Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

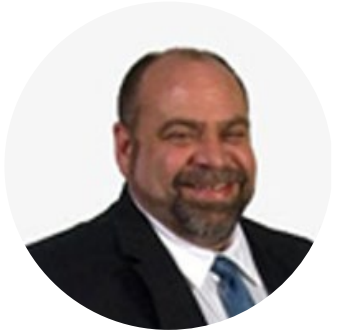
Mental Health Equity

How is data shaping policy?

Shale L. Wong, MD, MSPH
Executive Director, Farley Health Policy Center
Professor and Vice Chair for Policy and Advocacy
Dept of Pediatrics, CU School of Medicine

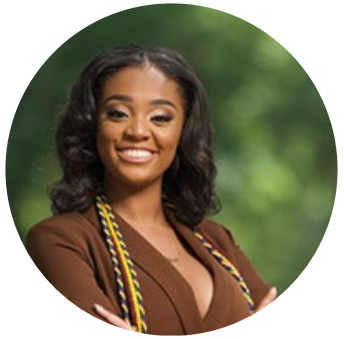














Our Purpose

Develop and translate evidence to advance policies and integrate systems that improve health, equity, and well-being

Focus on local, state and federal policies that promote equitable health and combat systemic barriers and structural racism

Educate and mentor professionals to develop a health policy lens for approaching research and practice

Build relationships across sectors to reach, convene and engage communities and different audiences to discuss health

Translation for other audiences

Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Brief #17
March 2021

Policy Pathways to Address American Youth Firearm Injury and Death

Sindhu P. Sudanagunta, MD, Emma C. Gilchrist, MPH, Maya Haasz, MD and Shale L. Wong, MD, MSPH

This brief reviews the impact of gun violence on youth across the United States and articulates the evidence base for gun safety policies. These policies would strengthen federal legislation to protect American youth from suicide, homicide, and unintentional firearm injury and death:

- Child access prevention
- Safe storage
- Universal background checks
- Permits to purchase
- Extended waiting periods prior to firearms purchase
- Extreme risk protection orders
- Assault weapon and high-capacity magazine ban

Background

Every day, 83 children are injured or killed by guns in the United States.[1]

Firearm-related injuries are a leading cause of child and adolescent deaths, second only to motor vehicle crashes totaling 3,000 children and teens dying every year.[2] Of these deaths, homicide and suicide account for 59% and 35% respectively; the remainder are unintentional or undetermined causes.[2] Reducing gun violence injuries and deaths among American youth is imperative and requires a multifaceted approach.

Global Context

The burden of firearm violence and death are uniquely American problems.

The mortality rate from guns is notably higher in the U.S. compared to other countries. Over 91% of firearm deaths among children and adolescents in high income countries occurred in the United States.[3] Despite similar overall crime rates, the gun homicide rate is about 25 times higher in the U.S. than other Western democracies, and 49 times higher for those aged 15-24 years.[3] For example, the U.S. has 10 times the rate of gun homicides than Japan, Germany, and the United Kingdom combined.[3] In 2016, the U.S. had the highest gun suicide rate compared to 189 other countries.

THE TOLL OF GUN VIOLENCE ON YOUTH IN THE U.S.

A child or adolescent is killed with a gun every **2 hours and 48 minutes in the U.S.**

91% **of firearm deaths among** all high-income countries worldwide **occur in the U.S.**

Firearm-related deaths are the leading cause of mortality among Black youth

Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Brief #10-a
September 2020

Medicine Beyond Borders

A Call to Action: Providing Care via Forensic Examinations and Legal Referrals

Puja Shah, MPH; Janine Young, MD; Shale Wong, MD, MSPH

Background

There are more migrants worldwide fleeing war and systematic discrimination since immediately post-World War II.[1]

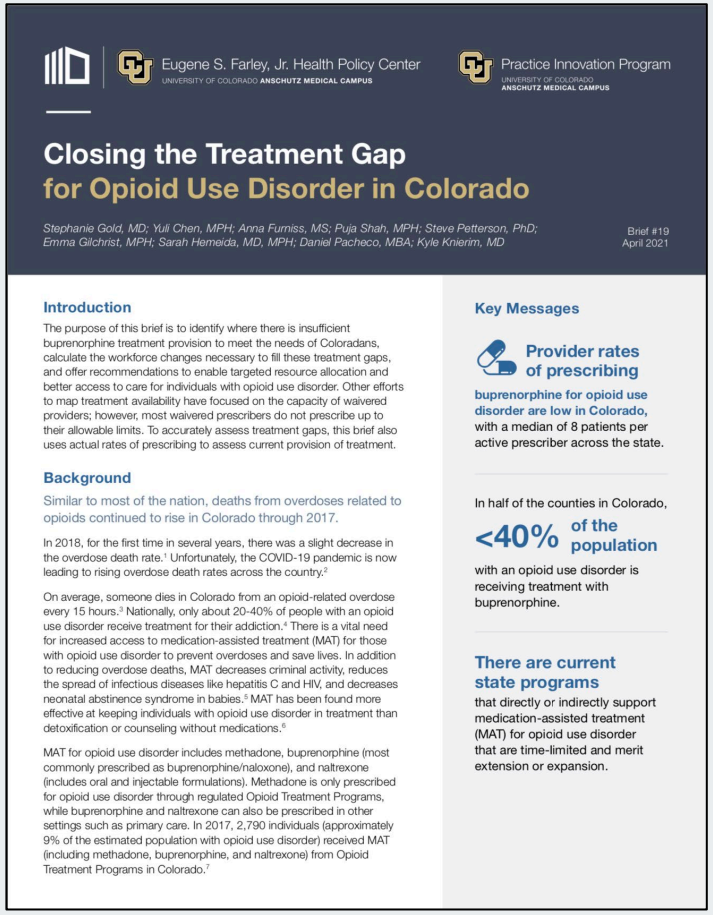
However, US asylum seekers have no legal right to court-appointed attorneys in their immigration proceedings, nor medical/mental health forensic examinations, and, in fact, the vast majority have neither. As such, national asylum grant rates range from 23-37.5%.[3,4] With the addition of legal representation, one study demonstrated that asylum grant rates increase from 24% to 41% (N=746);[5] add to legal representation medical/mental health forensic examinations, and the grant rate increases to 85-89%.[3-5]

With these significant disparities in asylum grant rates, human rights clinics have been established to provide pro bono medical/mental health forensic examinations and legal services for asylum seekers. Two examples of human rights clinics are the Denver Health Human Rights Clinic (HRC) in Colorado and the Yale Center for Asylum Medicine in Connecticut. The HRC works with the Rocky Mountain Immigrant Advocacy Network (RMIAN) and other immigration legal partners in order to ensure that individuals receive appropriate evaluation and representation for their asylum cases. Additionally, the HRC trains clinicians to identify patients with possible asylum-eligible histories and refers them to legal services for further evaluation. The Yale Center for Asylum Medicine conducts forensic medical interviews and examinations for asylum seekers who have been referred to the center and teaches health care trainees to perform these evaluations.

This brief provides information to help medical and mental health providers better identify eligible cases and refer asylum seekers to legal services through local agencies and to increase access to medical/mental health forensic examinations by increasing the number of trained clinicians.

By understanding asylum and other legal status options, providers can improve health outcomes in the following ways:

1. **Learn how to identify immigrants who may qualify for asylum and other legal statuses**
2. **Refer to legal resources and advocates**
3. **Learn how to perform medical or mental health forensic examinations**



Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Practice Innovation Program
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Closing the Treatment Gap for Opioid Use Disorder in Colorado

Stephanie Gold, MD; Yuli Chen, MPH; Anna Furniss, MS; Puja Shah, MPH; Steve Petterson, PhD; Emma Gilchrist, MPH; Sarah Hemeida, MD, MPH; Daniel Pacheco, MBA; Kyle Knierim, MD

Brief #19
April 2021

Introduction

The purpose of this brief is to identify where there is insufficient buprenorphine treatment provision to meet the needs of Coloradans, calculate the workforce changes necessary to fill these treatment gaps, and offer recommendations to enable targeted resource allocation and better access to care for individuals with opioid use disorder. Other efforts to map treatment availability have focused on the capacity of waivered providers; however, most waivered prescribers do not prescribe up to their allowable limits. To accurately assess treatment gaps, this brief also uses actual rates of prescribing to assess current provision of treatment.

Background

Similar to most of the nation, deaths from overdoses related to opioids continued to rise in Colorado through 2017.

In 2018, for the first time in several years, there was a slight decrease in the overdose death rate.[1] Unfortunately, the COVID-19 pandemic is now leading to rising overdose death rates across the country.[2]

On average, someone dies in Colorado from an opioid-related overdose every 15 hours.[3] Nationally, only about 20-40% of people with an opioid use disorder receive treatment for their addiction.[4] There is a vital need for increased access to medication-assisted treatment (MAT) for those with opioid use disorder to prevent overdoses and save lives. In addition to reducing overdose deaths, MAT decreases criminal activity, reduces the spread of infectious diseases like hepatitis C and HIV, and decreases neonatal abstinence syndrome in babies.[5] MAT has been found more effective at keeping individuals with opioid use disorder in treatment than detoxification or counseling without medications.[6]

MAT for opioid use disorder includes methadone, buprenorphine (most commonly prescribed as buprenorphine/naloxone), and naltrexone (includes oral and injectable formulations). Methadone is only prescribed for opioid use disorder through regulated Opioid Treatment Programs, while buprenorphine and naltrexone can also be prescribed in other settings such as primary care. In 2017, 2,790 individuals (approximately 9% of the estimated population with opioid use disorder) received MAT (including methadone, buprenorphine, and naltrexone) from Opioid Treatment Programs in Colorado.[7]

Key Messages

Provider rates of prescribing

buprenorphine for opioid use disorder are low in Colorado, with a median of 8 patients per active prescriber across the state.

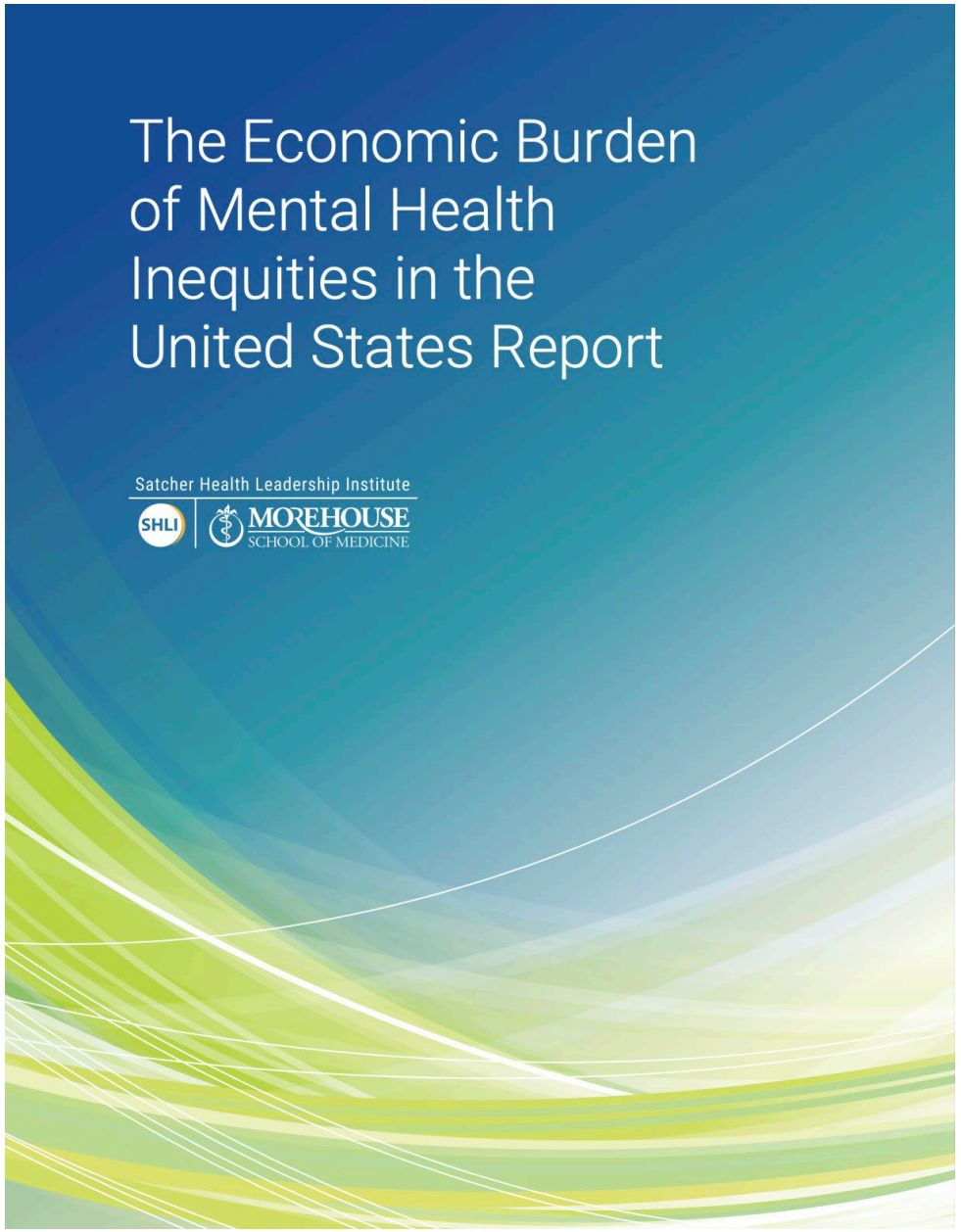
In half of the counties in Colorado, **<40%** **of the population** with an opioid use disorder is receiving treatment with buprenorphine.

There are current state programs that directly or indirectly support medication-assisted treatment (MAT) for opioid use disorder that are time-limited and merit extension or expansion.

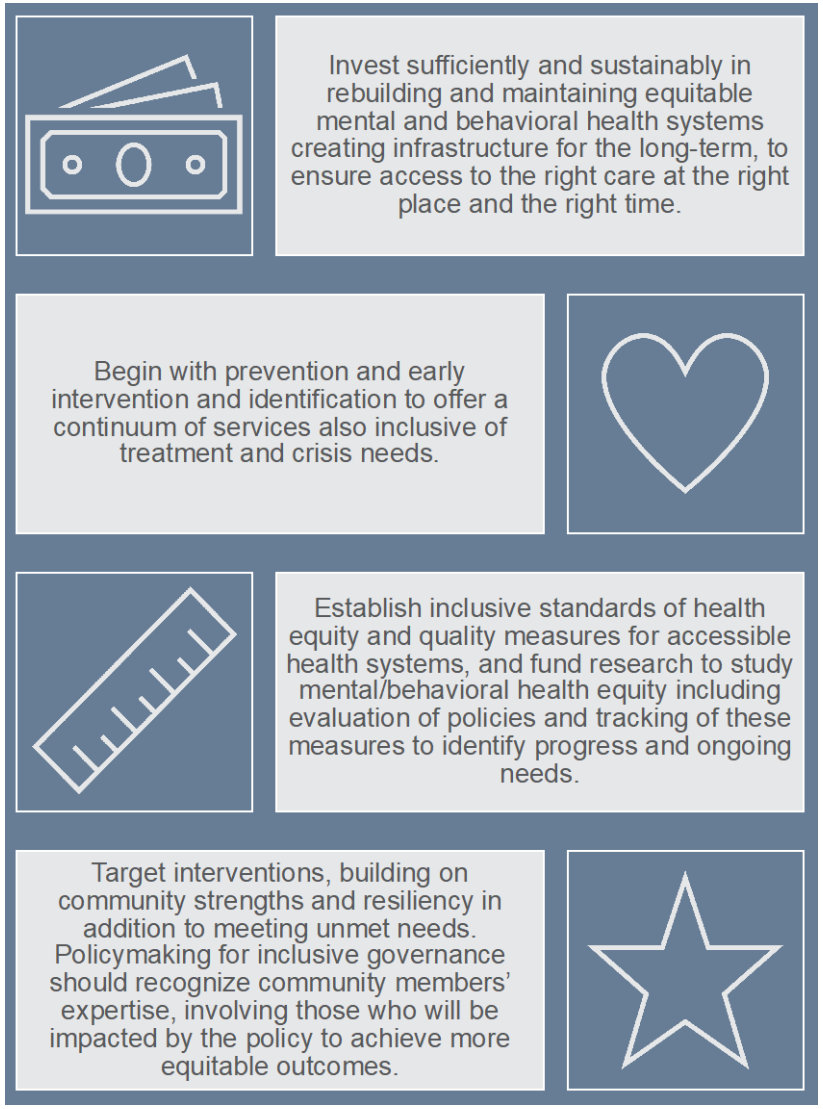
Advocacy for equity in social policy

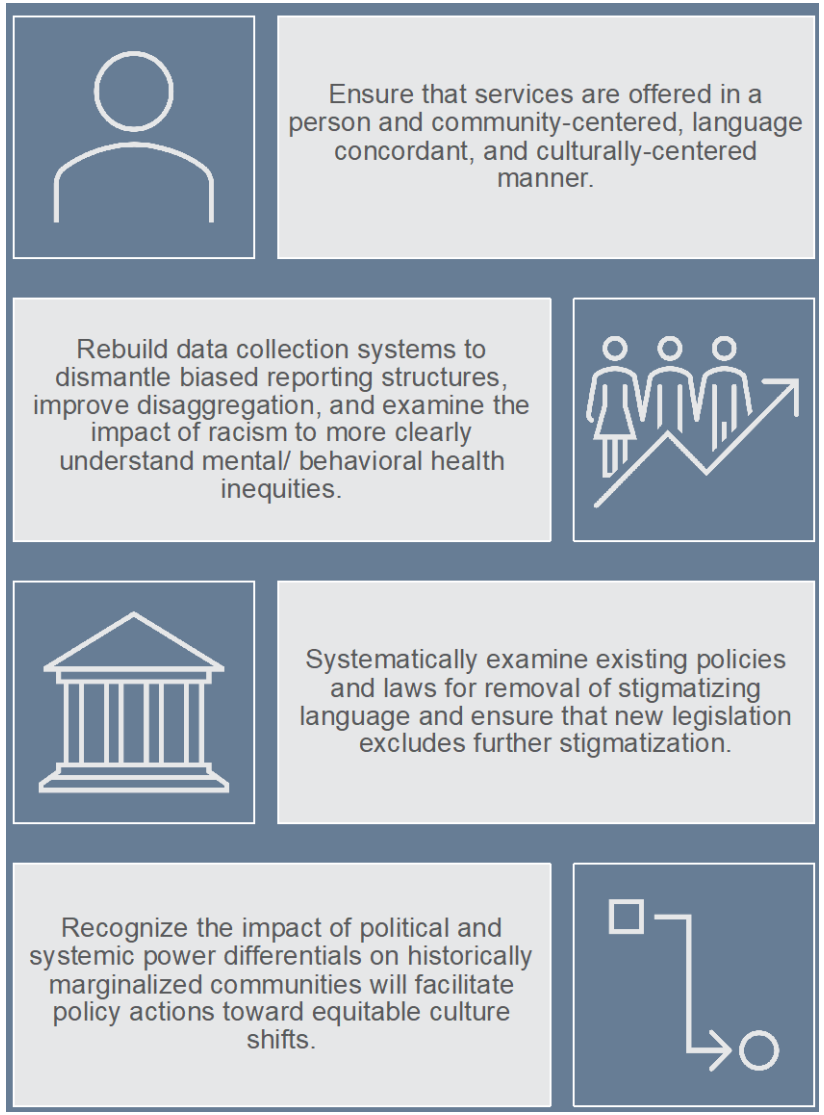
"There is no health without mental health."[1]

-Dr. David Satcher, 16th U.S. Surgeon General


The Economic Burden of Mental Health Inequities in the United States Report
Satcher Health Leadership Institute
SHLI
MOREHOUSE
SCHOOL OF MEDICINE

Policy principles to balance inequities





Disaggregate data

Black/African American	Black/African American
Native American/Alaska Native	Native American/Alaska Native
Native Hawaiian	Native Hawaiian/ Other Pacific Islander
Other Pacific Islander (Guamanians/ Chamorro's and Samoans)	
Native Hawaiian/Other Pacific Islander (selected both categories)	
Asian Indian	Asian
Chinese	
Filipino	
Japanese	
Korean	
Vietnamese	
Other Asian (other than Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)	
Asian multiple categories (multiple Asian categories selected)	
Multi-race (more than one race selected)	Multi-race
Hispanic/Latin(o)(a)(x)	Hispanic/Latin(o)(a)(x)
White	White


“Our lives begin to end the day we become silent about things that matter.”
--Dr. Martin Luther King, Jr.

Eugene S. Farley, Jr. Health Policy Center

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**