Rural Health Inc. Opioid Response Consortium Strategic Plan
Anna, IL
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Grantee Organization	**Rural Health, Inc.**	
Grant Number	G25RH40059	
Address	513 N. Main Street, Anna, IL 62906	
Service Area	Union, Johnson, and Massac Counties in southern IL	
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Background

The needs assessment study of the RCORP planning grant segues to a strategic planning process. The needs assessment study showed that there is a significant impact that parental OUD has on children and prospect of children being referred to the child protective services. The needs assessment showed a genuine fragmentation in substance use services, approaches towards polysubstance use, and reciprocation with child welfare system. There is a high prevalence of stigma in the area in regards to harm reduction approaches, substance and mental health not only among the persons who uses but also among the providers. There is a need to provide and assess the impact of culturally and linguistically appropriate awareness education to improve public knowledge and understanding of evidence-based OUD and MUD overdose prevention, treatment and recovery services and support local and regional primary prevention activities particularly targeting the youth in general and in schools in particular. The following strategic plan aims to fulfil the expressed need for a more integrated and comprehensive coordination of primary care, behavioral health and community organization activities to address the gaps in services to cogently target the OUD, MUD and their impact on the welfare of children.

Strategic Plan Details

A. **Vision**: For Johnson, Massac, and Union Counties to be free of intergenerational OUD, and a community that leads the nation in quality substance use service delivery.
B. **Mission**: To reduce the occurrence of OUD in Johnson, Massac, and Union Counties and mitigate the impacts on children of substance use in the family by integrating community substance use services with local child welfare and developing the workforce in both fields.
C. **Assessment and Summary**: The needs assessment study highlighted the following areas key areas

- Polysubstance use and drug testing services is a major problem in the area. Illinois Criminal Justice Information Authority (ICJIA) in 2017 show there has been a 26% rise in both opioid and meth use. The Rural Health Inc patient utilization data show that there has been 48.8% cases of all Medically Assisted Therapy (MAT) clients are addicted to both the opioid and the meth substances. A 2017 National Drug Threat Assessment Survey (NDTAS) data show there has been a 30% rise of meth related arrests in the project area. 65% of the providers in the needs assessment survey for the RCORP planning grant have expressed concerned over the undetermined mixing of meth with opioid. Focus group data of person who use drugs (PWUD) show that most of the time they do not realize if the opioid they consume from the street is laced with meth or not. 94% of the providers in their survey expressed need for more prevention work regarding polysubstance use and claimed that most of the focus right now are focused on treatment. Currently, Community Action Place, a local drug testing organization provides mobile drug testing services in the area. In the focus group with persons in recovery the respondents have pointed out that they suspect the methamphetamine they buy from the street were laced with fentanyl. Both of them conceded that mixing stimulants like methamphetamines (uppers) with opioid like fentanyl (downers) helped them extend the addictive effects of the stimulant longer than usual.
- Need for Harm Reduction Treatment (MAT/MAR) expansion: The needs assessment study also indicated that there is need for expanding the MAT/MAR workforce and

outreach, the proportion of MAT/MAR patients (around 90 in last three years) is very small compared to the total number of patients 14487 patients seen by RHI. The needs assessment study suggest that the incidence of opioid and meth addiction could be at least 200% more than the amount of patient who access MAT-MAR treatment. The number of physicians per 10000 people who have buprenorphine-waiver is 2.3 compared to the state 2.95 and the nation 4.06. Johnson County has only 2 facilities that provide medically assisted treatment (MAT) or medically assisted recovery (MAR).

- Stigma Reduction The needs assessment has identified a strong prevalence of internalized stigma at every level of opioid and meth response measures. The stigma mostly stems from perspectives that view addiction as a moral issue instead of a health issue. All stakeholders, primary care providers, behavioral health counselors, person in recovery and other influencers have all expressed and acknowledge the prevalence of stigma in the need assessment study. There is a 0% involvement of faith-based organizations in the opioid or meth related harm reduction initiatives in the project area and that comes mostly from the affinity of faith-based organizations to an abstinence-only approach and being suspicious of other harm reduction programs. 60% of the respondents suggested that they do not know of any faith-based organization in the project area that is working towards opioid/meth recovery. Harm reduction education purposefully involving materials that share the concerns of the community, present data, literature, case studies and weave them into customize narratives to engage communities in thinking and asking questions about their presumptions. Harm reduction education need to begin with the providers of both primary and behavioral healthcare stripes followed by PWUD, person in recovery, their families and other stakeholders in the community**.** Promotion of SIU's ECHO program in the community also needs to be a part of the strategy. Consultation and education on different levels of integrated health care while implementing MAT to the local service provider would help bring more awareness on how MAT is implemented.
- Workforce Needs According to the Community Behavioral Healthcare Association of Illinois (CBHA) and SIU-med forum discussion, Southern Illinois has been referred to as a "service desert" by regional and state organizations. There is a noticeable absence of primary care physicians per 100,000 population in the project area. The ratio of population to primary care physicians in Illinois being 1240:1, in Union county 1340:1, in Johnson county 12600:1, and in Massac county 4970:1. The number of mental health provides are also alarming in the state of IL 580:1, in Union county it is 920:1 (County Ranking and Roadmap, 2017). In the need assessment survey, the providers of substance use services in the project area believe that the project area's health care workforce suffer from lack of trauma-informed behavioral health providers (18), substance use providers (17) peer support specialists (16), integrated health workers (16), and social workers (12). According to respondents, providers treating opioid and/or meth addiction need further training on countering stigma on suboxone/methadone treatment (23), trauma-focus attention (22), harm reduction approaches (21), cognitive behavior and exposure-based therapies (20), and working with child victims of parental drug use (20). The survey respondents identified workforce challenges such as retention of behavioral health workforce (18), retention of social workers (14), recruitment of behavioral health workforce (12), retention of clinicians (9), recruitment of MAT workforce (9), and recruitment of social workers (9) impacting quality of service delivery. Furthermore,

respondents identified the following challenges healthcare organizations face while trying to improve workforce capacity: high case load (32%), lack of resources (31%), lack of training options (12%), lack of motivation (9%), and lack of leadership (9%). As stated earlier in the needs assessment report that higher caseload has been cited by the providers (32%) as one of the main reasons for burnout in the project area followed by lack of resources in the settings of their work (31%). In the Provider's Survey providers called for more investment in the general infrastructure in the area (31%) and increase in resources so that better pay and effective training and retention of the healthcare workforce could be done. Workforce shortage, high case overload and compromised competencies have been often cited challenges in the need assessment. Recruitment and retention of the workforce is very important. Strategies around workforce development, training, recruitment and retention need to be a part of the strategic plan.

- Children as Vulnerable Group: Opioid/Meth addictions not only affects the individual addicts, but also negatively impacts their families – especially children. Parental opioid and meth use disorders (OUD-MUD) severely impact children, especially in rural areas with a compromised access to transportation, support and recovery services. 90% of providers surveyed had come across children that had been adversely affected by parental addiction to opioids and meth. As for the kind of addiction most prevalent among children under the age of 18, 28% identified addiction to opioid, 23% identified meth, and 23% identified the combination of opioid and meth together. 97% of providers felt there is a need for more community education and awareness about opioids/meth and their impact on children. 86% of providers were unaware of any initiative trying to work with children specifically affected by parental opioid/meth addiction. About 96% of respondents believed that children (under the age of 18) are affected by parental opioid/meth addiction, and 40% either called or knew someone that called child protective services because of addiction of parents. 99% of respondents believed that people ages 18-25 are affected by opioid/meth addiction. Over 50% of respondents knew people that have young children (age 0-12) and are addicted to opioid and meth. 8 respondents said they know 10 or more people with opioid and meth addiction that also have young children. 62% of respondents felt that parental misuse of opioid and meth together put children at the most risk compared to either opioid misuse alone (14%) or meth misuse alone (19%). Data connecting children impacted by substance use and parental addiction needs to be collected Involving local administration of child protective services, local court system, law enforcement, public health centers and substance use providers. A system of local data accessible and stored needs to be conceived as a pilot project.
- Social Determinant of Heath Providers felt that to better attract and retain substance use workforce, greater attention should be given to the following: sufficient resources (34%), investment in general infrastructure in the project area (32%), better marketing of the assets that already exist in the area (23%), and better leadership (11%). When asked about any asset building initiatives that could make the region more attractive to future workforce, providers prioritized new jobs initiatives (26%), new investment in infrastructure (18%), growth in new business prospects (13%), and arrival of new industries (11%). The community health assessment data from Southern Illinois Health (SIH) that runs many nonprofit hospitals and clinics in the Southern Illinois region, has identified (2018) several social determinants of health including lack of access to

transportation, low education, high level exposure to violence, lack of social support, unemployment, and risky health behavior as the barriers to better health in the region. The poverty rate is very high (18.4%) compared to the state (13.5) and the U.S. (14.6). The median household income in Massac County is 42,168 which is significantly lower than 61,229 for the state, and the nation 57,652. Median annual household income in Johnson County is $45,743 which is lower than the state of Illinois (61,223) and the U.S. (57,652). Poverty rates however, in Johnson County, are lower (11.8%) compared to the state of Illinois (13.1%) and the U.S. (14.6%). Similarly, unemployment rate in Johnson County is 5.7% compared to the state of Illinois which is 6.6% and the U.S. at 6.6%. Almost 19% of Johnson County's population work in more physically strenuous and injury prone sectors such as construction, mining and natural resources, manufacturing, trade, transportation, and utilities. The number of industry dependencies in Johnson County is 0 compared to the state 0.38 and the country at 0.5. The number of business establishments per 100 workers is 4 compared to 5 for the state of Illinois and 5.5 for the country. High poverty rate and lack of employment made people to leave the county as the net migration rate per 100 people for Johnson County is in the negative (-2.7) compared to the state (0.4) which is terrible and the country (2.9). Almost 26% of the population work in injury prone professions such as construction, mining and natural resources, trade, transportation, and utilities. The industry dependence status of Massac County is low (only 1). An understanding of the sociocultural factors, impact risk and health seeking behaviors, social networks, and disease transmission is important to bring involve local businesses, chamber of commerce and other entities to improve the socio-economic outlook of the region.

- Telecommute, Telehealth Impetus: In rural areas transportation can be a persistent challenge to ferry patience, stakeholders, and others in locations to meet. However, the Corona virus outbreak has sped up the process of telecommuting. Though Internet infrastructure is not very steady in the project area, however, new impetus towards improving the Internet infrastructure could provide a better telecommunicating solution to the transportation problem. Strategies regarding creation of telehealth infrastructure and training involving best practices need to be strategized. A strategic decision on telehealth and telecommuting would determine outreach and access to services.
- Drug Education**:** One element of spreading awareness is creating focus groups among behavioral health practitioners, PWUD, person in recovery, and different targeted groups about drug education, in a lucid simple basic manner. A broad-stroke campaign about the abstinence-based drug education only reinforces stigma. Drug education related to component, mixing of drugs, dosage awareness and methods of administration need to be part of the prevention, treatment and recovery methods. The relations between drug abuse and infectious diseases also need to be part of that plan.

D. Problem Statement: The opioid overdose deaths in Johnson County are 29/100000 people between the ages of 15-64 which is higher than the state (20.6) and the nation (18.3). The drug overdose mortality rate in Massac County between the age group of 15-64 is 27.1 deaths per 100000 population which is higher than the state at 26/100000. Drug overdose mortality rate in Union County is 22.5 deaths per 100000 population for those age 15-64. Union County is considered a health professional shortage area for both mental health and primary care providers. There are 15 opioid overdose deaths in Union, 11 in Massac, and 9 in Johnson. 33% inject drugs every 1-4 days and 50% inject drugs 3

times a day. 30% use opioid medication. 28% use opioid and mix it with meth (Illinois Department of Public Health, 2019).

System of Care Infrastructure: In spite of a few federal grants prompting organizations to form consortiums and other currently no infrastructure exists in the project area that actually shares patients information, revenue and meet workforce shortage needs on Memorandum of Understandings (MoUs). Southern Illinois University's Center for Rural Health and Social Development (CRHSD) works as an information hub and ECHO training provider to the southern Illinois. Most of the organizations work on their own turfs and operate in silos. Though the needs assessment study has 71% providers stating that there is a need for a system of care time integration, resource mobilization and coordination of substance use related services, but the reality is lack of trust and knowledge about the process of system of care involvement has been an ongoing challenge in the region.

Service Desert and Medically Underserved Area: According to the Community Behavioral Healthcare Association of Illinois (CBHA) and SIU-med forum discussion, Southern Illinois has been referred to as a "service desert" by regional and state organizations. Although significant progress has been made regarding workforce development and training, a mental health workforce shortage continues in the region. Two recent studies found a significant gap between the need and treatment capacity in the project area when it comes to OUD. The availability of MAT in Illinois is a dismal 2.2 per 1000 people leading a significant number of opioid abusers without any remedy. Moreover, the Illinois Consortium of Drug Policy (2019) found that Illinois ranked first in the US for the decline in the treatment capacity with state funded treatment capacity being the 3rd worst. This underlines the importance of expanding access to MAT services in southern Illinois which is designated as Health Professional Shortage Area (HPSA) for Medical (low income population) and Mental health (geographic designation).The project area is not only a medically underserved area, but it also faces challenges in recruiting and retaining competent medical and behavioral health workforce.

Meth Use Increase: An analysis of 2018 Adult Redeploy Illinois (ARI) data found indications of methamphetamine use have increased 26%. The emphasis of existing federal funding in the region focused on OUD and not on additional SUDs such as methamphetamine. Therefore, it is important to include other SUDs and their moderating effect in amplifying the negative impact of OUD in a certain area.

Impact of parental substance use on children: The needs assessment study showed that there is a significant impact that parental OUD has on children and prospect of children being referred to the child protective services, yet the child protective services and the substance use services in the project do not share data or provide services in consort with each other. The needs assessment showed a genuine fragmentation among the child welfare system, the substance use providing systems, the law enforcement and the school systems. Focus group interviews with child welfare administrators and case workers showed pointed out no existing coordination between the substance use and child welfare services in the area. In fact, during the data collection for the need assessment no record of parental substance use data connecting to child protective investigations could be found. The parental substance use related data are broadly categorized under neglect that had contributed to the retrieval as well. The local county judge from the Union County

had recently observed that parental opioid use disorder related referral to the child welfare system have been increasing in the county for last couple of years. 90% of providers surveyed had come across children that had been adversely affected by parental addiction to opioids and meth. . Over 50% of respondents knew people that have young children (age 0-12) and are addicted to opioid and meth. 8 respondents said they know 10 or more people with opioid and meth addiction that also have young children. 62% of respondents felt that parental misuse of opioid and meth together put children at the most risk compared to either opioid misuse alone (14%) or meth misuse alone (19%). 85.7% of the providers reporting to the need assessment study stated that they did not know of any initiative in the project area or the surroundings that specifically focus on children affected by parental opioid/meth addiction. A focus group was conducted among three child welfare administrators in the project area. The administrators identified Allegation 60 and 65 of Illinois CPS codes that dealt with the collection of information involving referral of children to the Child Protective Services. The following themes emerged from the focus group deliberations of the child welfare administrators:

a) There are too many protective custodies in the area due to parental drug use.
b) There is no coordinated data gathering efforts that are in place.
c) The likelihood of parents referred by the CPS to the local available SUD treatment services in the area is very slim. The CPS administrators felt that the responsiveness is very low in the SUD services system in the area.
d) There is a dearth of behavioral health providers in the area with skills to address parental substance use or even address children with trauma from parental substance use. This is elaborated in the following comment:

"They have no real treatment for the parents. They already know it is a problem. They need providers that can address SUD in parents. They need experienced professionals and a solid treatment program. Many years ago, SIU had a program for sexual abuse treatment. It offered grant funded therapy for parents, group/family, and children. Meth and opioids aren't easy to walk away from."

e) Domestic violence treatment option in the area are limited.
f) There has also been a significant increase in adolescents using opiates and meth.

E. **Target Population:**
    a. **Direct target** - citizens of Union, Massac, and Johnson counties
    b. **Indirect target** – primary care prescribers, providers, substance use therapists/counselors, parents, youth, concerned community members and influencers
F. **Goals and Objectives**
    a. **Goal # 1:** Facilitate collaboration between primary care and specialty care providers and the recovery community to support the development and implementation of comprehensive and integrated systems of care that provide increase access to a full spectrum of treatment and recovery support services for people with opioid use disorder and meth use disorder.
        i. **SMART Objective # 1:** By December, 2025 Increase the number of OUD workforce in the project area by 20

Strategy 1: Increase the number of MOUD providers in the project area from 4 to 8 by July of 2024, and increase the number of OUD/MUD certified paraprofessional providers in the project area from 0 to 5 by July of 2024

Strategy 2: By December, 2025, promote proactive measures to outreach participation of persons with OUD/MUD in prevention, treatment and recovery services in the project area by 40%

ii. **SMART Objective # 2:** Improve interagency treatment coordination by implementing a shared database (non-existent as of 2021) by 2025 that would allow for the sharing of individual patient information, workforce availability, revenue and waiting lists across substance use providers in the consortium to streamline efforts and increase access to substance use services.

Strategy 3: By December 2023, educate consortium members on technicalities of a system of care approach

Strategy 4: By December 2025, implement a system of care approach that would allow for the sharing of individual patient information, workforce availability, revenue and waiting lists across substance use providers in the consortium to streamline efforts and increase access to substance use services.

iii. **SMART Objective # 3**: By December, 2025 Integrate the pharmaceutical and counseling services of MAT/MAR from SAMHSA Integrated care level 3 to level 6 by improving coordination among consortium partner organizations

Strategy 5: By July 2023 implement culturally and linguistically appropriate 2 trainings annually to MAT providers on the different levels of integrated health care guideline by SAMHSA to primary care and behavioral health serving organizations in the project area that participate in the MAT program.

Strategy 6: By July 2023 incorporate 2 consulting sessions annually with administrators of organizations providing behavioral counseling and suboxone prescribing on how to integrate their services as per the SAMHSA integrated care levels.

G. **Goal # 2:** Reduce stigma towards persons with OUD/MUD (both personal and institutional) and harm-reduction treatment approaches through evidence-based training, workshops and community awareness campaign

a. **SMART Objective # 4:** Provide quarterly stigma reduction trainings to the substance use providers, child welfare workforce, law enforcement and school workforce twice a year from December 2023.

Strategy 7: By July 2023 begin provide 1 training quarterly focusing on train-the-trainer on stigma reduction in faith communities, law enforcement officers and school teaches/administrators through an evidence-based anti-bias curriculum

Strategy 8: Conduct a community-wide stigma reduction campaign between July 2023 and December 2025.

b. **SMART Objective # 5** Implement quarterly training and continuing education units (CEUs) for primary care, behavioral health, and child welfare providers that clarify the differences between harm reduction and abstinence-based approaches to substance use treatment

Strategy 9: By July 2024 begin conducting culturally and linguistically appropriate 2 trainings annually on the differences in principles of harm reduction and abstinence models to conjoint audience of primary care and behavioral health staff engaged in MAT

Strategy 10: By December 2023 implement subcommittee within the consortium involving faith-based organizations and law enforcement organizations to provide culturally and linguistically appropriate discussion and technical support on stigma towards harm reduction approaches.

H. **Goal # 3:** To establish a mechanism, currently nonexistent as of 2021, to collect and store data within the Department of Child and Family Services (DCFS) system to identify children referred to Child Protective Services impacted by parental addiction to opioid/meth in the project area by December 2024.

i. **SMART Objective # 6:** Integrate the systems of child protective services (CPS) and substance use provisions for parents, siloed and fragmented as of 2021 within the project area, and create a data sharing protocol between the systems to ease parents, whose children have been referred to the CPS, access substance use services by December, 2024.

Strategy 11: : By October 2024, create an intersystem of protocol to assess, treat and refer parents with OUD/MUD identified in the CPS investigation with the OUD/MUD recovery support groups and resources in the project area.

Strategy 12: Identify and implement a database through which the parental OUD/MUD assessment data can be integrated with child protective services investigation data and be shared with the substance use providers within the project area by December 2023.

Strategy 13: Establish a subcommittee, non-existent as of 2021, within the RCORP consortium to facilitate care coordination and communication between substance use and child protective services by December 2022.

ii. **SMART Objective # 7:** Connecting parents with OUD/MUD of children referred to CPS to recovery communities and assist them in accessing recovery support resources, non-existent in the project area as of 2021, by December 2023.

Strategy 14: By October 2024, implement an intersystem of protocol to assess, treat and refer parents with OUD/MUD identified in the CPS investigation with the OUD/MUD recovery support groups and resources in the project area.

Strategy 15: By December 2024, Increase participation for parents with OUD/MUD, whose children are referred to CPS, to recovery support groups and services.

Action Plan

SMART Objective: 1				
By December, 2025 Increase the number of OUD workforce in the project area by 20				
Activities	**Timeline**		**Who Is Responsible?**	**Process Indicators with Metrics**
	Start Date	**End Date**		
Recruit primary care professionals interested in pursuing waiver status and leverage state resources for financial and education programs to received MAT certification.	10/22	Ongoing	Project Director SIU-SOM	# of MAT Providers
Increase the number of local professionals who access technical assistance programs such as the ECHO.	10/22	Ongoing	Project Director Project Coordinator SIU-SOM	# Providers Registered for ECHO
Increase the number of certified peer support providers in communities through community partners recruiting and retaining this role.	10/22	Ongoing	Training Coordinator Consortium Sub-Committee	# of Peer Support Certifications in Community; Training Documents
Collaborating with Egyptian Mental Health to train all Rural Health, Inc. staff and community members on how to use Narcan.	10/22	Ongoing	Project Director Project Coordinator Training Consultant (Matt Buckman) Person in recovery Consortium members	# Naloxone supply in the project area
Become a Behavioral Health Workforce Education and Training (BHWET) in partnership with Southern Illinois University School of Medicine to help in future training and recruitment of locally embedded licensed counselors/social workers	10/22	7/23	Project Director	Assignments of BHWET interns among consortium organizations Participating in BHWET grant writing process
Strategy 2: By December, 2025, promote proactive measures to outreach participation of persons with OUD/MUD in prevention, treatment and recovery services in the project area by 40%				
Activities	**Timeline**		**Who Is Responsible?**	**Process Indicators with Metrics**
	Start Date	**End Date**		
Enhance telehealth services within the project area	7/23	Ongoing	Project Director Project Coordinator All other consortium members Training Consultant (Matt Buckman) Evaluation Consultant (Dhru Mukherjee)	# of telehealth clients
Promote mobile drug testing services to increase pharmacologically-informed screenings	10/22	Ongoing		# drug testing done
Coordinating with the local syringe exchange program and consulting blood testing data from those programs	10/22	Ongoing		# blood testing data consulted
SMART Objective: 2				
Strategy 3: By December 2023, educate consortium members on technicalities of a system of care approach				
Activities	**Timeline**		**Who Is Responsible?**	

	Start Date	End Date		Process Indicators with Metrics
Seek continuous technical assistance about the opportunities of creating a system of care connecting various substance use prevention, treatment and recovery services	10/22	Ongoing	Project Director	# technical assistant calls
Hold quarterly consultation with individual consortium members in their organizational location to discuss their concerns about system of care approach	12/23	Ongoing	Project Consultant (Matt Buckman) (Dhru Mukherjee)	# individual consultation calls
Provide quarterly 1 workshop with consortium partners on legal, ethical and financial components of participating in a community-based system of care	7/23	Ongoing	Project Consultant (Matt Buckman) (Dhru Mukherjee)	# attendance to work Evaluation data of workshop
Strategy 4: By December 2025, implement a system of care approach that would allow for the sharing of individual patient information, workforce availability, revenue and waiting lists across substance use providers in the consortium to streamline efforts and increase access to substance use services.				
Activities	**Timeline**		**Who Is Responsible?**	**Process Indicators with Metrics**
	Start Date	**End Date**		
Identify the common areas of cooperation in sharing resources, waiting lists and referral information and incorporate that in the Consortium MoU	7/23	Ongoing	Project Consultant (Matt Buckman) (Dhru Mukherjee)	List of common areas of cooperation
Identify and adopt a common database system to manage the workflow of a system of care in healthcare information sharing across organizations	10/23	Ongoing	Project Director Project Consultant (Matt Buckman) (Dhru Mukherjee)	Identification and adoptional of database
Recruit a contact person with each participating consortium organization to address client needs, referrals, workforce shortage issues, training and other strategies.	12/23	7/24	Project Director	Confirmation of hiring
SMART Objective: 3				
Strategy 5: By July 2023 implement culturally and linguistically appropriate 2 trainings annually to MAT providers on the different levels of integrated health care guideline by SAMHSA to primary care and behavioral health serving organizations in the project area that participate in the MAT program.				
Activities	**Timeline**		**Who Is Responsible?**	**Process Indicators with Metrics**
	Start Date	**End Date**		
Develop/Adapt for educational materials and content for didactic awareness training that incorporate harm-reduction approach, knowledge about drug use including implications of the methods of administration, impact of poly-substance use, influence of co-occurring mental health issues and	10/21 – Year 1, Quarters 1&2	4/25 Ongoing	Project Director Project Coordinator Prevention Consultant (Dhru Mukherjee) Consortium members	Updated educational and promotional materials approved by the consortium

impact of drug abuse on children's welfare				
Create a regional learning network for support staff such as nurses, medical assistants, case managers, and community health workers to discuss best practices and aid MAT service delivery	12/24	Ongoing	Project Director Project Coordinator Training Consultant (Matt Buckman) (Dhru Mukherjee) (Ginger Meyer)	Learning network launched # participation in learning network
Conduct 2 trainings annually on the differences in principles of harm reduction and abstinence models to conjoint audience of primary care and behavioral health staff engaged in MAT	July 2022	Decembe r 2025.	Project Director Project Coordinator Training Consultant (Matt Buckman)	# trainings # consultations Harm reduction assessment scores

Strategy 6: By July 2023 incorporate 2 consulting sessions annually with administrators of organizations providing behavioral counseling and suboxone prescribing on how to integrate their services as per the SAMHSA integrated care levels.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Conduct 2 workshops to educate on the different levels of integrated care and clarify differing perceptions	6/23	6/24/	Project Director and Project Consult	Commencement of workshops Attendance
Provide one to one assessment of integrative care at individual consortium member organizations	1/24	12/24	Project Consultant (Dhru Mukherjee)	# assessments conducted Assessment report
Organizations create organization-level actions to elevate the integrated health levels	1/25	12/25	Consortium Members	# Integrated Health Assessment Tool (SAMHSA)

SMART Objective: 4

Strategy 7: By July 2023 provide education on stigma reduction to faith communities, law enforcement officers and school teaches/administrators through an evidence-based anti-bias curriculum

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Develop/Adapt for educational materials and content for didactic awareness training that incorporate the role of trauma, cooccurring mental health disorders, and other social determinants of health that lead to OUD/MUD	6/23	12/24	Project Coordinator and Consortium Subcommittee	Finalization of material
Increase faith-communities understanding of substance use disorders that adversely affect mental, physical and spiritual beings by incorporating moments of education worship in partnership with local churches	10/22	Ongoing	Consortium Faith-subcommittee	# education infusion during worship
Holding two trainings annually with faith-based, schools and law enforcement administrators focusing	12/23	Ongoing	Project Consultant and Training Coordinator	Training curriculum approved by the consortium # trainings conducted

on train-the-trainer on stigma reduction				Training evaluation scores

Strategy 8: Conduct a community-wide stigma reduction campaign between July 2023 and December 2025.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Develop and disseminate communication materials and other resources to increase understanding of families and caregivers on facts around opioid misuse to reduce stigma.	10/22	12/23	Project Director Project Coordinator Training Consultant (Matt Buckman) (Dhru Mukherjee) (Ginger Meyer)	Approval of material by the consortium
Identify local key communication venues for target populations, including web-based social networking sites and print and broadcast media	10/22	Ongoing		# venues came in contact List with name of venues
Conduct biannual evaluation of the stigma education campaign	7/24	Ongoing	Dhru Mukherjee (Evaluation Consultant)	# Evaluation outcome report

SMART Objective: 5

Strategy 9: By July 2024 begin conducting culturally and linguistically appropriate 2 trainings annually on the differences in principles of harm reduction and abstinence models to conjoint audience of primary care and behavioral health staff engaged in MAT

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Develop/Adapt for educational materials and content for didactic awareness training that incorporate harm-reduction approach, knowledge about drug use including implications of the methods of administration, impact of poly-substance use, influence of co-occurring mental health issues and impact of drug abuse on children's welfare	10/22	12/23	Project Director Project Coordinator Project Consultant (Dhru Mukherjee) Consortium members	Updated educational and promotional materials approved by the consortium
Identify and implement 1 educational training per quarter year-round on the harm reduction approaches to conjoint audience of primary care, behavioral health care and and child welfare workers	12/23	Ongoing	Project Training Consultant (Matt Buckman) and Project Coordinator	Commencement of training # Attendance list

Strategy 10: By December 2024 implement subcommittee within the consortium involving faith-based organizations and law enforcement organizations to provide culturally and linguistically appropriate consultation and technical support on stigma towards harm reduction approaches.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Create a taskforce to hold bimonthly discussions on commonalities between faith-based approaches and harm reduction treatments	10/22	6/23	Project Consultant (Dhru Mukherjee) Project Coordinator	Commencement of meetings

By December 2024, implement Culturally and Linguistically Appropriate Services (CLAS) standard at every health and child welfare services organizational communication and documentation process.	7/23	12/24	Project Director Consortium Members	CLAS standards implemented at consortium partner organizations
By July 2024, implement stigma reduction curriculum in organizational onboarding processes for consortium member organization.	10/22	7/24		Stigma reduction curriculum incorporated at the organizational onboarding process

SMART Objective: 6

Strategy 13: By October 2024, create an intersystem of protocol to assess, treat and refer parents with OUD/MUD identified in the CPS investigation with the OUD/MUD recovery support groups and resources in the project area.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Consult with the TAP system in Tennessee to learn about their CPS-SUD integrated system	10/22	6/23	Integration Consultant Ginger Meyer	# consultation sessions
Draft a protocol laying out details of the process of screening, referral, treatment and recovery of parents with OUD/MUD from CPS to the SUD support services in the project area	7/23	12/23	Project Consultant (Dhru Mukherjee) Child Welfare Integration Consultants (Matt Buckman and Ginger Meyer) and Stephanie Grigsby (CPS	Drafting completed
Finalize the protocol through an MoU signing between CPS and the Consortium	1/24	7/24	Project Director and CPS Administrator	MoU signed.

Strategy 14: Identify and implement a database through which the parental OUD/MUD assessment data can be integrated with child protective services investigation data and be shared with the substance use providers within the project area by December 2023.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Explore and evaluate existing models of screening, referrals and data sharing mechanisms existing	4/23	12/23	Child Welfare Integration Consultants (Matt Buckman and Ginger Meyer) and Stephanie Grigsby (CPS Administrator and consortium member)	Completion of identification with thrashed out details of the system integration and protocol
Identifying a data sharing system to track the screening data across child protective services and substance use services to inform referral to substance use providers	1/24	6/24		Identification and installation of the data tracking system
Pilot installation of a data sharing protocol of SUD parental OUD assessment system within CPS investigating system	7/24	12/25	Project Director and CPS Administrators	Beginning of a pilot OUD integrated CPS data sharing

Strategy 15: Establish a taskforce, non-existent as of 2021, within the RCORP consortium to facilitate care coordination and communication

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Creating a taskforce consisting of the consortium members and CPS representatives to coordinate integration of assessment and referral systems between CPS and Substance Use provision infrastructures	10/22	4/23	Project Director and Project Coordinator	Consortium approval of the taskforce
Disseminate technical assistance and education material about the benefits of system integration of child protective services and substance use services	4/23	Ongoing	Project Consultant (Dhru Mukherjee)	Hold at least 2 evidence-based building discussions sessions between consortium members and CPS administrators
Recruit two screeners to be placed in two Child Protective Services offices to coordinate parental referral and case management	12/23	4/24	Project Director CPS Administrator	Completion of personnel recruitment

SMART Objective: 7

Strategy 16: By October 2024, implement an intersystem of protocol to assess, treat and refer parents with OUD/MUD identified in the CPS investigation with the OUD/MUD recovery support groups and resources in the project area.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Screen parents identified in the child protective investigation for OUD/SUD	10/24	Ongoing	Screening personnel	# screening OU/MUD conducted
Refer parents with OUD/MUD from child protective investigation to MAT/Substance use treatment	10/24	Ongoing		# referrals from child protective services to substance use services
Increase participation of parents with OUD/SUD in the recovery groups	10/24	Ongoing		# of parents with OUD/MUD from CPS participating in recovery support groups

Strategy 17: By December 2024, increase participation for parents with OUD/MUD, whose children are referred to CPS, to recovery support groups and services.

Activities	Timeline		Who Is Responsible?	Process Indicators with Metrics
	Start Date	End Date		
Conduct 1 orientation training annually to CPS investigators and administrators on the recovery-oriented system of care	10/24	Ongoing	Project Director Child Welfare Integration Consultant (Ginger Meyer) Stephanie Grigsby (Child Protective Services Administrator) Prevention Consultant (Dhru Mukherjee)	Orientation training installed and completed
Conduct parenting classes for CPS referred parents in collaboration with Stress and Trauma Treatment Center	6/23	12/25		Approval from the consortium of the class schedule # classes conducted during the project timeframe
Hold 1 training annually for recovery peer support specialists to engage	7/24	Ongoing		# of training completed

parents with OUD/MUD in the community of persons in recovery					

Sustainability Planning

One important finding of the planning grant needs assessment focused on coordination of services and translating this into recovery activities is no exception. This project will expand the system of care within the service area by developing new partnerships and strengthening existing ones between RHI, local inpatient treatment centers, and the criminal justice system. Additionally, referral mechanisms will be created to improve access to services such as housing, employment, food assistant, transportation, and other services. Community engagement will be of utmost importance, especially given the geographic challenges that are ubiquitous in rural areas. Local faith-based organizations, schools, colleges, and law enforcement agencies. By working with these groups, we aim to saturate the community with the necessary resources and referral mechanisms to help someone sustain long-term abstinence.

Department of Children and Family Services (DCFS): Recently a pilot project was proposed to DCFS for creating a coordinating infrastructure between child protective services and the OUD consortium. The goal is to create better systemic coordination in sharing information and services by integrating the child protective services with that of substance use disorder related services in the project area. The pilot project will engage clients from the child welfare systems in services that help parents overcome barriers due to opioid/meth use disorders, cooccurring mental health disorders, domestic violence issues. This proposed project shall increase their access to services to help them achieve and maintain permanency and improve self-sufficiency. The Pilot Opioid Use Disorder (OUD) in Child Welfare will assist vulnerable families so children can be cared for in their own home, by increasing engagement, retention and recovery maintenance of parents with OUD-MUD and cooccurring disorders. The two medical social associates budgeted in the project will work full time with the child welfare administration and service use providers in the area to facilitate services, coordinate systems, share information and inform ongoing needs assessment and outcome evaluation. The two medical social associates will carry out intensive outreach with strength-based engagement, comprehensive assessment, referral to Medically Assisted Treatment (MAT), and other treatment services, pre-treatment, intensive care management, follow-up and treatment support. The pilot project should be cost-effective and reduce the movement to foster care and increase permanency planning in the family environment. Sharing of information and integrating of community-wide system can mitigate costs and increase service accessibility. The current federal grants supporting opioid use related consortiums can help us integrate substance use services better. The integration of services will increase sustainability. Eventually, the core team of this project plans to apply for Behavioral Health Workforce Education and Training (BHWET) grants from Human Resources and Services Administration (HRSA) to continue to train and retain professional and paraprofessional workforce in the area working towards improving the intersection between child welfare and substance use services. If the pilot project show encouraging outcomes in helping parents reduce their barriers that could save potential costs for the DCFS. Similar to the Targeted Assessment Program (TAP) in Kentucky the pilot program could be enhanced and embedded in the existing funding mechanisms.

Sustaining Consortium membership and support

The consortium has been formed after securing funding from HRSA RCORP planning grant mechanism. The consortium members have worked together carrying out a needs assessment study of the project area, putting together a strategic plan and having consortium members ascertain their roles through a MoU agreement. The core consortium members have had a long-standing relationship working in various projects. Various extant federal, state, and locally funded engagements among the partner organizations have already strengthened a trust based working relationship in them. Dr. Matt Buckman, Dr. Dhru Mukherjee and Ginger Meyer have work together with each and every member representing a partner organization in the consortium. This amount of history and trust are conducive to develop commitment that will help maintain stakeholder confidence as the consortium expands. As the consortium grew, the members have gotten to know each other, however, the interdisciplinary and varied nature of the group also bring about challenges. The needs assessment study brought many dysfunctionalities that previously existed in the project area, for example, child welfare administrators are critical of the substance use providers since they feel the substance use providers are lax with parental substance use issues, there had been complains from faith-based organizations and child welfare investigators about how law enforcement take a softer approach to substance use arraignments. Lack of understanding about harm reduction methods among many provider organizations admixed a faith-based traditional stigma towards harm reduction, mental health and substance misuse further fuel differences. The consortium does provide a safe place for the members to confer. The deliberations about drug use and their correlations with co-occurring mental health disorders have found sympathetic ears among the naysayers. The proposed harm-reduction training in the implementation grant can provide additional opportunities to clarify differences in principles and knowledge on drug use, treatment approaches and rational behind harm reduction methods. The formal meetings and shared social media presence do provide a sense of community among the consortium members. The key personnel of the program also hold high regard in the community and own soft power to hold the group together. Every consortium member is compensated and have been working towards sustainability funding applications together which could also play an important role in strengthening the group together. As the consortium is expanding in size many sub-committees under specialized areas such as child welfare, psychostimulant addiction and so on help the consortium to work on specialized narrow topics and create further in-group bonding.

Secure target-populations support and engagement

Engagement of communities needs to be done in a strategic manner. Since different counties have different types of substance use patterns and the response system, a system of care approach through the consortium needs to be build up. There are two barriers to engaging the PWUD, a) lack of funding to do enough outreach, recruit and train competent workforce, and b) lack of consensus in the community about the different approaches to drug treatment practices that create silos the provision of services. In order to engage the community around prevention, treatment and recovery goals of the project area there needs to be provider education followed by community education and dialogue on the harm reduction approaches. There is a great distrust about any services in the region that has anything to do with the government. Collating MAT services with drug dealing causes further misunderstanding. Often the providers themselves perpetrates such prejudices. Moreover, the overwhelming of the substance use response system

due to high case load, inadequate workforce and lack of resources and training opportunities are essential barriers to community engagement. Finally, Covid 19 pandemic and the social restrictions led to the shrinking of services and mobilities would create additional challenges to PWUD outreach. The telehealth and telecommuting infrastructure too are crucial to maintaining the effectiveness of the consortium, and connecting services and messages to their targets.

Leverage partnerships

It is essential for long term sustainability during the implementation stage. Identifying suitable partners, leveraging an existing trust relationship, leveraging on existing federal, local, and state funded projects are important in maintaining sustainability in the future. It will augur well that many partner organizations have been successful in receiving funding together and have had a history of creating new projects and sustaining them. Signing an MOU is the first step towards building sustainability. Bringing together so many partners and encouraging information sharing and open communication will open door for future fund raising and collaborative opportunities. All partners must have a voice in the discussion and be part of creating a vision. Only with that level of buy-in that sustainability is possible. While partners will make monthly at a minimum during the project, they will continue to meet quarterly after the project ends. They will join work groups as specific issues arise or as needed to fulfill program needs. In partnership with the Southern Illinois University, the partners will develop sustainable training process to continue to train community members and students to generate a sustainable workforce. One example of leveraging partnership will be the way the Department of Child and Family Services (DCFS) joined the consortium to create a drug screening program not only in the project but also looking into installing that practice in their regular system, and that kind of state connection could only be secured through leveraging personal and professional networks of the consortium members. The partner organizations will continue to seek funding projects and to help with mileage and other costs associated with participating in the partnership. It is encouraging that the participating organizations and the key members of the project have had a successful history of working together and receiving outside funding.

Financial Sustainability

The RCORP planning grant had led to the onset of this project. The consortium held together its core, expanded and recruited new members. The proposed implementation grant funding is a step towards that direction. The consortium also plans apply for the RCORP psychostimulant grant program to explore intervention for meth use disorder in the area. While planning on workforce development and the high turnover of the primary care as well as the behavioral health professional has posed a challenge for agencies in the region. The Behavioral Health Workforce Education and Training (BWHET) funding mechanism from HRSA creates funding to recruit and training college students to become professional integrated multidisciplinary providers in the region from the graduate programs of social work, counseling and rehabilitation counseling at SIU. A few key members of the consortium did apply for that grant. Moreover, the paraprofessional program of the BWHET lets organizations train community-based peer support specialists using federal incentives. Moreover, if the RCORP implementation grant could demonstrate that there is a value in creating a mechanism to gather parental substance use data during child welfare investigation and if that show to bring the substance use providers and the child protective services to work together to help the families in the area, there could be a strong possibility to advocate to the State Department of Child and Family Service (DCFS) to adopt one

of the project area counties for as a pilot project with state funding. The DCFS regional administrator is already part of the grant. These initiatives seek to continuously engaged in seeking funding from state and federal sources.

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