five*

TYPE OF REFERRAL OR SERVICE PROVIDED	n	*Percent of client interactions*
Referral to MAT/MOUD	730	6.4%
Referral to inpatient treatment and recovery services	632	5.6%
Referral to outpatient treatment and recovery services	1,466	12.9%
Referral to withdrawal management	1,068	9.4%
Referral to other treatment and recovery services	1,449	12.7%
Referral to housing or sober living	4,487	39.4%
Referral to food/nutrition resources	517	4.5%
Referral to employment	517	4.5%
Referral to legal services	289	2.5%
Support with going to court, meeting with probation/parole, or support with legal processes	558	4.9%
Referral to education	237	2.1%
Provided client with transportation or referred to transportation resources	694	6.1%
Talked to client and provided support	10,335	90.8%
Discussed naloxone	1,494	13.1%
Gave client naloxone	991	8.7%
Discussed fentanyl test strips (Added May 1, 2023)	204	1.8%
Gave client fentanyl test strips (Added May 1, 2023)	418	3.7%

TYPE OF REFERRAL OR SERVICE PROVIDED	n	*Percent of client interactions*
Crisis management	1,653	14.5%
Referral to primary care or other medical resources	313	2.7%
Referral to support groups	1,574	13.8%
Referral to harm reduction resources	916	8.0%
Referral to financial resources	517	4.5%
Referral to child care resources	32	0.3%
Helped client get identification or other needed documents	151	1.3%
Helped client get a phone	124	1.1%
Other referrals or services	1,635	14.4%
Total referrals or services provided	33,001	-

*Most client interactions resulted in more than one service or referral provided, therefore percentages equal more than 100%.

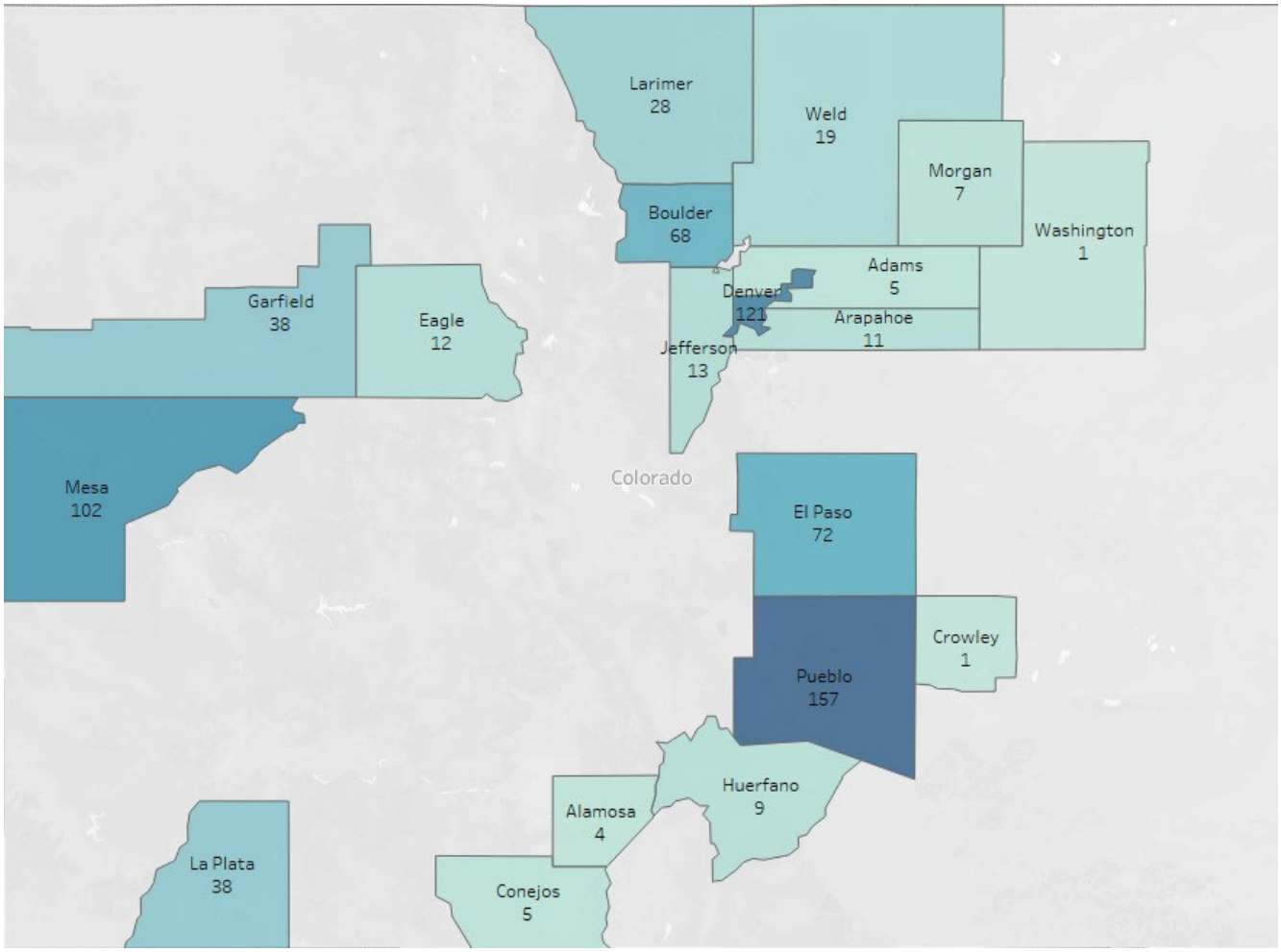
Exhibit 5. Most frequent referrals and services provided



*"Talked to client" was an option peers could select when they felt that they had spent significant effort providing socioemotional support enough to count as a service provided.
**"Other referrals or services" was a category in the online data collection and tracking tool designed to capture services provided that did not fall into the 25 categories specifically named in the tool. Peers had the option of including additional details in an open text box.

To better understand where peers worked and where there was additional need, geographic location was summarized. Peers were able to indicate where they interacted with clients on the tracking tool. Exhibit 6 shows the MAT/MOUD referrals logged by peers by county. While the areas of the state served by peers show large numbers of individuals getting connected to MAT/MOUD, there were significant areas of the state that did not receive peer program services. Expanding the peer program to additional counties across the state should be considered by BHA and their Managed Service Organizations (MSO) partners.

Exhibit 6. Referrals to MAT/MOUD by peers (October 2022 – September 2023)*



*The City of Aurora spans three counties. Five client records marked as Aurora mapped in Arapahoe County. Eighteen client records had no associated location.

Beginning May 1, 2023, peers were asked to report when they discussed or disbursed fentanyl test strips with clients as a service. Additionally, peers were able to specify how many naloxone kits they distributed directly to clients. Previous months only asked peers to identify when they distributed naloxone and did not request a count of how many kits were given out. This addition to their monthly report also asked about trainings they conducted for the public about naloxone and fentanyl test strips and harm reduction supplies given out during these trainings.

Since May 1st, peers reported giving 554 naloxone kits directly to clients. Additionally, during that same time, peers conducted 32 naloxone trainings and distributed 255 naloxone kits in those trainings. Peers also reported distributing 567 fentanyl test strips directly to clients and gave out 259 test strips during 16 public trainings on fentanyl testing.

SUPPORTING PEERS

Consistent Training and Onboarding

Similar to prior evaluation findings, intentional onboarding and training surfaced as a fundamental need to the success of peers. Quality training for peer recovery coaches is essential to ensure that they can provide effective and safe support to individuals in recovery. Such training equips them with the knowledge and skills needed to navigate the complexities of substance use disorders, mental health issues, establish ethical boundaries, and develop the skills to fully support clients in need.

As part of the SOR funding, the peer manager conducts regular trainings that are available to any current or prospective peer in the state at no cost to participants. During the fifth year of the SOR peer program, the peer manager held a total of eleven training sessions for 247 participants. Exhibit 7 details the trainings conducted by the peer manager during the grant year.

Exhibit 7. Trainings conducted by the SOR peer manager during the grant year

TYPE OF TRAINING	TIMES CONDUCTED	PEOPLE TRAINED	CREDIT HOURS
Harm reduction & fentanyl test strip training	3	125	0
Recovery Coach Academy	3	38	30
Ethical Considerations for Recovery Coaches	3	58	16
Suicide prevention for non-clinical workers	2	26	6

Quality Supervision and Support

Quality supervision and support for peers surfaced continually as a theme during interviews. Quality supervision is important for peers as it enhances their effectiveness and ensures the highest standards of care for individuals in recovery. Supervision provides a structure for ongoing learning, skill development, and professional growth and helps coaches stay up to date with best practices in the field. It also offers a space for reflection and processing the emotional challenges that can arise in this role, reducing burnout and compassion fatigue. Moreover, quality supervision helps maintain ethical boundaries and accountability, ultimately leading to better outcomes for those in recovery and the overall success of peer recovery programs.

Interviewees from several organizations described developing wrap around supervision for peers, where they had multiple individuals specifically to support them in their professional role. These peer supervisors valued having peers in their setting and noted the unique way they were able to support

clients. Peers of these supervisors reported feeling well supported and able to work through challenging situations with clients. Some SOR-funded peers worked closely with their local supervisors, while others had little interaction. For peers that reported not having a quality relationship with their supervisor, those supervisors were consistently the supervisors that did not respond to participate in evaluation interviews.

Consistent with previous evaluation findings, some peers reported that their position was not respected within their organization and that they encountered stigma from other clinical colleagues based on their lived experience with substance use and their level of education. One peer described, "It's been challenging to have people listen to me, even though I am out in the community, I have lived that life before. I see what people need, but because I don't have those credentials, it would just be passed on sometimes. … That to me is the most important thing, is to understand what peers do and to put your trust in them because they're not stupid. They have been there, and they've climbed out of that place, and that's pretty powerful." Interviewees said it was important to ensure that SOR-funded peers are hired in agencies that have committed supervisors who can integrate peers into teams in a way that values peer contribution and voice in a client's care. Several interviewees suggested that to foster a supportive culture for peers, peers should be welcomed into staff and clinician meetings and have a voice in programmatic decisions and discussions on client care.

Pay, Benefits, and Professional Development

Consistent with previous evaluation findings, many peer supervisors and peers were concerned with the level of financial compensation for peers, which varied widely across the state. Under the contracting structure in place during the multiple SOR grants, the MSOs allowed agencies employing peers to determine their pay rate and benefits up to the allotted amount set in the grant. As a result, some peers were compensated with a competitive wage and benefits, while others made minimum wage or just above minimum wage. Several interviewees in various roles reported they were concerned that instances of low pay contributed to high turnover rates, burnout, low professional respect, or peers needing to take on multiple jobs to support themselves.

The ethics of a grant-funded peer program paying some of its participants below the living wage in the state of Colorado [7]raises concerns about standards and social responsibility. While grant funding often comes with limitations and restrictions, it is essential to prioritize the well-being of the program's peers. Paying a wage that does not meet the cost of living in the state can lead to financial hardship and undermine the program's goals. Ensuring fair compensation for peers is not only a matter of ethical responsibility but also essential for social equity and the success of the program. A living wage not only recognizes the value of the work performed by peers but also supports their ability to fully participate and make a meaningful impact within the program, thus aligning with broader ethical principles of social justice and equity. One peer described the challenges of working a full-time position under the SOR grant, while also needing to have another job to cover basic expenses, "I can't live on what I get paid right now, so I have a second job. … I'm trying to move ahead in every way that I know how, but there's

[7] $19.22 per hour for the state and at least $20.25 for Denver County is the living wage. https://livingwage.mit.edu/

no raise in the future. There's nothing coming down the pipe, so I have to use other options and other ways to get to a sustainable lifestyle."

Another peer reported, "I only take home $900 a month, and I have to stretch that every paycheck. That is nothing."

In addition to many peers feeling pressure from low wages, several reported that their organizations would not supply them with basic items that other employees would receive, such as business cards or ID badges. These peers reported that they were told they would have to pay for their own business cards for their professional position, citing high turnover.

There was a large discrepancy in the degree to which peers were allowed to or supported in taking trainings as professional development for their role. Some supervisors expressed that they encouraged their peers to take any trainings that would advance their work, and those peers described how beneficial it was to be able to take ongoing trainings that were financially supported either through SOR grant funds or through their organization. Other peers reported that they were not permitted to take trainings that would occur during their working hours and that they would need to personally pay for any training.

Peers also discussed variation in how they were supported through their benefits. Comprehensive benefits are essential for peer recovery coaches, especially in a role that can be triggering due to its proximity to addiction, mental health challenges, and deaths of clients due to substance use overdose. Peers often work closely with individuals in early recovery, which can be emotionally taxing for the peers' own recovery. Comprehensive benefits, including mental health support and access to counseling (such as employee assistance programs), healthcare coverage, protected time off, and quality supervision can provide essential safeguards to help peer recovery coaches maintain their own well-being and resilience in the face of difficult situations.

Contracting structures between BHA and the MSOs allows for many benefits in implementing tailored health initiatives across the state. Therefore, there is the opportunity as well as an imperative for BHA to coordinate with the MSOs to ensure minimum supports are available for peers including pay/benefits, level and type of supervision, and professional development.

CHALLENGES AND OPPORTUNITIES TO IMPROVE

Consistency in Understanding the Peer Role

Organizations have incorporated peers in varying ways to align with their specific models and goals with minimal requirements or guidance from their MSOs or BHA. Some treatment centers integrate peers as part of a multidisciplinary team, enhancing the support network available to clients. Others engage peers in aftercare and relapse prevention programs, extending the continuum of care beyond the initial treatment phase. In some cases, organizations have embedded peers in outreach efforts and harm reduction initiatives to connect with individuals in crisis.

While this flexibility worked well for some organizations and peers, other peers and their agencies expressed wanting more guidance on ways they could operate their program, structure the role of peers, and align activities with BHA and SOR aims. Concerns were expressed by supervisors of peers that they were not implementing the peer program in the manner supported by the grant. These individuals were unsure to what extent they should design the program to fit their local contexts or instead to fit the program to a particular model for the state, particularly in order to maintain grant-funded support.

Supervisors at treatment organizations not fully understanding the roles and responsibilities of grant-funded peer recovery coaches can be a significant obstacle to the effective functioning of such programs. When supervisors lack a comprehensive understanding of these roles, it can lead to misaligned expectations, inadequate training, and a potential mismatch between the skills and goals of the peer coaches. Some local supervisors expressed that their SOR funded peers should only be supporting and interacting with clients already enrolled in treatment at their specific agency, while most SOR peers were doing outreach in the community to help enroll individuals not engaged in treatment.

To ensure the success of these programs, it is essential for supervisors to understand the unique strengths and contributions that peer recovery coaches bring to the table, which can empower individuals on their journey to recovery. This understanding is not only vital for the peers' effectiveness but also for the overall quality and impact of the treatment organization's services. Common understandings could be developed through more networking opportunities for supervisors required trainings to supervise SOR peers, manuals, or regular calls with BHA and the grant peer manager.

Challenges with Peers' Lived Experience

One significant challenge in the field of peer recovery coaching is that many individuals who are well-qualified for the role may have criminal backgrounds linked to their own experiences with substance use. These backgrounds can create administrative barriers that restrict their ability to enter various spaces and provide much-needed support to those struggling with addiction. This presents a dual challenge, as it not only limits the opportunities for highly empathetic and relatable individuals to help those in need but also perpetuates the stigma and exclusion that people in recovery often face. While this challenge has improved since the first SOR grant, it is still a limiting element to the success of the program recognized by many agencies participating in the peer program. One peer supervisor described, "When you have somebody that's new and you have their lived experience as a strong plus in their life, part of that lived experience is also a barrier for them getting into the systems they need to do their work."

Staffing and Resources

Peers and supervisors widely cited limited peer staffing and limited recovery resources as continued challenges to effectively supporting their communities. Consistent with previous evaluation findings, peers and their supervisors who worked in rural parts of the state consistently expressed the need for more peer coverage in their geographic areas, particularly southern and western Colorado. In some parts of the state, peers were assigned upwards of 15 rural Colorado counties[8] to support, a task that

[8] See Appendix C for peer staffing goals under SOR.

was viewed as impossible to fulfill. Peers in rural areas of the state reported they sometimes spent multiple hours driving to different locations while what was most needed was a local individual who would foster better connections with the community. Additionally, peers in rural parts of the state were frequently only allotted part time hours, further challenging their ability to support their catchment area.

While the program has been structured on paper to provide peer coverage to every Colorado county, in practice, as evidenced by data collected from peers (see Exhibit 6), many counties did not have coverage by SOR-funded peers. One interviewee described, "That's also an issue with the peer workforce development. They're just adding resources where there's already stuff going on. They are funding agencies that already have a list of people waiting for them versus hitting a spot where there's less resources. This new peer workforce collaborative - they have a new statewide task force of 12 people, but when they did the announcement on that list, only four of those folks came from rural parts of the state who weren't on the I-25 corridor."

BHA should consider funding additional peer positions in rural parts of the state to better support the development of a statewide peer infrastructure. BHA should also consider establishing standards related to the geographic area peers are expected to cover in their grant role.

One supervisor specifically wanted to see more peers staffed in hospital emergency departments to help identify and support individuals who are experiencing substance use disorder and relying on emergency departments for care. This model has been tried in the state by other funding agencies with success in reducing recidivism as well as connecting patients to community supports.[9]

The other resource-related challenge felt acutely by peers and their supervisors was the extended wait time to connect clients to treatment. Peers described the frequent challenge of working with someone who is ready to go to treatment, only to find that all treatment resources available might have days or weeks until they are able to see the client. Getting someone into substance use treatment as soon as they are ready is of paramount importance for several reasons. First and foremost, the window of opportunity when someone is motivated to seek help can be fleeting. Delaying their entry into treatment by even a few days can lead to changes in their mindset, increased doubts, and possibly a return to drug or alcohol use, making it harder to re-engage them in the treatment process. One peer described, "That's our biggest challenge is finding placement. You're intoxicated. You're about to be kicked out of your place. You want help but get told to sit around for six months while we wait for something to open up. It doesn't work like that."

[9] The Evaluation Center, University of Colorado Denver (2021). *Emergency Department Recovery Support Specialist Pilot Program Phase II Report*. Technical report submitted to the Colorado Consortium for Prescription Drug Abuse Prevention. https://srchope.org/wp-content/uploads/2021/12/FINAL_EDRSS-Phase-II-Report-1.pdf

Building Collaborative Networks

The contracting structure between BHA, MSOs, and individual agencies under SOR helped to streamline many processes to implement programs across the state in ways that are tailored to the unique needs of different communities. However, interviewees reported some on-going confusion within the peer program about how to access information to address needs or questions and where certain programmatic decision points lie. This challenge has remained consistent since the beginning of the peer program under SOR.

While peers benefited from having a connection to the grant via the statewide peer manager position, many supervisors in treatment agencies and community organizations around the state expressed wanting a comparable connection. These interviewees felt detached and unsure of what was needed or expected related to the grant or supervision of peers, as these positions often varied from other professional peer positions in the same locations. Most of these supervisors wanted more communication and connection to BHA staff to ask questions, troubleshoot ideas, and to be more aware of what other individuals working with the grant were doing.

While peers had some familiarity with other resources and programs available through the SOR grant, many supervisors were not aware of other SOR programs and resources. BHA should consider implementing more training, professional networking, and opportunities for peer supervisors to ensure that effective messaging is provided about what exists through the same or similar funding streams. This would help supervisors to support peers and their agencies and leverage SOR programs to create a more efficient pipeline to support a wide array of individuals at multiple steps in their treatment and recovery journey.

RECOMMENDATIONS

The following recommendations are informed by the qualitative and quantitative data collected during the fifth-year evaluation of the peer program under SOR. The recommendations below are designed to inform programming and should be considered in alignment with other statewide behavioral health initiatives.

- BHA should coordinate with MSOs to establish minimum expectations for peer compensation, including pay, benefits, professional development available, and degree of supervision provided. Compensation for SOR-funded peers should be at or above a living wage and should meet or surpass the average wage for peers employed by other grants or funding pools. BHA should work with MSOs to ensure that SOR-funded peers are placed in organizations that are able to fully support these individuals as professional peers, including providing the same professional materials, such as business cards and ID badges, that are available to other staff.
- BHA should establish strategies to improve communication, training, and networking to support peer supervisors, similar to what is in place for the professional peers. These strategies should include minimum expectations for peer supervision, the type of work expected of peers, what resources are available under the SOR grant, and opportunities for peer supervisors to ask questions and network with each other and grant staff.
- BHA should consider funding additional peer positions in rural parts of the state to better support the development of a statewide peer infrastructure and to increase the reach and impact of the program. This would include areas not along the Front Range. BHA should also consider establishing standards related to how many counties or how much geographic area peers are expected to cover in their grant role.
- BHA should consider the development of a decentralized directory/database of all certified peers in the state along with what supports they provide. BHA could also consider supporting more professional networking events for peers, such as conferences.

APPENDIX A: METHODS

BACKGROUND

Evaluators began the evaluation of the peer program under the first SOR grant by conducting a literature review and facilitating the development of a logic model and an evaluation plan in collaboration with leaders at BHA. The purpose of the evaluation was 1) to document the reach and impact of the peer program, 2) to better understand the role of the peer, and 3) to identify needed support for both individuals and the program across the state. The evaluation was guided by the RE-AIM Framework[10] which is used in the public health field to provide a comprehensive approach to planning, implementing, and evaluating the effectiveness of public health programs. It is a useful model when working with program planners to inform the development and implementation of interventions. The framework contains five primary steps (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and asks several basic questions:

1. REACH: What are the characteristics of the intended program and how successful is the program at reaching this population?

2. EFFECTIVENESS: What is the primary outcome(s) of the program and how effective is the program at affecting those outcomes?

3. ADOPTION: What are the characteristics of the setting in which the program is being implemented and what effect does the setting have on program implementation? What are the characteristics of the staff and what impact do these characteristics have on program implementation?

4. IMPLEMENTATION: What adaptations have been made during implementation?

5. MAINTENANCE: How has the program been integrated into the organization and/or the local community?

Most notably, under adoption and implementation, the RE-AIM framework allows for a rich, contextual exploration of programs, the environment in which they run, and the communities that they are connected to. While the scope of the peer evaluation was set to the duration of the SOR grant, the RE-AIM framework provided a road map for long-term evaluation.

Under the second SOR grant, the evaluation was condensed to monitoring referrals only. The evaluation was expanded again under the third (and current) SOR grant.

DATA COLLECTION

Interviews

Evaluators conducted a total of 20 interviews during the fifth year of SOR with peers, local peer supervisors, and the peer manager of the grant. Interviews were conducted by telephone or

[10] Belza, B., Toobert, D., Glasgow, R. (2005). *RE-AIM for Program Planning: Overview and Applications*. Center for Health Aging and National Council on Aging.

videoconference. Each lasted between approximately 25 to 90 minutes. With permission, all interviews were audio recorded and professionally transcribed.

Document Review

Throughout the period of the evaluation, evaluators reviewed a variety of documents including contracts, data collection forms, and professional review forms to better understand the language being disseminated about the peer program and reporting requirements. Additionally, evaluators reviewed the IC&RC peer certification materials and attended a peer certification training to understand the professional requirements.

Referral Activity and Tracking

Evaluators developed and piloted a secure online data collection and tracking tool through the University of Colorado's REDCap system. This instrument was designed to be installed on peers' work cell phones as a way for them to capture the location and types of referrals or services they provided. This data collection system allowed evaluators to produce maps of where peers made contacts and referrals by region. The pilot of this tool ran from August 14 - September 3, 2019. Evaluators based the metrics tracked in this tool on grant language as well as feedback from the focus group and initial key informant interviews. This tool was revised based on further feedback from BHA and grant leadership and relaunched in October 2019. This version of the tool did not automatically track location, and instead allowed Peers to input location and was accessible through a smartphone or a computer. Peers have used this tool since then, and evaluators have made updates to the tool at each new SOR grant renewal to fit the grant tracking needs as well as the evolving work of peers. Evaluators offered in-person, telephone, and email technical assistance to peers throughout the course of the grant as needed.

The RMCP peer data were tracked internally in RMCP software and shared with TEC on a quarterly basis.

DATA ANALYSIS

Evaluators analyzed all qualitative data using NVivo14 (QRS- International). Both inductive and deductive coding was completed to allow for assessment of set concepts while identifying emergent themes.

Peer referral and activity data was analyzed monthly for peers, and quarterly for the entire peer program. Mapping was done quarterly using Tableau software.

APPENDIX B: ACRONYMS

Acronym	Meaning
BHA	Behavioral Health Administration
MAT/MOUD	Medication-assisted treatment / Medication for opioid use disorder
MSO	Managed Service Organization
OUD	Opioid use disorder
RMCP	Rocky Mountain Crisis Partners
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response grant
SSPA	Sub state planning areas
SUD	Substance use disorder
TEC	The Evaluation Center
WAGEES	Work & Gain Education & Employment Skills program

APPENDIX C: PEER EMPLOYMENT UNDER SOR

The following table details peer employment goals during SOR. It indicates which agencies were selected by MSOs within each region to support the peer program and the FTE allotment for employment. Throughout the course of the grant, actual FTE filled by peers varied due to turnover.

MSO	SSPA	Counties	Agency	FTE
Signal	1	Morgan	Centennial Mental Health	0.2
Signal	1	Weld	Northern Colorado Health Alliance	0.3
Signal	1	Larimer, Weld, Logan, Sedgwick, Phillips, Morgan, Washington, Yuma, Elbert, Kit Carson, Lincoln, Cheyenne	North Range	1.0
Signal	1	Larimer	Homeward Alliance	0.5
Signal	2	Denver, Jefferson, Adams, Arapahoe	Mile High Behavioral Healthcare	1.0
Signal	2	Denver, Adams, Arapahoe	University of Colorado ARTS Program	1.0
Signal	2	Denver, Jefferson, Adams, Arapahoe	Servicios da la Raza	2.0
Signal	2	Denver Jefferson, Adams, Arapahoe	Empowerment Program	
Diversus Health	3	Lake, Park, Douglas, Chaffee, Teller, El Paso, Fremont, Custer	Diversus Health	2.0
Signal	4	Pueblo	Christlife Ministries	1.0
Signal	4	Saguache, Mineral, Rio Grande, Alamosa, Conejos, Huerfano, Costilla, Pueblo, Las Animas, Crowley, Otero, Kiowa, Bent, Baca, Prowers	Crossroads	2.0
Signal	4	Alamosa	San Luis Valley - Behavioral Health Group	1.0

West Slope Casa	5	Mesa	Mind Springs Health	1.0
West Slope Casa	5	Hinsdale, San Juan, Dolores, Montezuma, LaPlata, Archuletta	Axis Health System	1.0
West Slope Casa	6	Mesa, Delta, Montrose	Peer 180	1.0
West Slope Casa	6	Garfield, Eagle, Pitkin	Mind Springs Health	1.0
Mental Health Partners	7	Boulder	Mental Health Partners	0.5
Rocky Mountain Crisis Partners	NA	Statewide	Rocky Mountain Crisis Partners	3.0

MISSION

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