# SB202 MSO Community Action Plan

REQUEST FOR APPLICATION


SIGNAL BEHAVIORAL HEALTH NETWORK
6130 GREENWOOD PLAZA BLVD, #150, GREENWOOD VILLAGE, CO 80111

# Rural Outpatient RFA (S4-1718-RO)

## 1 Overview and Timeline

### 1.1 About Signal Behavioral Health Network

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

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

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

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

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

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

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

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

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

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

## 1.3 RFA Community Action Plan Priority Area

Rural Outpatient

## 1.4 Objective

With Medicaid expansion, there is greater access to SUD outpatient services to clients in need. However, in rural areas there are typically not enough geographically accessible clinics to reasonably meet the needs of all of the residents in Colorado. Additionally, even for remotely accessible clinics, there may not be sufficient service billing to achieve sustainability. In these cases this funding could be used to bridge the gap in funding, sustaining and expanding outpatient SUD services.

## 1.5 Location

The services outlined in this document should be located in any or all of the following Colorado counties: Crowley, Kiowa, Huerfano, Las Animas, Otero, Bent, Prowers, Baca, Saguache, Mineral, Rio Grande, Alamosa, Conejos, or Costilla

## 1.6 Submission Deadline and Instructions

Providers interested in offering this service should submit their proposal in Word format. The associated budget should use OBH's capacity budget protocol in Excel format. Proposals should be submitted via email to the below email address. Signal will acknowledge receipt of each proposal. If no acknowledgement occurs, respondents to this request for proposal should resubmit.

proposals@signalbhn.org

The deadline for submission is no later than 6/15/2017. Signal will begin considering requests for funding as soon as we have received those applications and will begin funding as soon as possible.

## 1.7 Budget

Providers should include a budget for offering this service in one or more of the locations, using the State Office of Behavioral Health (OBH) capacity budget protocol worksheet (Appendix A). Signal recognizes that this funding is only a part of the support necessary to provide the service. Additional funds are required via Medicaid, other governmental sources, client fees, grants, local hospital support, and other sources. The OBH capacity protocol provides a mechanism to capture all funding sources relative to total expenses. Signal's funding can be used to cover any shortfall that may exist. Details of the protocol are available upon request.

It is important to note that there are two forms a service expansion may take:

1) **Increase of clients serviced:** In other words, an existing program could be expanded to serve more clients.
2) **Expansion of facility:** A new or expanded facility may be required to serve more clients. Effectively, these are one-time costs associated with the expansion.

## 1.8 Term of agreement

Signal seeks provider agencies who will offer or deploy the services outlined beginning as soon as possible, with optional renewals of the contract in subsequent years. This funding is available for the State Fiscal Year of July 1, 2017 through June 30, 2018.

# 2 REQUESTED SERVICES

The objective of the utilization of these funds is to provide access to effective substance use disorder services across the state of Colorado, in the regions identified.

## 2.1 OVERVIEW OF SERVICES

Outpatient services should include: screening, assessment, intake, and if appropriate entry, into one of four levels of care within outpatient services, or if a more intensive level of care is required, arranging a warm handoff, including transportation, to the appropriate level of withdrawal management or level of residential/inpatient services. All these levels of care have been defined by the American Society for Addiction Medicine (ASAM) based on the intensity of services that correspond to multidimensional patient needs. Signal is interested in four ASAM levels of care specific to the provision of outpatient services. Care should be provided within the ASAM guidelines for these levels of care.[2] For a complete discussion and definition of these and other levels of care, it is highly recommended responding providers and their clinical staff have a command of "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions"; third edition 2013.

Signal desires provision of the following ASAM (American Society of Addiction Medicine) defined levels of outpatient care listed below, with ASAM short definitions [1]:

- *Early Intervention* (Level 0.5), "Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder"
- *Outpatient Services* (Level 1), "Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies"
- *Intensive Outpatient Services* (Level 2.1), "9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability"
- *Partial Hospitalization Services* (Level 2.5), "20 or more hours of service/week for multidimensional instability not requiring 24-hour care"[2]

## 2.2 KEY ELEMENTS

Provide screening, assessment, ASAM early intervention, outpatient, intensive outpatient, and if feasible, partial hospitalization services (Levels 0.5, 1, 2.1, 2.5).

### 2.2.1 Duration of stay

Outpatient treatment varies in terms of dose, duration, intensity, and restrictiveness depending upon the unique needs, function, and progress of the individual. There should be no fixed length of stay, or program duration. Services may be focused on "habilitation" or "rehabilitation". Length of stay shall be determined by ASAM best practices (see, Care Management in Required Best Practices section).

### 2.2.2 Use of Evidence-based Practices

The content of outpatient treatment should employ known evidenced-based practices; in particular, those published by National Quality Forum (NQF)[5,6,7], Substance Abuse and Mental Health Services Administration (SAMHSA)[3,4,8,11,12,13], National Institute on Alcohol Abuse and Alcoholism (NIAAA)[10], and National Institute on Drug Abuse (NIDA)[9]. Use of evidence-based and best practices is required. The provider should demonstrate a mechanism for ensuring fidelity to the specific evidence-based practice models employed.

### 2.2.3 Involuntary Commitment

It is required that entities operating outpatient treatment provide services related to Involuntary Commitment (IC) of individuals afflicted with substance use conditions, as is as defined for both alcohol related IC (C.R.S. §27-81-112) and drug related IC (C.R.S. §27-82-108). Compliance with the "Involuntary Commitment Manual" published by Office of Behavioral Health (OBH), a guide and resource for OBH licensed addiction treatment providers that are involved in the care and dispositioning of clients that require Involuntary Commitment (IC) to addiction treatment, is required. This manual covers both Emergency Commitment and Involuntary Commitment procedures and relies heavily on statutory guidance. A primary function of residential treatment units is to stabilize individuals under involuntary commitment to a point where a less restrictive outpatient level of care is appropriate to provide the balance of needed treatment. It is essential outpatient service providers coordinate with residential treatment providers to enable a smooth and rapid transition to outpatient services for those under involuntary commitment.

### 2.2.4 Care Requirements

Patients currently receiving FDA approved medication for substance use disorder treatment will be admitted to all outpatient treatment facilities. Admission will not be denied, nor will medication be discontinued as a routine condition admission. This applies to all FDA approved medications for treatment of substance use disorders. Providers shall explicitly and intentionally provide assessment for appropriate medication which can be initiated and maintained for appropriate duration during, and after, active outpatient services. It is essential existing prescribed medications be maintained in collaboration and coordination with the prescribing medical provider. Substance use disorder treatment medications which will be continued in an outpatient environment should, if possible, be initiated while individuals are still in residential treatment units. Transportation shall be part of the services provided/arranged. The TIP 45 consensus panel noted, "although it is the philosophy of some … treatment facilities to discontinue all medications, this course of action is not always in the best interest of the patient. Abrupt cessation of psychotherapeutic medications may cause severe withdrawal symptoms or the reemergence of a psychiatric disorder. As a general rule after medical review, therapeutic doses of medication should be continued" throughout a course of treatment. Decisions about discontinuing the medication should involve the individual's prescribing physician/nurse practitioner/physician assistant, as well as the substance use disorder treatment provider.[3]

There shall be comprehensive case management (including outreach) attached to and integrated with the outpatient treatment facilities. It is expected there will be meaningful continuing care collaboration with, and coordination of care with, primary care providers, other outpatient services, residential treatment units, drug-free housing resources, as well as other community treatment and recovery resources.

When a client, already engaged in a particular level of outpatient treatment needs higher intensity of care—either outpatient or residential services—it is expected the client will also remain connected to the original service provider. This provides for continuity of care when the client returns to the lower intensity services.

All treatment units must include "personnel who are familiar with the features of substance use withdrawal syndromes, have training in basic life support, and have access to an emergency medical system that can transport patients to emergency departments and other sites for clinical care"[3]. It is essential that staff in outpatient, and other clinical services, have a sufficient level of knowledge

regarding withdrawal symptoms so they have the ability to recognize any current or delayed withdrawal symptoms that may require management.

### 2.2.5 Reporting and Coordination

Outpatient treatment facilities shall track and report to Signal/MSOs instances when it is necessary to "wait list" or divert individuals to other providers. This will enable coordination of utilization within regions to be able to enhance access to services.

## 2.3 Models for Delivery in Rural or Frontier Settings

Due to lower availability of substance use disorder services in rural and frontier areas,[14,15] access to such services is often the primary concern for these populations. Barriers to access such as lack of transportation, inadequate staffing, stigma, and absence of sustainable funding disproportionately affect individuals living in rural areas, thus cost-effective and sustainable practices are especially important in these settings.[14,16] The following approaches have been recommended to minimize the impact of locality on rural populations for improving access to substance use disorder services.[14]

### 2.3.1 Recommendations

Telehealth has gained increasing support as a cost-effective way of providing prevention, intervention, and care coordination services.[17] Additionally, literature reviews and meta-analyses have found telehealth to be just as effective as traditional therapy.[18,19] Telehealth offers a particularly relevant solution to increasing access to services in rural areas that have larger underserved populations, and are more vulnerable to barriers around mobility and transportation.[14,16] Increasing utilization of telehealth also addresses other barriers to access such as staffing and patient volume issues in rural clinics.[14,16]

There has also been recent research suggesting the effectiveness of smart phone technology in recovery support.[20] ACHESS, a relapse prevention program delivered through a smartphone application, is now listed on the National Registry of Evidence-based Programs and Practices (NREPP) as an evidence-based practice.

Primary medical and behavioral health care integration is especially important in rural settings where primary care providers may be residents' only point of contact with the health system. Training functionally independent providers in mental and behavioral health first aid could decrease community stigma related to seeking help for substance use disorders, while increasing community awareness of problem substance use warning signs.[14] The World Health Organization reports that health care integration is most effective when it is fully supported by health policy, legislative framework, and policy leadership.[21]

# 3 Response Format

Respondents to this proposal request should include the following elements:

1. When referencing this RFA, use RFA **#S4-1718-RO**
2. Business Proposal, indicating compliance, understanding, and restatement of all provisions and requirements listed in section 2.
3. Signal Credentialing: except for the OBH license, all documents and items required in the Signal Credentialing list in Appendix C.

4. This RFA is supported using Capacity as the reimbursement. Respondent should include a budget narrative, as well as:
    a. If this RFA indicates fee-for-service reimbursement, then the provider should submit requested rates.
    b. If capacity funded, then provider should submit an OBH capacity (see Appendix A) budget for SFY1718.
5. The goal of for increased number of indigent clients served. This funding is intended to serve indigent clients. Indigent clients are defined as individuals whose household income is at or below 300% Federal Poverty Level (FPL).
6. The following representatives should be identified. Include name, title, email address, and phone number for each.
    a. Proposal lead
    b. Chief Executive Officer, Executive Director, or equivalent.
    c. Chief Financial Officer, or equivalent
    d. Clinical Director
7. A timeline, including
    a. Project start
    b. Intermediate milestones
    c. Service delivery start (if applicable)
8. Location (or multiple locations) that this proposal covers.

# 4 EVALUATION AND DECISION

Signal will review all proposals upon receipt (no later than 6/15/2017). Failure to provide a complete set of information requested in this document may result in exclusion from consideration.

Signal may seek clarifying information as necessary to make an informed decision either from the respondent provider or from other sources.

After selection of a provider or providers for these services, Signal will notify remaining respondents of the decision.

# 5 REFERENCES


[1]Substance Abuse and Mental Health Services Administration. *Recovery and Recovery Support* https://www.samhsa.gov/recovery

[2] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, & Miller MM, Eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance -Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013

[3]Center for Substance Abuse Treatment. (2015). Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 45. HHS Publication No. (SMA) 15-4131. Rockville, MD: Center for Substance Abuse Treatment.

[4]Center for Substance Abuse Treatment. (2015) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series, No. 27, (revised 2015), Rockville, MD: Center for Substance Abuse Treatment.

[5]NQF (National Quality Forum) *National voluntary consensus standards for the treatment of substance use conditions: Evidence-based treatment practices*. Washington, DC: NQF; 2007

[6]NQF (National Quality Forum) Power EJ, Nishimi RY, Kizer KW, Eds. *Evidenced-Based Treatment Practices for Substance Use Disorders*. Washington, DC: NQF; 2005.

[7]National Quality Forum. A Path Forward to Measuring Continuing Care Management for Substance Use Illness: Patient-Focused Episodes of Care, Washington DC 2009

[8]Substance Abuse and Mental Health Services Administration. (2013). Substance Abuse Treatment for Persons with Co-occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. (SMA) 13-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[9]National Institute on Drug Abuse. (2012). Principles of Effective Treatment. In Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

[10]National Institute on Alcohol Abuse and Alcoholism. (2016) professional Education Materials: Resources for clinicians, physicians, social workers, and other health professionals. https://www.niaaa.nih.gov/publications/clinical-guides-and-manuals

[11]Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism, *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.* HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[12]Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006 (rev 2013)

[13]Center for Substance Abuse Treatment. *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series, No. 34. HHS Publication No. (SMA) 12- 3952. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999 (rev 2012).

14.Western Interstate Commission for Higher Education. (2015). Needs Analysis: Current Status, Strategic Positioning, and Future Planning. Retrieved from Colorado Department of Human Services Office of Behavioral Health Website: http://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/OBH-Needs-Analysis-Report2015-pdf.pdf.

15. Hartley, D. (2004). Rural health disparities, population health, and rural culture. *American Journal of Public Health*, *94*(10), 1675-1678.

16. The U.S. Department of Health and Human Services. (2016). *Rural Behavioral Health: Telehealth Challenges and Opportunities.* Retrieved from the Substance Abuse and Mental Health Service Administration website. http://store.samhsa.gov/shin/content/SMA16-4989/SMA16-4989.pdf.

17. Wade, V. A., Karnon, J., Elshaug, A. G., & Hiller, J. E. (2010). A systematic review of economic analyses of telehealth services using real time video communication. *BMC Health Services Research*, *10*(1), 233.

18. Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. A. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*(2-4), 109-160.

19. Richardson, L. K., Christopher Frueh, B., Grubaugh, A. L., Egede, L., & Elhai, J. D. (2009). Current directions in videoconferencing tele-mental health research. *Clinical Psychology: Science and Practice*, *16*(3), 323-338.

20. Gustafson, D.H., McTavish, F.M., Chih, M., Atwood, A.K., Johnson, R.A., et al. (2014). A Smartphone Application to Support Recovery From Alcoholism: A Randomized Clinical Trial. *JAMA Psychiatry*, 71(5), 566-572. doi:10.1001/jamapsychiatry.2013.4642.

21. World Health Organization, World Organization of National Colleges, & Academic Associations of General Practitioners/Family Physicians. (2008). *Integrating mental health into primary care: a global perspective*. World Health Organization.

# Appendix A

## OBH Capacity Budget Template

| | | | | |
|---|---|---|---|---|
| **Provider Name:** | | | | |
| **Program Name:** | | | | |
| **Contract Period:** | | | | |
| | | | | |
| | | **Budget** | **YTD Actual** | **Variance** |
| | **EXPENSES** | | | |
| **Personnel:** | | | | |
| | Clinical | - | | |
| | Support | - | | |
| | Kitchen | - | | |
| | Operations | - | | |
| | Other | - | | |
| | | | | |
| | **Total Personnel** | **-** | | |
| **Client Expenses:** | | | | |
| | Kitchen Supplies | | | |
| | Client Food | | | |
| | Client Transportation | | | |
| | Medications | | | |
| | Medical Supplies | | | |
| | Personal Hygiene Items | | | |
| | Laundry/Linens | | | |
| | Client Recreation | | | |
| | Purchased Services | | | |
| | Contractors | | | |
| | Other | | | |
| | | | | |
| | **Total Client Expenses** | **-** | | |
| **Occupancy:** | | | | |
| | Janitor | | | |
| | Supplies | | | |
| | Utilities | | | |
| | Phone | | | |
| | Rent | | | |
| | Equipment Lease | | | |
| | Building Maintenance | | | |
| | Grounds Maintenance | | | |
| | Other | | | |
| | | | | |
| | **Total Occupancy** | **-** | | |
| **Operating:** | | | | |
| | Insurance | | | |
| | Auto Expense | | | |
| | Staff Development | | | |
| | Employee Training | | | |
| | Travel & Lodging | | | |
| | Business Meals | | | |
| | Mileage | | | |
| | Computer Supplies/Equipment | | | |
| | Office Supplies | | | |
| | Postage | | | |
| | Printing | | | |
| | Dues, Fees & Licenses | | | |
| | Equipment & Furnishings | | | |
| | Renovation & Construction | | | |
| | Depreciation | | | |
| | Advertising | | | |
| | Public Relations | | | |
| | Legal | | | |
| | Audit | | | |
| | Consultants | | | |
| | Other | | | |
| | | | | |
| | **Total Operating** | **-** | | |
| **Indirect:** | | | | |
| | Finance & Accounting | | | |
| | Contracting & Purchasing | | | |
| | IT System & Services | | | |
| | Legal | | | |
| | Human Resources | | | |
| | | | | |
| | **Total Indirect** | **-** | | |
| | | | | |
| | **Grand Total Expenses** | **-** | | |
| | | | | |
| | **Revenue Offsets** | | | |
| **Client Services:** | | | | |
| | Medicaid Fee for Service Cash | | | |
| | Medicaid Capitation Encounters * | | | |
| | OBH Indigent Encounters * | | | |
| | 3rd Party Insurance Cash Receipts | | | |
| | Medicare Cash | | | |
| | Self-Pay | | | |
| | Cash from Other Sources | | | |
| | **Total Client Service Cash** | **-** | | |
| | | | | |
| ** Encounters valued using the current year's fee for service schedule issued by OBH and not to exceed contract amount* | | | | |
| | | | | |
| **Contracts and Grants:** | | | | |
| | MSO Revenue (from other OBH contract budget lines) | | | |
| | Non-Governmental Contracts | | | |
| | Other State Revenue/Accrual | | | |
| | Local Funds/Accrural | | | |
| | Federal Grant Funds/Accrual | | | |
| | Public Support | | | |
| | Other Funds (Specify below) | | | |
| | Description | | | |
| | Description | | | |
| | **Total Contracts and Grants** | **-** | | |
| | | | | |
| | **Grand Total Revenue Offsets** | **-** | | |
| | | | | |
| **Net Cost Invoiced**** | | **-** | | |
| **Net Cost Invoice may not exceed the OBH Contract to exceed price for this capacity based contract exhibit or contract. | | | | |
| | | | | |
| **Exempt Revenue Offsets** | | | | |
| Private Grant Funds | | | | |
| Private support or donations | | | | |
| In-kind donations | | | | |
| Local Hospital funds | | | | |

# Appendix B

## Signal Credentialing

# Signal Behavioral Health Network

Credentialing for Membership as a Signal Provider

## CREDENTIALING DOCUMENTATION

Below is a listing of the documentation required for application as a credentialed provider with Signal Behavioral Health Network.

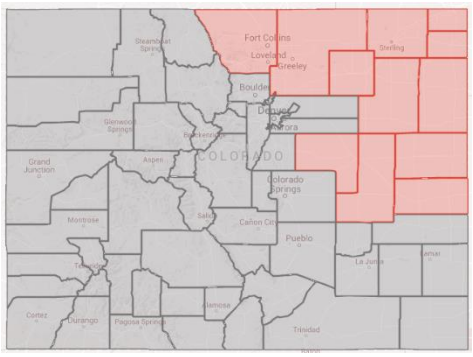
a) Copies of all current OBH licenses
b) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
    - JCAHO/CARF/COA approvals, if applicable
    - Residential Child Care Facility license, if applicable
    - Residential Treatment Center license, if applicable
    - Drug Enforcement Administration Provider certification, if applicable
    - Drug Enforcement Administration Physician license(s), if applicable
    - Federal Drug Administration and Pharmacy Board registration, if applicable
c) Federal tax ID number
d) Certificate of general liability and professional liability insurance, professional automobile, and general office insurance. The professional liability policies shall have a minimum coverage limit of $1,000,000 per individual occurrence and $1,000,000 aggregate. Exceptions to these minimum coverage requirements will be considered on a case-by-case basis.
e) Certificate of worker's compensation insurance, if applicable
f) Certification of malpractice insurance for doctors/nurses, if applicable
g) Certification of Director's and Officer's Insurance, if applicable
h) Notification if insurance was ever denied or canceled and the reason(s) for any such denial or cancellation
i) Most recent list of the members of the Provider's Board of Directors, if applicable
j) List of current Provider clinical staff including credentials, CAC level, and date of hire. Credentials refer to any educational degrees, any professional licenses, and any type of teaching certificates.
k) Notification that all current clinical staff have been reviewed in the DORA database for any disciplinary actions and a description of the Provider's response to any disciplinary actions discovered
l) Notification of any investigation of the agency by any regulatory agency that resulted in any type of corrective action or change in status during the two years prior to submission of the credentialing packet. Regulatory agencies include, but are not limited to, OBH, DMH, JCAHO, and CARF.
m) Notification of compliance with all HIPAA regulations, if applicable
n) Notification of any Federal debarment
o) Copy of most recent financial audit and management letter
p) Copy of most recent agency approved budget
q) Number of pregnant women and injecting drug users served in the past 18-months

# Appendix C

## Signal Sub-State Planning Areas

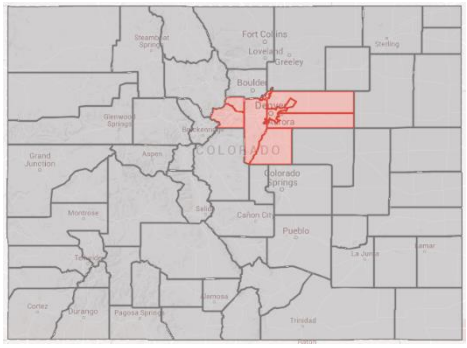
## SSPA 1: Northeastern Colorado

- Cheyenne
- Kit Carson
- Larimer
- Lincoln
- Logan
- Morgan
- Phillips
- Sedgwick
- Washington
- Weld
- Yuma



## SSPA 2: Denver Metro and Foothills

- Adams
- Arapahoe
- Broomfield
- Clear Creek
- Denver
- Douglas
- Gilpin
- Jefferson



## SSPA 4: Southeastern Colorado & SLV

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