Implementation Grantee

**H.O.P.E. for a Drug Free Stephens**: The Stephens County Opioid Crisis Response Initiative, H.O.P.E. (Heroin Opioid Prevention and Education) for a Drug Free Stephens, has attacked opioid use disorder (OUD) head-on by reducing the prescription rate for and use of opioids and controlled substances in Stephens County by (1) engaging stakeholders and the community through the consortium, (2) implementing prevention strategies through education and community awareness, (3) supporting treatment for OUD in person and via telemedicine, (4) using data to track and report the improved long-term outcomes for the patients with OUD, and (5) implementing a sustainable OUD prevention, treatment, and recovery program that uses quantifiable metrics to assess the impact of the program and plan for future needs of the community. The key to success of this initiative during the RCORP-Implementation phase will be establishing credible baseline data and measuring progress of the data as they implement core activities of the grant and realize outcomes through the initiative’s efforts.

Highlights of the initiative’s Year 1 efforts include a partnership with the drug court to implement a remote patient-monitoring app (My Charlie) to connect individuals to a treatment/recovery specialist in real time with just the click of a button on a smartphone; participation of more than 100 people in the 1st Annual 5K HOPE Walk and Run to raise community awareness; a partnership with the Stephens County School System to support opioid-affected youth and prevent OUD in school-age children; a Prescriber’s Forum to educate providers on the
alternatives to prescribing opioids and the benefits of Medication assisted treatment; distribution of Narcan to first responders along with training in Narcan’s use; funding a certified addiction counselor at The Hope Center to counsel uninsured individuals with OUD and SUD; and finally, getting Phase One of the Sustainability Plan underway with planning for a residential detox treatment facility (outpatient services targeted to begin in January 2021). H.O.P.E. for a Drug Free Stephens is making a difference in Stephens County, Georgia.

**MAT-Expansion Grantee**

**Summit Pacific Medical Center**: Summit Pacific Medical Center (SPMC), located in Elma, Washington, received a HRSA RCORP-Planning grant in 2018 and went on to receive both the RCORP Implementation and MAT Expansion Grants.

Through the Planning grant, Summit Pacific formed the Grays Harbor Opioid Response Consortium to investigate the local needs of Grays Harbor County, which is a significant hotspot of opioid activity in Washington State. Their findings revealed that the most significant barriers were not treatment-related; they were socio-economic challenges. SPMC determined that no single challenge was overwhelming to patients, but the variety of challenges they faced was the major problem. Since there was not a single bottleneck within the system but rather a variety of hurdles, SPMC focused its implementation addresses a variety of challenges. SPMC hopes that the process of getting help to those in need becomes smoother and easier to navigate.

The funding was addressed through 9 project areas:

1. **Project 1: Public Education Outreach** - To provide key funding for educational outreach through various public forums
2. **Project 2: Harm Reduction** - To fund the purchase a recreational vehicle (RV) for the Grays Harbor Public Health and Social Services Department to replace its current RV, which is used for the county-wide syringe exchange service
3. **Project 3: Continuing Education and Training in Best Practices** - To pay speakers and trainers who provide trainings that qualify for continuing education credits and/or to pay for providers’ trainings to obtain Drug Addiction Treatment Act of 2000 (DATA) waivers
4. **Project 4: Workforce** - To provide funding to pay for internships to people seeking degrees in fields that directly impact the opioid crisis
5. **Project 5: Transportation**
   a. **Part 1**: To implement a program that provides transportation services to patients for whom existing public options are not viable as a proof of concept and to explore the viability of this model
   b. **Part 2**: Establish a fund to provide bus passes and tokens for public transit and widely distribute bus passes to patients in need
6. Project 6: Housing - To provide funding for individuals who are enrolled into the county’s Diversion Court program to support stable housing while they are completing their program plan
7. Project 7: Peer support - To facilitate and fund interagency peer-to-peer recreational recovery activities
8. Project 8: Collaboration - To provide financial support so the consortium can have an operational budget that funds collaboration efforts otherwise not be possible (e.g., website development or resource guides)
9. Project 9: Regulations - To reimburse key consortium members for time, travel, and expenses for educating decisionmakers on the impacts of current policies and the impacts that specific changes will have on rural regions

While the COVID-19 pandemic has affected each these efforts, the members of the consortium are continuing to work to maintain the intent of each of these while making required adjustments to meet the new and changing requirements.

In addition to the implementation efforts, SPMC started their own Low Barrier Walk-in Medication-Assisted Treatment (MAT) Initiation clinic in February 2019. They have adopted a nurse care model and rotate their staff providers through the clinic to provide MAT as well as various primary care services. They have been working to increase their patient volumes to long-term sustainable levels. They have already grown beyond their original footprint and have had to expand hours and staff. While COVID-19 has impacted the number of patient visits, SPMC has not restricted any service because of the pandemic and anticipates that its future growth will require them to expand into a new facility.

Plastic II Grantee

Executive Office of the Governor of Delaware: Delaware’s Rural Subcommittee provides leadership and guidance to the state’s rural opioid use disorder (OUD) response planning efforts from the perspective of organizations and individuals living and working in rural communities. The Division of Public Health is leveraging another important aspect of its fight against the opioid crisis to support the Rural Subcommittee’s work—the Overdose System of Care (OSOC). Established by law, OSOC is charged with creating a statewide response system and protocols for responding to the epidemic of OUD-related overdoses. Delaware established the Rural Subcommittee under the umbrella of the larger OSOC structure to provide opportunities to share information with the larger OSOC Committee and support ongoing sustainability of the Rural Subcommittee. As part of the RCORP grant, the Rural Subcommittee will be responsible for leading a number of important activities to enhance and build OUD prevention and treatment services in rural Delaware.
Project Officer

Fraser Rothenberg Byrne, MPA: Ms. Byrne is a Public Health Analyst in the Federal Office of Rural Health Policy at the Health Resources and Services Administration. She leads the evaluation of the Rural Communities Opioid Response Program (RCORP), a portfolio of over 300 awards to address SUD/OUD in rural communities. She has more than 12 years of experience in research, evaluation, and health policy, specifically focused on vulnerable populations. In her free time Fraser enjoys spending time with her husband, daughter, and extended family. Her favorite activities include gardening, DIY projects, hiking, traveling, cooking, and eating delicious food.

Technical Expert Lead

Robert Childs, MPH: Robert Childs is a technical expert lead (TEL) at JBS International, Inc. (JBS) whose work focuses on providing technical assistance (TA) to rural overdose prevention projects across the United States. Most recently, he worked as the North Carolina Harm Reduction Coalition’s (NCHRC’s) Executive Director from 2009–2018, where he oversaw the agency’s operations, program implementation, and innovations. At NCHRC, he specialized in harm reduction practice, overdose prevention and response initiatives, drug policy advocacy and reform, media affairs, jail-based health interventions, law enforcement assisted diversion (LEAD), and law enforcement occupational safety and drug overdose response. Mr. Childs also helped develop the largest syringe exchange network and community- and law enforcement-based naloxone distribution programs in the Southern United States during his tenure there. He has been invited to speak at the United Nations, the U.S. Congress, the Office of National Drug Control Policy, the Food and Drug Administration, and multiple state legislatures on his work. Mr. Childs worked with NCHRC in leading the campaigns to pass comprehensive 911 Good Samaritan and naloxone bills in 2013, 2015, and 2017 as well as syringe decriminalization, biohazard collection, and syringe exchange bills in 2013, 2015, 2016, and 2017. He helped start the South's first LEAD program in Fayetteville (2016) and helped set up other programs throughout North Carolina and in other states. His work has been featured in The New York Times, The Lancet, People, The Wall Street Journal, USA Today, The Daily Beast, Kaiser Health News, Fox News, NBC News, ABC News, Human Rights Watch, Governing, Morbidity and Mortality Weekly Report, NPR, and The Huffington Post.
Robert is well known for having multiple accents. He was born in the United Kingdom and has since lived in Germany, the American Midwest, the Pacific Northwest, Upper New England, New York City, North Carolina, and now East Tennessee. Robert also grew up in a multi-lingual household, where Swahili, German, Afrikaans, and English were spoken. In his spare time, Robert spends a lot of time hiking and swimming in lower Appalachia with his two children, volunteers with local naloxone distribution efforts, and is an avid Scrabble player.

**Best Practice of the Month**

*Each month we will feature an RCORP relevant best practice. Please email zdhatt@jbsinternational.com with best practices you would like to see highlighted!*

“Cultural competence” refers to the ability to honor, respect, and understand the varying beliefs, languages, behaviors, and experiences of people across different cultures while also being aware of your own point of view. Cultural competence is a necessary skill for working effectively with diverse populations, including indigenous communities, communities of color, rural communities, and other marginalized groups (e.g., migrant workers). Establishing cultural competence as a professional norm, especially in the context of providing behavioral health services, is vital. It is necessary to learn about the people and communities we work with to understand how their histories, values, and identities may impact the lives and needs of the individuals seeking care. Cultural competence is based on the premise that the more we ground our service delivery in the culture of the people with whom we work, the greater our competence is in practice. It is important to be self-aware and insightful about the ways that our own history and culture impacts the work we do, as well as to understand local health disparities, to ensure that we provide behavioral health services for people from diverse backgrounds and cultures tailored to meet their needs.

While there are innumerable factors affecting culturally competent practice, the following considerations should be considered:

1. **Historical Trauma and Historical Context**
   - According to Maria Yellow Horse Brave Heart, historical trauma refers to the “cumulative emotional and psychological wounding over one’s lifetime and from generation to generation following loss of lives, land and vital aspects of culture” (Brave Heart et al., 1998). Historical trauma contributes to health inequities, strong mistrust of outsiders, a collective sense of hopelessness, and high rates of poverty and disease. These experiences can undermine the resilience and strength of individuals and their communities.
   - It is also important to consider how major historical patterns and events such as colonization, genocide, slavery, Jim Crow laws, discrimination, and the forced relocation, torture, and decimation of American Indian and Alaskan Native populations have a lasting impact on people and regions, resulting in subsequent challenges that many communities face, often for generations, to improving health and equity for community residents (NORC Walsh Center for Rural Health Analysis, 2018).

2. **The Culturally Sensitive Approach and the Culture-Centered Approach**
   - A culturally sensitive approach aims to accomplish objectives by adapting mainstream communication and practices to the cultural characteristics of the
population and incorporating cultural characteristics, values, beliefs, experiences, and norms of the target population (Greene-Moton et al., 2019).

- Alternately, the culture-centered approach builds communication and interventions from the culture of the target population as constructed by community members, by understanding that local meanings, risks, issues, and their potential solutions develop from within (Stubbe, D., 2020). In this approach, external helpers adapt themselves to the individual or community with whom they are working, rather than structuring ways for the individual or community to participate in accordance with mainstream practices.

3. Social Determinants of Health

- Access to resources such as food supply, housing, income, social supports, transportation, education, and health care significantly influence population health outcomes, especially in rural areas and in communities of color. The inequitable distribution of these life-enhancing resources across populations and geographies can significantly affect a person’s length and quality of life and is a root cause of health disparities.

- Laws, policy, historical practices, and public opinion influence the availability and distribution of these resources across different social groups, including those defined by socioeconomic status, race/ethnicity, sexual orientation, sex, disability status, religious preference, and geographic location. Principles of social justice also play an important role. Appreciation of how societal conditions, health behaviors, and access to health care affect health outcomes can increase understanding about gaps and barriers that exist and what is needed to move toward health equity in rural communities.

4. Self-Awareness and Etiquette

- Prior to introducing yourself to a community, examine your own belief system. Avoid making assumptions. Preferred body language, posture, and concept of personal space depend on community norms and the nature of the personal relationship. Observe others and allow them to create the space and initiate or ask for any physical contact. Adapt your tone of voice, volume, and speed of speech patterns.

- Rapport and trust do not come easily or quickly. Learn not to take it personally. You may experience people expressing their mistrust, frustration, or disappointment from other situations that are outside of your control.

- Make deliberate, structural consortium choices, such as staffing and partnerships, to ensure that the necessary voices are represented to promote and further enable cultural-centered programming.

While there are volumes written about culturally competent practice in behavioral health, a few resources to begin establishing a foundation of knowledge are linked below. If you would like technical assistance to improve your culture-centered practice, please contact your TEL.

**Helpful Links:**

1. [A Treatment Improvement Protocol: Improving Cultural Competence](#)
2. [AI/AN Culture Card: A Guide to Build Cultural Awareness](#)
3. [The National Tribal Behavioral Health Agenda: December 2016](#)
4. [Identity and Cultural Dimensions: Latinx/Hispanic](#)
5. [Identity and Cultural Dimensions: Black/African American](#)
6. [Identity and Cultural Dimensions: LBGTQI](#)
7. [Social Determinants of Health in Rural Communities Toolkit](#)

**Citations:**


