OPCA

Oregon Primary Care Association

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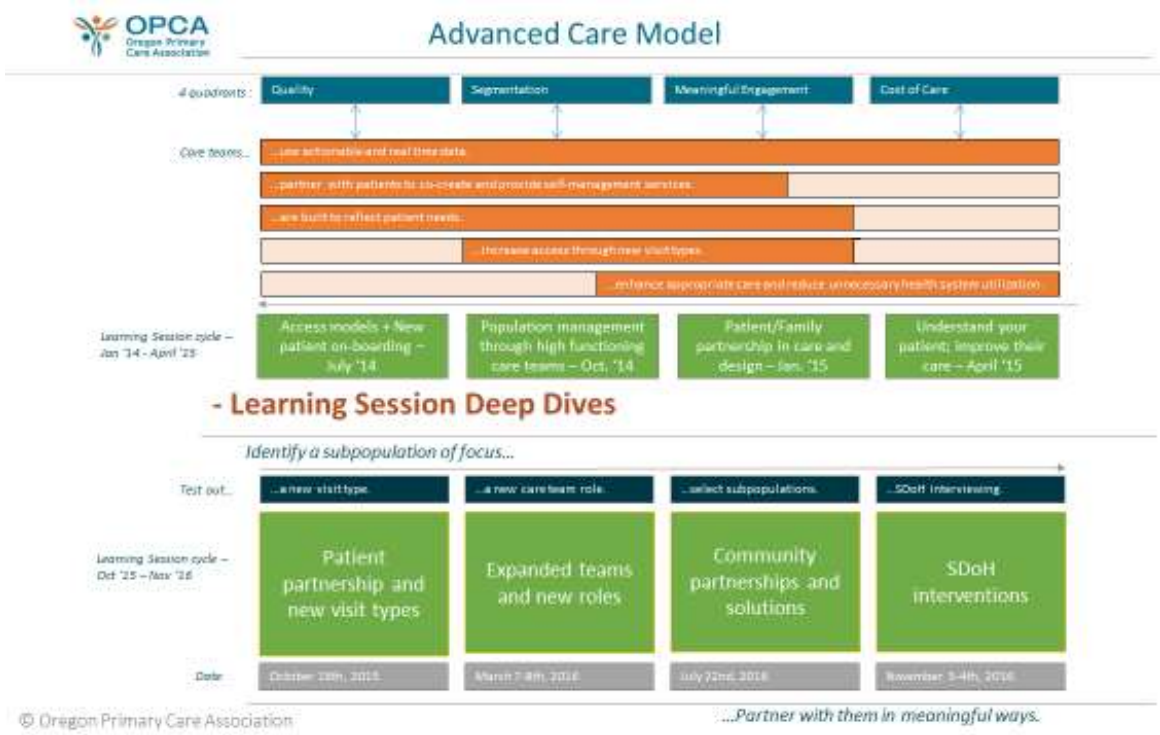
Advanced Care Learning Community

January 15, 2018

Red Lion Jantzen Beach

Welcome!

APCM
Learning Community



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2014 -- 2018

2018 -- ??

Why Substance Use Disorder?

- Roughly 9.6% of Oregonians suffer from SUD.[1]
- Roughly 9.4% of Oregonians have been diagnosed with Diabetes (up to 12% may suffer undiagnosed).[2]
- There are more deaths, illnesses and disabilities from substance use than any other preventable health condition.[3]
- Less than 10% of people with an SUD receive treatment at a specialty facility.[4]

1. https://www.oregon.gov/gov/policy/Documents/Addictions-Whitepaper-101218.pdf
2. https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DIABETES/Documents/OregonDiabetesReport.pdf
3. https://www.drugabuse.gov/publications/health-consequences-drug-misuse/death
4. https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

What else does SUD have in common with Diabetes?

- It is a chronic disease and responds best to a “combination of self-management, mutual support, and professional care provided by trained and certified professionals.”[1]
- It can be treated in primary care using a chronic disease management approach guided by the chronic care model.[2]
- Patients can achieve sustainable management of their condition, even though they may experience relapse.

1. https://www.asam.org/resources/definition-of-addiction
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756688/

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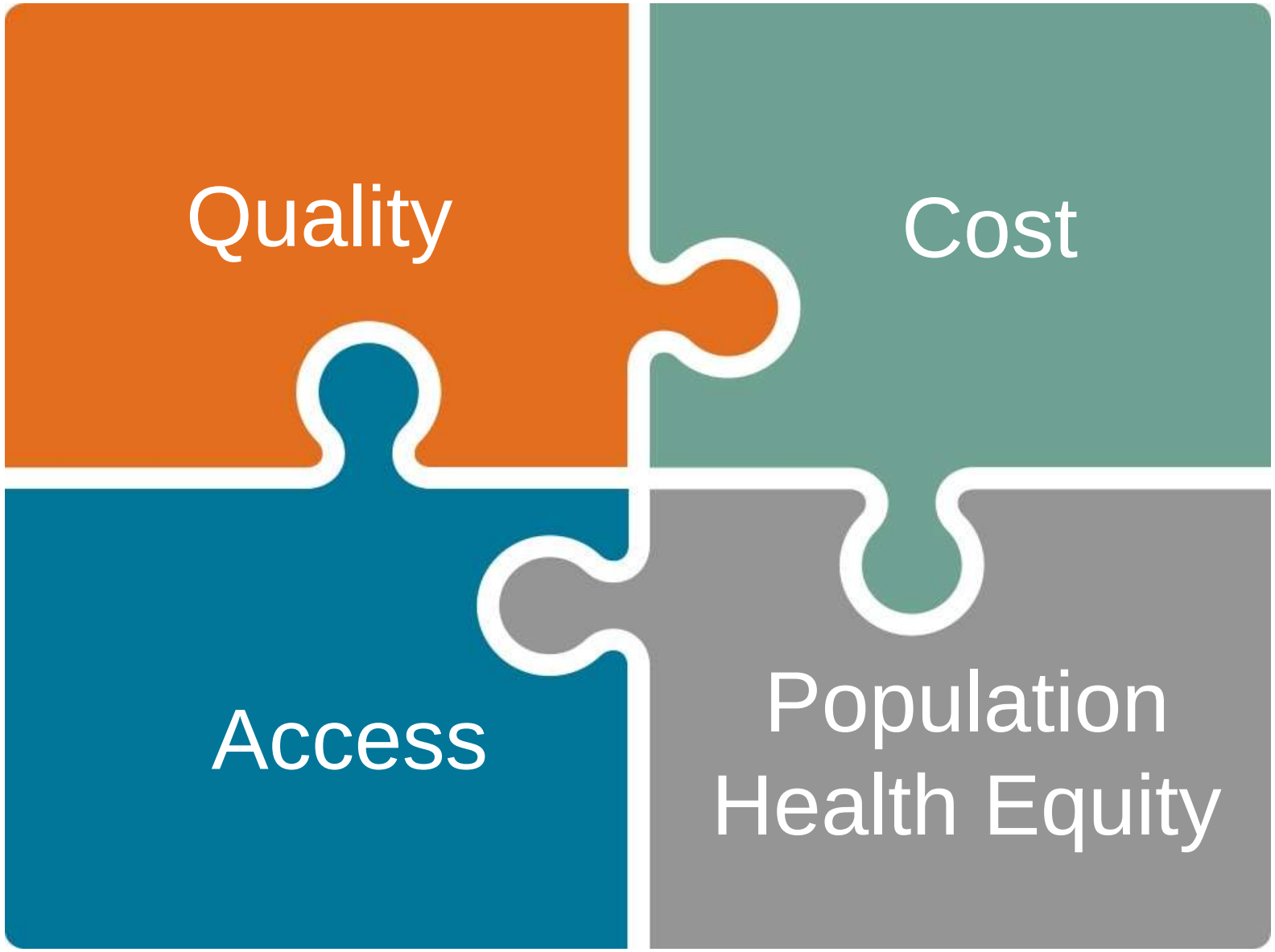
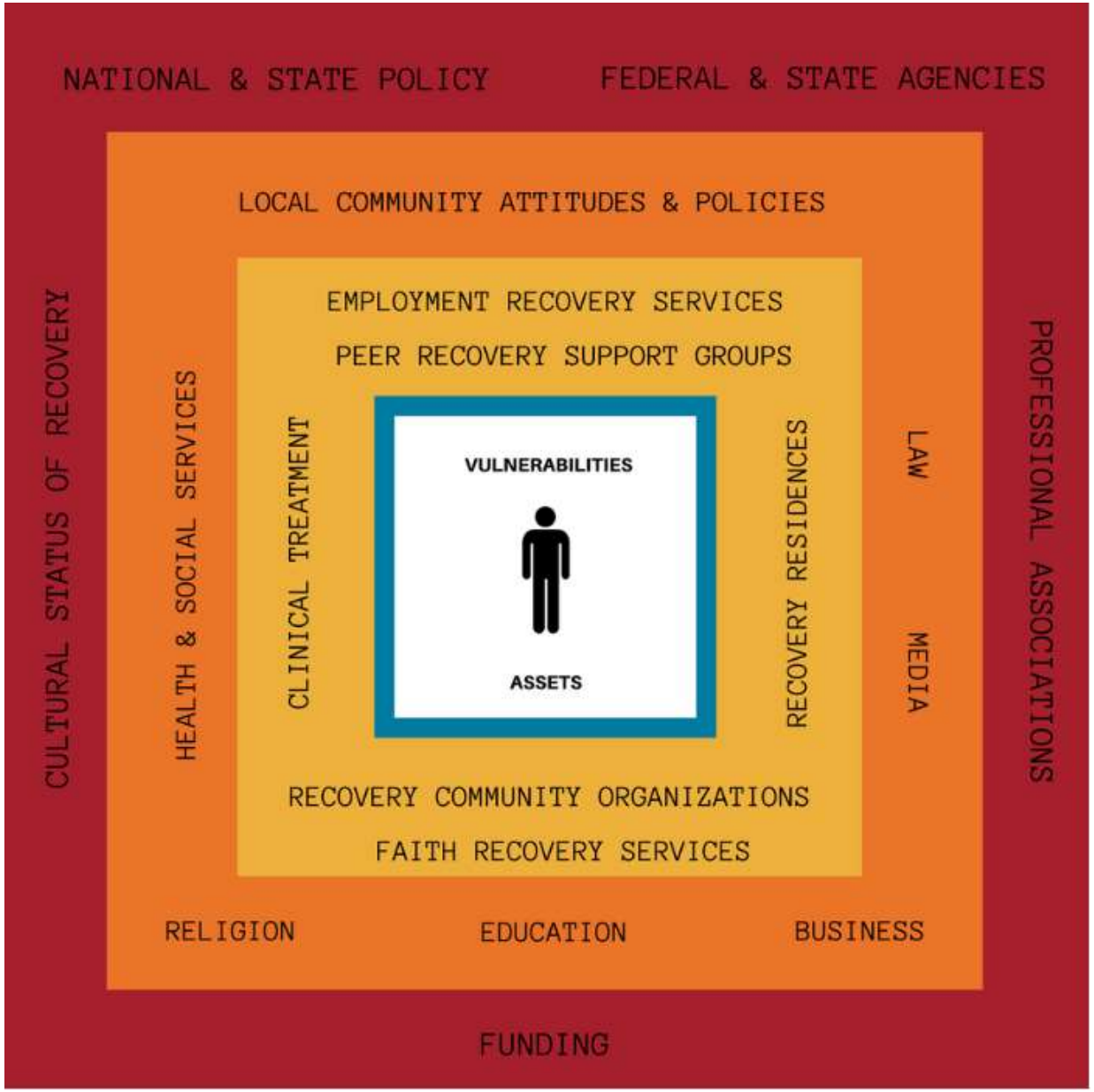
circle arrow by Tinashe Mugayi fro the Noun Project

Quadruple Aim



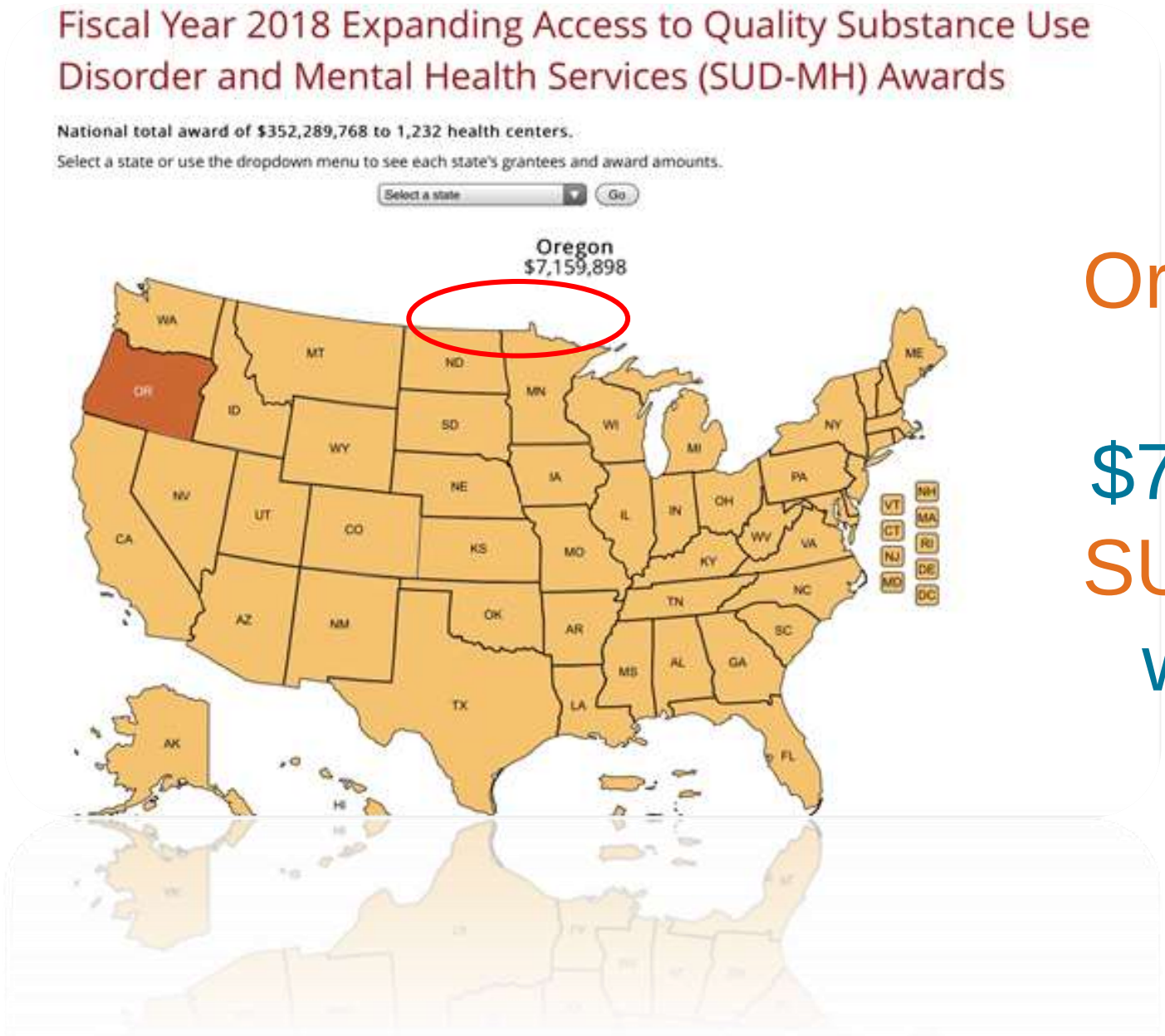


https://www.recoveryanswers.org/resource/recovery-oriented-systems-care/

This sounds a lot like addressing the social determinants of health, doesn't it?

Recovery Oriented Systems Of Care

Wellness-Oriented Systems of Care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk of chronic health conditions.



Oregon health centers received over $7,000,000 to expand SUD-MH services and we want to support you!

Medication-Assisted Treatment at Oregon Health Centers

2016	2017
• 15 health centers • 72 providers • 950 patients • Average of 13 patients per provider	• 22 health centers • 119 providers • 2,169 patients • Average of 18 patients per provider

Objectives

- Explore the viability and implementation of new and unique team roles and effective, trauma informed practices for whole person treatment of substance use disorders in primary care
- Learn from specialty behavioral health experts about evidenced based and promising practices for delivering integrated care in either primary care or behavioral settings
- Consider the medical and social determinants of health disparities for people affected by SUD and behavioral health conditions as well as the promise of the Recovery Oriented System of Care for improving population health

Upcoming Learning Opportunities for Responding to SUD in Primary Care!

Introduction to Motivational Interviewing

In partnership with the Northwest Addiction Technology Transfer Center

February 14-15, Portland

March 14-15, Medford

Behavioral Health Directors Peer Network Launching in 2019! Stay tuned for more info!

Legislating SUD/OUD Policy in 2019

Advanced Care Learning Community

January 2019

Oregon's Legislature

- Oregon's legislature meets annually
  - Session lasts 160 days in odd-numbered years and 35 days in even number years
- 2019 Session convenes **January 22, 2019** *(next week!)*
- 2019 makeup:
  - 30 Senators (18 D, 12 R)
  - 60 Representatives (38 D, 22 R)
  - = Supermajorities in both chambers

2019 Session at a Glance

- Budget
  - Health care gap of $830M
    - New revenue sources (may) include:
      - Corporate tax ($2B) to (largely) fund education (K-12)
      - Tobacco tax (raises tax $2 on cigarettes and includes increased taxes on e-cigs/vaping products; expected to bring in $95M this biennium)
      - Liquor licensing fee increase
      - Health insurance premium tax
      - Hospital tax (raised from 5.3% to 6%)
      - Employer tax (assessment on employers who do not meet threshold health care contributions on behalf of their workers)
- Policy themes
  - Housing
  - Foster care
  - CCO 2.0
  - Vaccines

SUD/OUD State Policy

- Opioid Epidemic Task Force
  https://www.oregon.gov/gov/policy/Pages/Opioid_Epidemic_Task_Force.aspx

  - Convened by Gov. Brown in September 2017
    - Membership includes medical experts, drug treatment specialists and government officials

    - Charged with following priorities:
      - Reducing the number of narcotic pills in circulation
      - Improving access to high quality treatment
      - Facilitating data sharing
      - Promotion of cutting edge education efforts

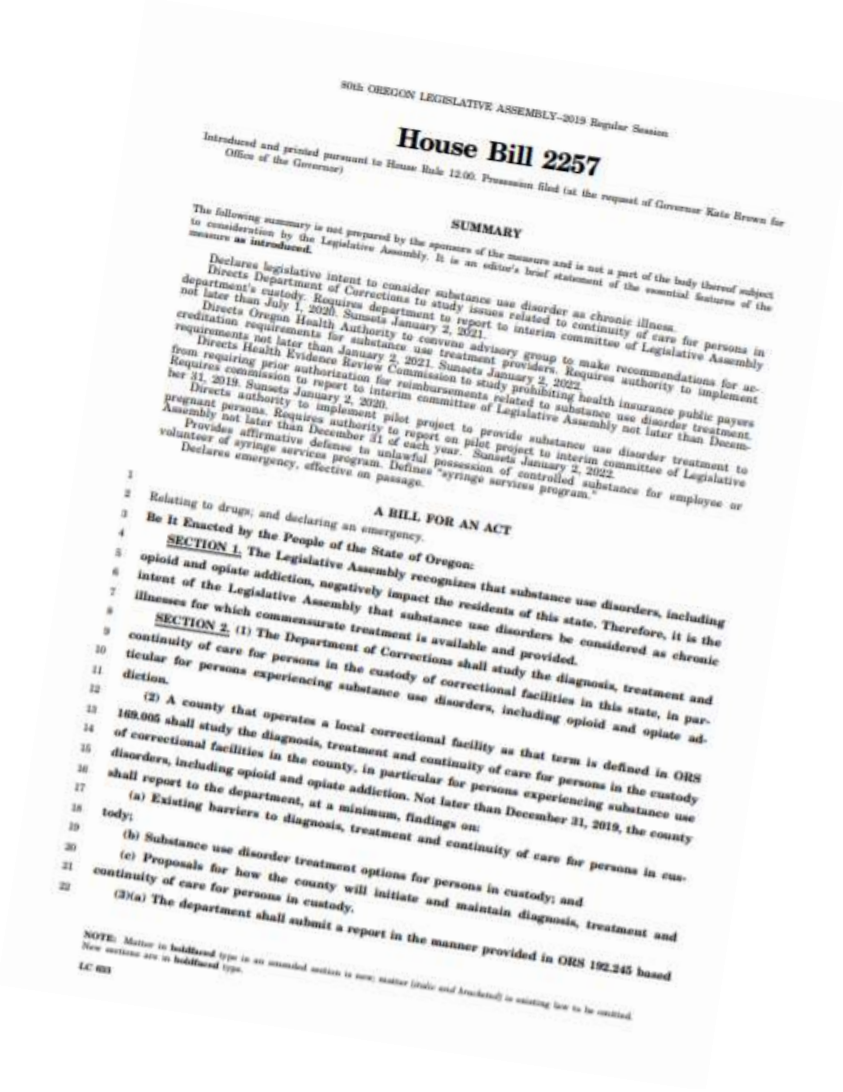
Opioid Epidemic Task Force: Legislation

- HB 4143 (2018)
  - Required all prescribers to register to use the PDMP
  - Directed DCBS to study barriers to effective treatment for and recovery from SUD
  - Allocated $2M to Multnomah, Coos, Jackson and Marion counties to pilot an immediate access to appropriate evidence-based treatments for individuals who have experienced an overdose

Opioid Epidemic Task Force: Legislation

continued

- HB 2257 (2019)
  - SECTION 1. The Legislative Assembly recognizes that substance use disorders, including opioid and opiate addiction, negatively impact the residents of this state. Therefore, it is the intent of the Legislative Assembly that **substance use disorders be considered as chronic illnesses for which commensurate treatment is available and provided.**
  - Does not allocate any funding, however, sets the stage for how SUD/OUD will be discussed in the legislature
  - Emergency clause; if passed, bill takes effect immediately upon passage



80th OREGON LEGISLATIVE ASSEMBLY–2019 Regular Session

House Bill 2257

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown for Office of the Governor)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Declares legislative intent to consider substance use disorder as chronic illness.

Directs Department of Corrections to study issues related to continuity of care for persons in department's custody. Requires department to report to interim committee of Legislative Assembly not later than July 1, 2020. Sunsets January 2, 2021.

Directs Oregon Health Authority to convene advisory group to make recommendations for accreditation requirements for substance use treatment providers. Requires authority to implement requirements not later than January 2, 2021. Sunsets January 2, 2022.

Directs Health Evidence Review Commission to study prohibiting health insurance public payers from requiring prior authorization for reimbursements related to substance use disorder treatment. Requires commission to report to interim committee of Legislative Assembly not later than December 31, 2019. Sunsets January 2, 2020.

Directs authority to implement pilot project to provide substance use disorder treatment to pregnant persons. Requires authority to report on pilot project to interim committee of Legislative Assembly not later than December 31 of each year. Sunsets January 2, 2022.

Provides affirmative defense to unlawful possession of controlled substance for employee or volunteer of syringe services program. Defines "syringe services program."

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to drugs; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Legislative Assembly recognizes that substance use disorders, including opioid and opiate addiction, negatively impact the residents of this state. Therefore, it is the intent of the Legislative Assembly that substance use disorders be considered as chronic illnesses for which commensurate treatment is available and provided.

SECTION 2. (1) The Department of Corrections shall study the diagnosis, treatment and continuity of care for persons in the custody of correctional facilities in this state, in particular for persons experiencing substance use disorders, including opioid and opiate addiction.

(2) A county that operates a local correctional facility as that term is defined in ORS 169.005 shall study the diagnosis, treatment and continuity of care for persons in the custody of correctional facilities in the county, in particular for persons experiencing substance use disorders, including opioid and opiate addiction. Not later than December 31, 2019, the county shall report to the department, at a minimum, findings on:

(a) Existing barriers to diagnosis, treatment and continuity of care for persons in custody;

(b) Substance use disorder treatment options for persons in custody; and

(c) Proposals for how the county will initiate and maintain diagnosis, treatment and continuity of care for persons in custody.

(3)(a) The department shall submit a report in the manner provided in ORS 192.245 based

NOTE: Matter in boldfaced type in an amended section is new; matter [italic and bracketed] in existing law to be omitted. New sections are in boldfaced type.

LC 623

HB 2257

continued

- Other key provisions:
  - Convenes advisory group to recommend accreditation requirements for treatment programs for substance use disorders, including opioid and opiate addiction; OHA to implement recommendations by January 2021
  - Commissions study by HERC on impact of prohibiting the use of prior authorization when reimbursing for the cost of treating substance use disorders by public payors; study to be completed by December 2019
  - Establishes pilot project to provide SUD treatment to pregnant persons for the duration of the pregnancy and up to 1 year following (fiscal of $5M included, 4 counties to be selected)
  - Department of Corrections study on continuity of care for incarcerated persons who are diagnosed and treated for SUD.

HB 2627

- (2) The Oregon Health Authority shall operate a peer managed recovery center in every city in this state that has a population of 100,000 or more. Each peer managed recovery center shall, at a minimum:

  (a) Offer culturally specific peer mentor support 24 hours per day;

  (b) Maintain a 24-hour telephone advice line;

  (c) Offer in-person peer support services for 12 hours each day;

  (d) Host five cognitive behavioral therapy sessions each day using a range of recovery models; and

  (e) Establish a memorandum of understanding with all residential and outpatient substance use disorder treatment providers within a 100-mile radius of the center to enable the center to connect with individuals completing treatment and advise the individuals of the services available from the center.

Thank you!

Reach your policy team at:

Danielle Sobel, OPCA Policy Director: dsobel@orpca.org

Marty Carty, Policy Senior Manager: mcarty@orpca.org

RECOVERY-ORIENTED PRIMARY CARE: PUTTING HEALTH CARE IN CONTEXT

OPCA Advanced Care Learning Community
Rachel Solotaroff, MD, MCR
President and CEO, Central City Concern
January 14, 2019

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How's it going?

"The barrier to change is not too little caring; it is too much complexity."

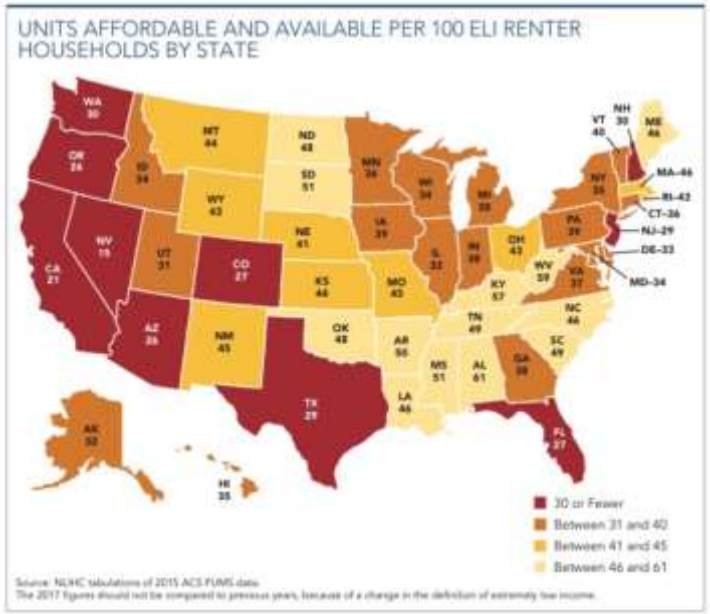
What Do I Mean by Complexity?

How many of you take care of patients who struggle with…

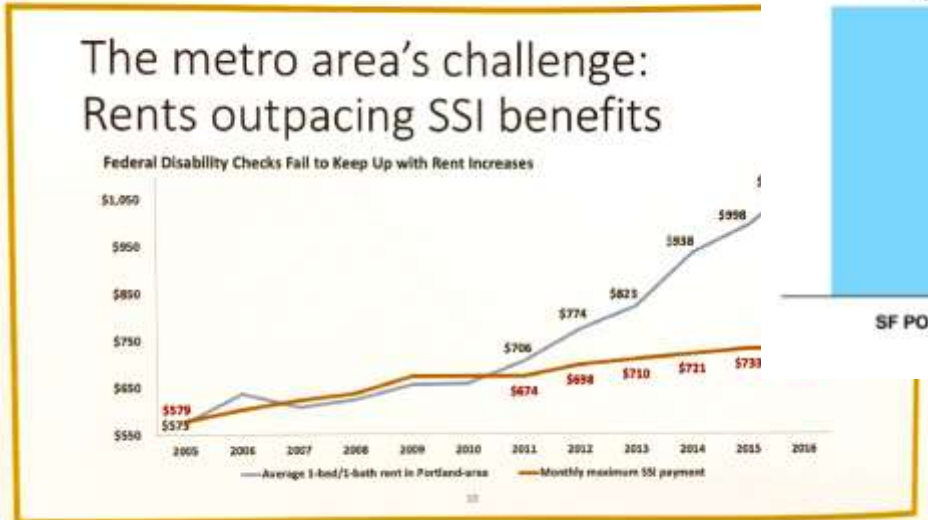
- **Paying their rent?**
- **Finding a job that pays the bills?**
- **Encountering racism and discrimination?**
- **Facing barriers because of a criminal history?**
- **Using alcohol or drugs for physical or psychological safety?**

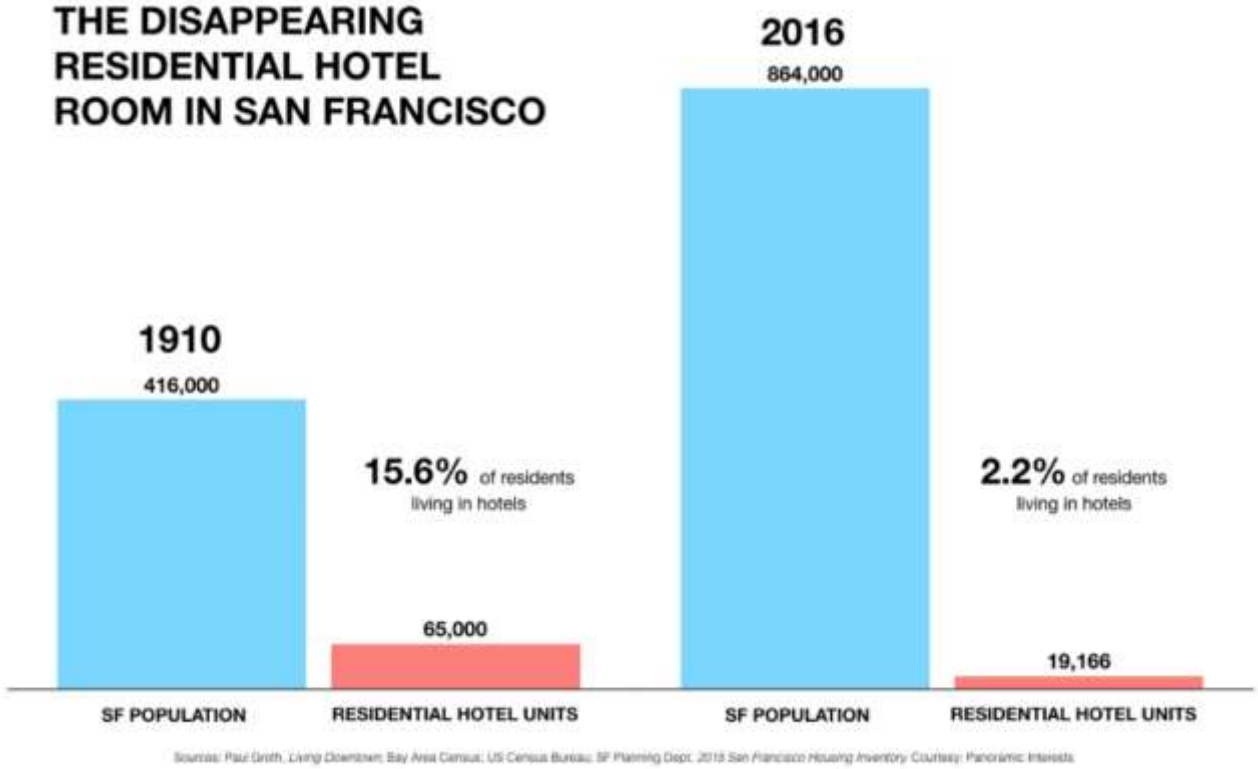
How many of you have staff who struggle with some or many of these same things?

Absence of Affordable Housing



Income vs Rent





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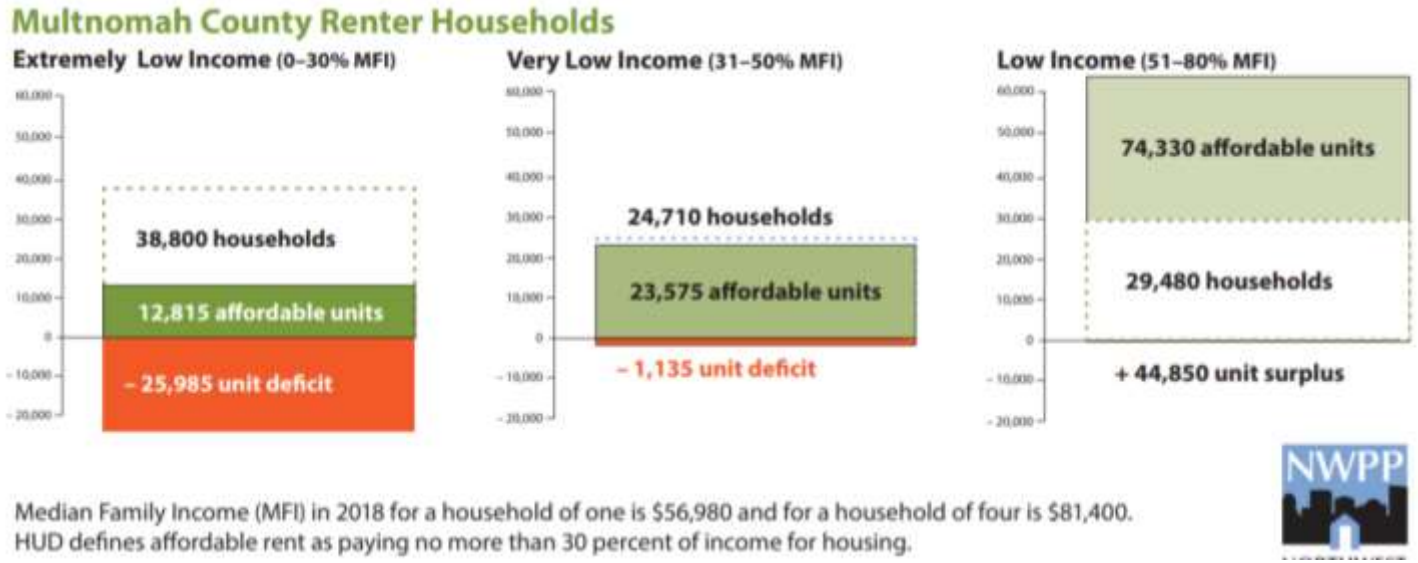
Absence of Affordable Housing

What We Need



Median Family Income (MFI) in 2018 for a household of one is $56,980 and for a household of four is $81,400.
HUD defines affordable rent as paying no more than 30 percent of income for housing.

What We Build

- Market: 4,669 units under construction.
  - .5% affordable at 60% MFI.

2015: City of Portland produced 182 units of affordable housing.

174 were at 60%

8 were at 0-30%

Prior three years: Averaging 300 units per year

Over 90% of delivered at 50%MFI or above.

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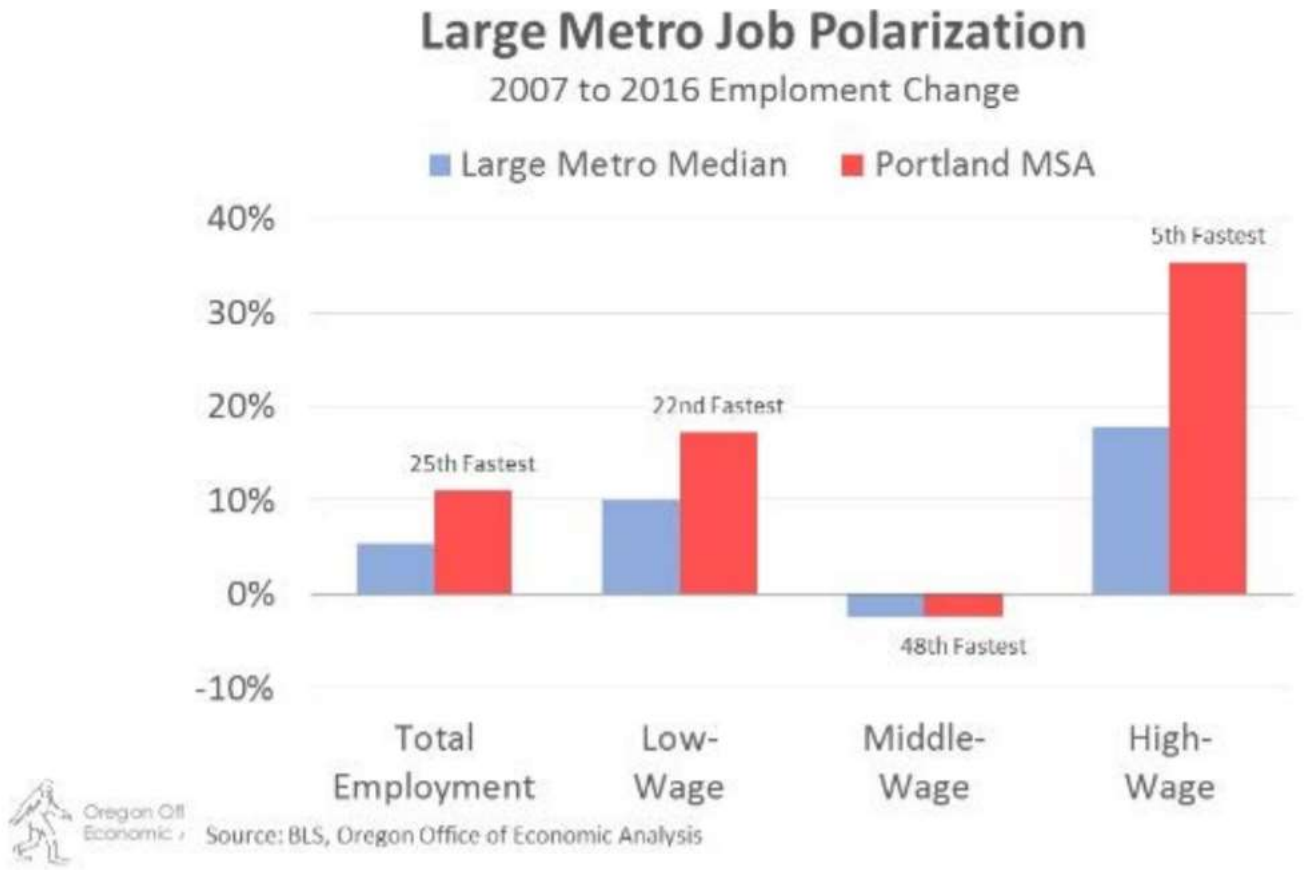
Absence of Meaningful Wage Jobs



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Structural Racism and Discrimination

Figure 1: Rate of incarceration in jail per 1,000 individuals, June 30, 2014

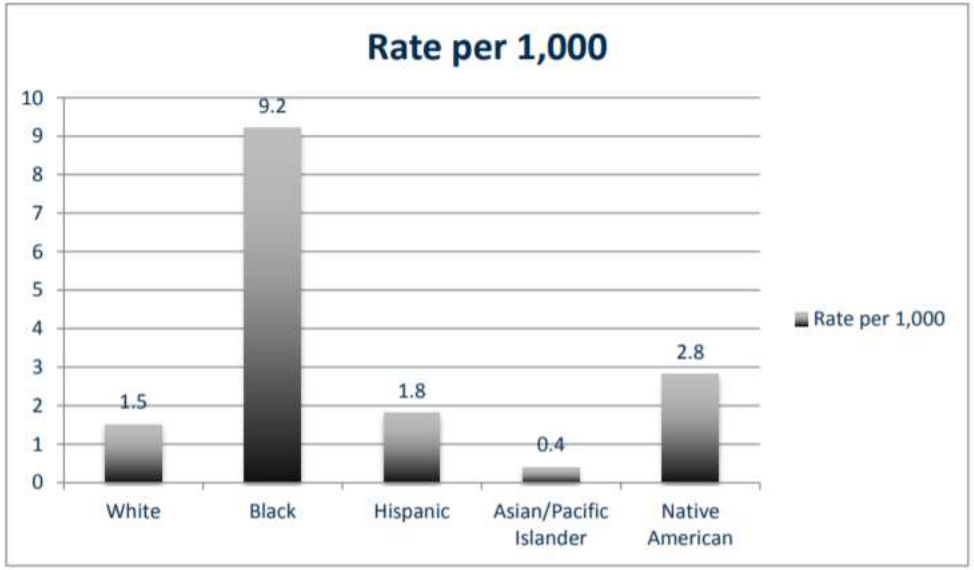
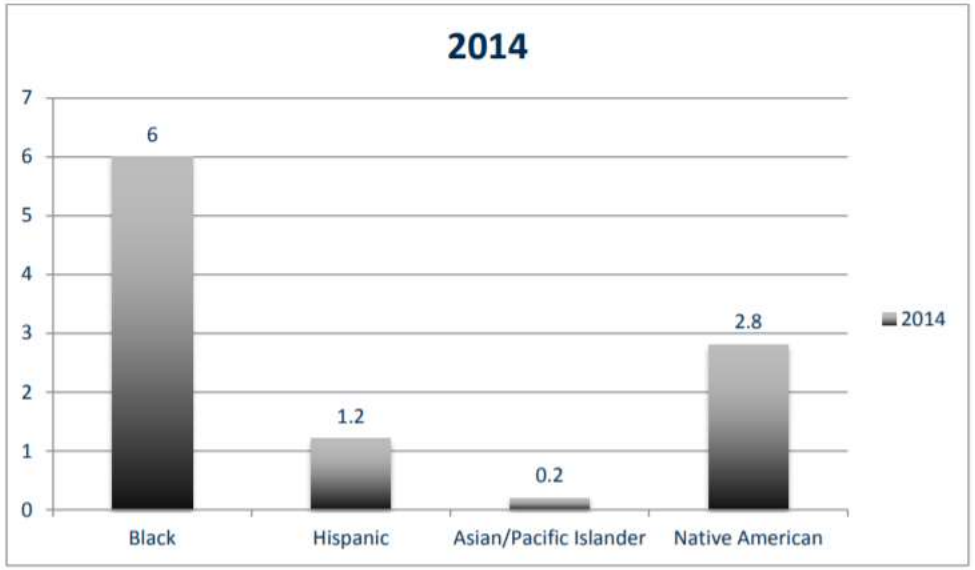


Figure 2: Relative Rate Index (RRI) of the Multnomah County Jail Population, 2014



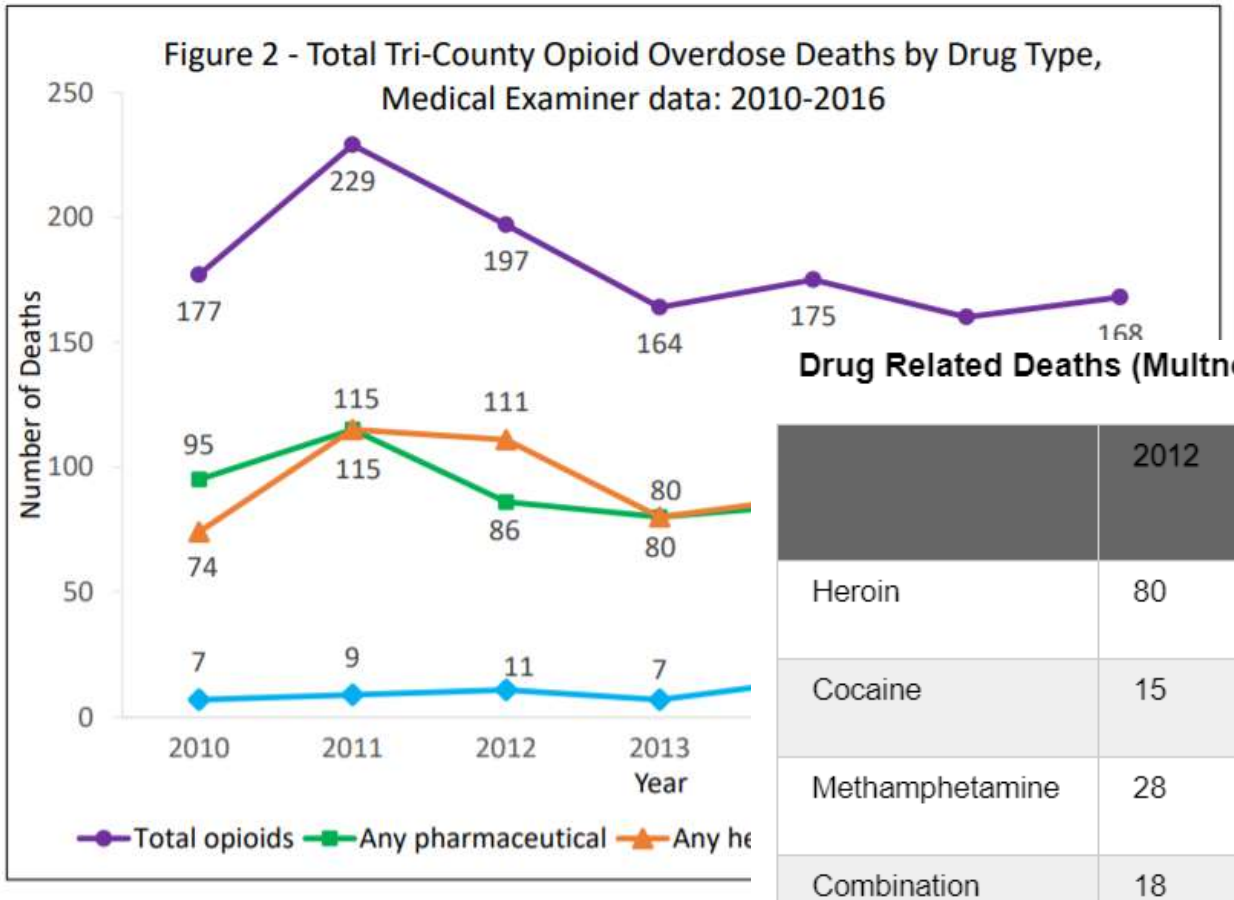
For every 1,000 White adults in Multnomah County, there are 1.5 White adults in jail.
For every 1,000 Black adults in Multnomah County, there are 9.2 AA adults in jail.

AA adults are 6.0 times more likely than Whites to be in jail (9.2/1.5 = 6.0)
Native Americans are 1.8 times more likely than Whites to be in jail

A study in 2015 found that African Americans in Oregon were convicted of felony drug possession at more than double the rate of white offenders.

Ferguson J. Safety + Justice Challenge. https://multco.us/file/48681/download

OPIOIDS AND METHAMPHETAMINES



Tri-County Opioid Safet

Drug Related Deaths (Multnomah County)

	2012	2013	2014	2015	2016	Five year Trend
Heroin	80	65	54	48	64	-20%
Cocaine	15	9	10	19	20	+33%
Methamphetamine	28	45	35	60	70	+150%
Combination	18	18	14	24	32	+78%
Total	103	102	85	103	121	+17%

Source: Oregon State Police, Medical Examiner Division.

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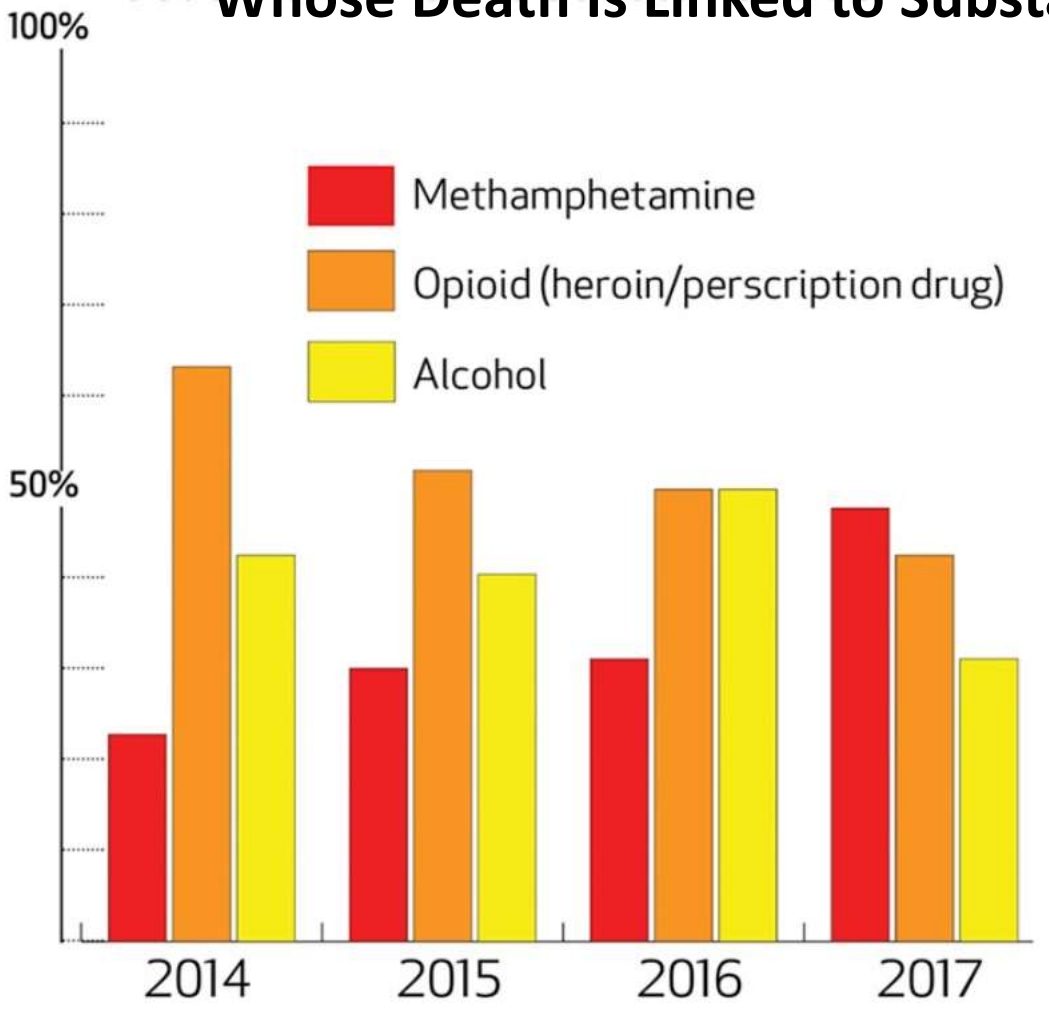
RISE IN METH-RELATED DEATHS AMONG HOMELESS

Cause of Death for Homeless People in Multnomah County Whose Death Is Linked to Substance Use



SOURCE: MULTNOMAH COUNTY MEDICAL EXAMINER

"Meth helps me stay awake so I have less chance of being victimized on the street."

"I started using meth at age 13. It would help me stay awake until my abusive stepdad went to sleep."

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So what am I talking about?

What we are trying to address in health care is often the culmination of many factors

1. **Identify the problem(s) you are trying to solve…you will likely need to do considerable segmentation**
2. **Consider the structural factors that drive that problem**
3. **As you design, implement and improve your program, think about if and how you are addressing those structural drivers**
4. **In addressing those drivers, ask yourself: is my health center best equipped to address these drivers? If not, who is better equipped to do this, and how can we support them?**

Examples

Brief Overview of Central City Concern

The Imani Center + Flip the Script

Fourth Dimension

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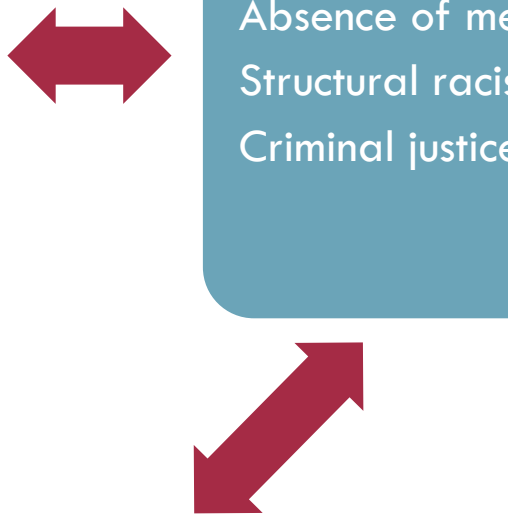
WHAT DRIVES HOMELESSNESS?

Individual Factors

- Early childhood adverse experiences
- Serious Mental Illness
- Substance use disorders
- Personal history of violence
- Youth: family conflict and victimizations, non-heterosexual sexual identify, having been in the childhood welfare system
- Criminal justice system interaction

Structural Factors*

- Absence of affordable housing
- Absence of meaningful-wage employment
- Structural racism and discrimination
- Criminal justice system interaction



HOMELESSNESS

*When structural factors become more pronounced, individuals with fewer individual vulnerabilities become homeless and rates of homelessness rise

Fazel et al *Lancet* 2014

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CENTRAL CITY CONCERN'S APPROACH

Direct access to housing which supports lifestyle change.

Integrated health care services that are highly effective in engaging people who are often alienated from mainstream systems.

HOMELESSNESS

Individual Factors	Structural Factors

Attainment of income through employment and/or accessing benefits.

The development of peer relationships that nurture and support personal transformation and recovery.

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EXAMPLE 1:

- African-Americans are over-represented among homeless in Multnomah County by a factor of 2 (16.2% vs 7%):
  - Mass incarceration of people of color
    - More difficult to get housing & employment upon re-entry
      - More difficult to engage in SUD and mental health care
        - Mainstream care is not culturally responsive

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Mainstream Care is not Culturally Responsive Care

Treatment among communities of color is hindered by:

- Historical distrust of mainstream medical institutions
- Relative lack of treatment professionals from communities of color
- Culturally inappropriate settings and protocols
- Geographic distribution of treatment centers, even within metropolitan areas
- Complexities of enrolling in and using insurance

Treatment among communities of color is facilitated by:

- Investment in culturally-specific organizations
- Development of workforce that reflects served community
- Culturally appropriate settings and protocols (eg. longer duration of treatment, focus on intersection of race/culture, identity, oppression and resilience)
- Geographic distribution of treatment centers, even within metropolitan areas
- Community-based outreach

Substance Use Disorders in Oregon – Prevention, Treatment & Recovery.
Oregon Substance Use Disorder Research Committee, November 2017

The Imani Center at CCC

Cultural Healing
This group will explore cultural heritage issues pertaining to the African and African American experience as it relates to mental health and addiction, with particular emphasis on culturally specific themes. Specifically, the Cultural Healing Group will use the Creating Safe Spaces curriculum which is a trauma-informed, culturally specific mental health curriculum, as well as other teaching methods to present the group materials.

What's Your Plan
This group is centered on the idea that in order to be successful in recovery clients must have a plan. In this group, clients will learn how to write out their weekly plan for recovery with particular emphasis placed on their Care Plans. Clients will also learn new skills each week to support daily success.

Seeking Safety
This is a trauma and recovery group which focuses on Cognitive Behavioral Therapy as a central part of group therapy treatment. Seeking Safety is an evidenced-based curriculum that teaches clients a wide array of safe coping skills including but not limited to how to manage PTSD symptoms, cope with emotional pain through grounding techniques, and identify characteristics of safe and healthy relationships.

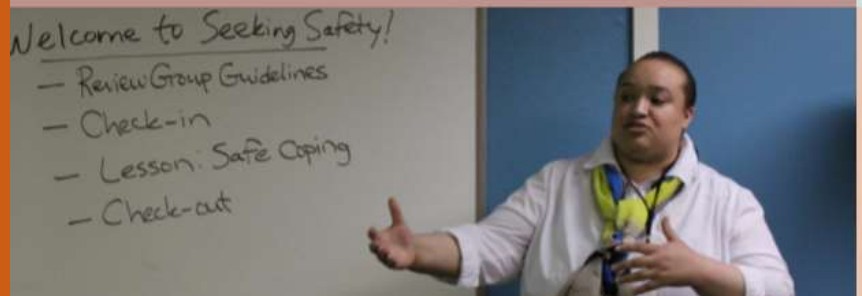
Soulful & Centered Moments
The purpose of this group is to reduce clients' stress and anxiety through teaching the practice of Mindfulness-Based Stress Reduction, which is an evidence-based treatment modality. Mindfulness-Based Stress Reduction was originally developed by Jon Kabat-Zinn and has been proven to produce positive health benefits and positive mental health outcomes in those that practice daily.

F.O.C.U.S.
The F.O.C.U.S. (Freeing Ourselves from Careless hostility and Understanding Systemic racism) group assists clients in learning Dialectical Behavior Therapy skills to effectively manage their anger from the Anger Management Workbook on the following areas: Investigating Attitudes About Anger, A New Perspective on Anger, Acknowledging Complexities of Anger, and Changing Your Experience of Anger. The group also uses the Getting Control of Yourself video. Each passage has a brief video segment that accompanies it and a lesson on Post Traumatic Slave Syndrome (PTSS), which explores the impact that intergenerational trauma and racism has had on African American people. The F.O.C.U.S. group discusses PTSS particularly as it relates to unresolved anger issues.

Empower You
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will to teach clients how to both express and manage their feelings in terms of race regarding entering/ re-entering the workforce, making healthier decisions, and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention.

The Recovery Process
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will teach clients how to both express and manage their feelings in terms of race regarding making healthier decisions and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention and mental health challenges in the early stages of recovery.

Women In Transition
This is a gender-specific group for women only. The group is designed to address both mental health and addictions issues with a strong emphasis on empowerment and connection with each other.



Positive Changes
This group is specifically designed to utilize the Cognitive Self Change model to support clients in learning life skills necessary to decrease their criminogenic factors. In addition, this group teaches additional life skills such as budgeting and renting, and provides clients the opportunity to complete Rent Well.

Men In Transition
This is a gender-specific group for men only. A wide spectrum of topics related to men and recovery will be discussed.

EXAMPLE 1:

- African-Americans are over-represented among homeless in Multnomah County by a factor of 2 (16.2% vs 7%):
  - Increased rates of incarceration
    - More difficult to get housing & employment
      - More difficult to engage in SUD and mental health care
        - Mainstream care is not culturally responsive

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Portland/Multnomah County Point In Time Count, February, 2017

FLIP THE SCRIPT

- A partnership between Employment, Housing and Criminal Justice partners
- For African-American men exiting criminal justice system
- Culturally specific:
  - Advocacy Coordinator
  - Housing and Employment Specialist
- Opportunities for policy and advocacy work by FTS clients
- Improved rates in:
  - Housing
  - Employment
  - MH/SUD recovery
  - Recidivism

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EXAMPLE 2

- Unaccompanied youth are increasing in the homeless population (13% increase in 2 years):
  - Many involved in foster care system
    - High degree of trauma
      - Health care (and recovery) networks are not oriented toward needs and culture of youth

Children under the Age of 18	Count 2015	Count 2017	Change
Ages 5 and younger	145	156	11
Ages 6-11	149	134	-15
Ages 12-17	80	92	12
Total	374	382	8

Unaccompanied Youth	Count 2015	Count 2017	Change
Under age 18	5	14	9
Ages 18-24	261	286	25
Total	266	300	34

Portland/Multnomah County Point In Time Count, February, 2017

FOURTH DIMENSION

- Peer-run organization for anyone 13-35 years old
- Low barrier to entry
- “Any time you need a peer, you get one”

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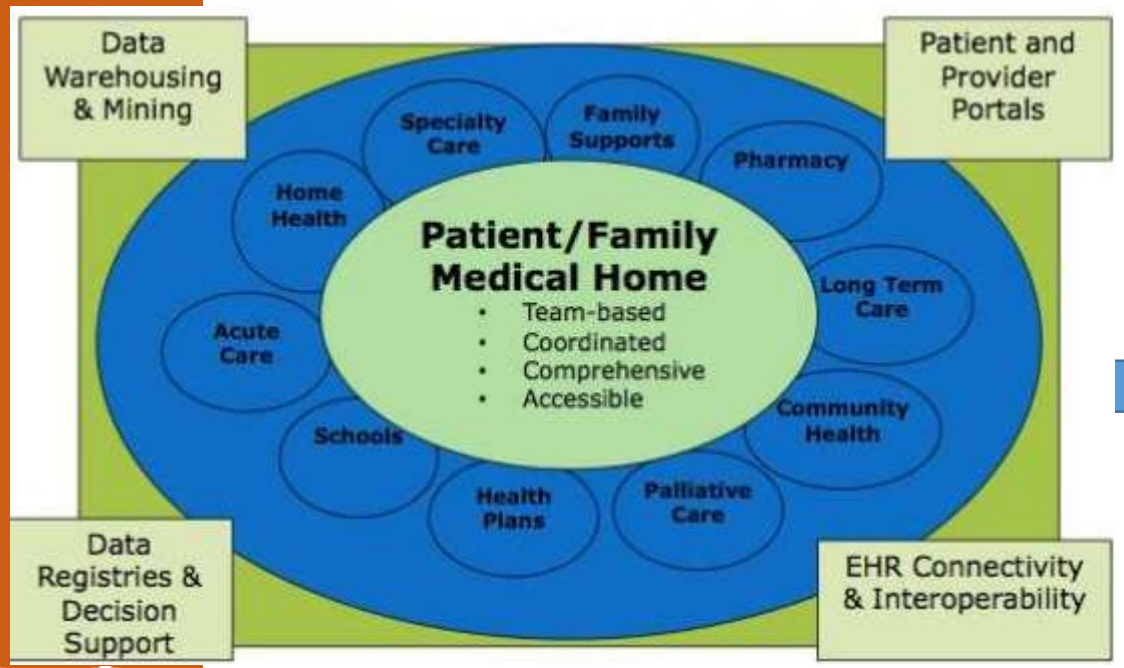
Inverting the health care paradigm…

Health-care Oriented



Recovery-Oriented

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EXERCISE

Think about a program you have started, or will start, in your health center:

1. **Identify the problem(s) you are trying to solve…you will likely need to do considerable segmentation**
2. **Consider the structural factors that drive that problem**
3. **As you design, implement and improve your program, think about if and how you are addressing those structural drivers**
4. **In addressing those drivers, ask yourself: is my health center best equipped to address these? If not, who is better equipped to do this, and how can we support and learn from them?**

CONCLUSION

Think about recovery-oriented as:

- **Looking deeply at root causes**
- **Understanding the role primary care can and should play**
- **Supporting the places and people where recovery matters most**

QUESTIONS AND DISCUSSION

Thank you!

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Health Resources and Services Administration

Addressing the Opioid Epidemic

Seattle Regional Office
Advanced Care Learning Community
Portland, Oregon
January 14, 2019

HRSA
Health Resources & Services Administration

Learning Objectives: How HRSA is Addressing the Opioid Crisis

Participants will have a better understanding of how HRSA is:

- Expanding access through health centers and other primary care settings.
- Connecting stakeholders to opioid-related resources.
- Providing regional surveillance through technical assistance events and activities.

HRSA
Health Resources & Services Administration

HRSA Overview

Health Resources and Services Administration (HRSA)

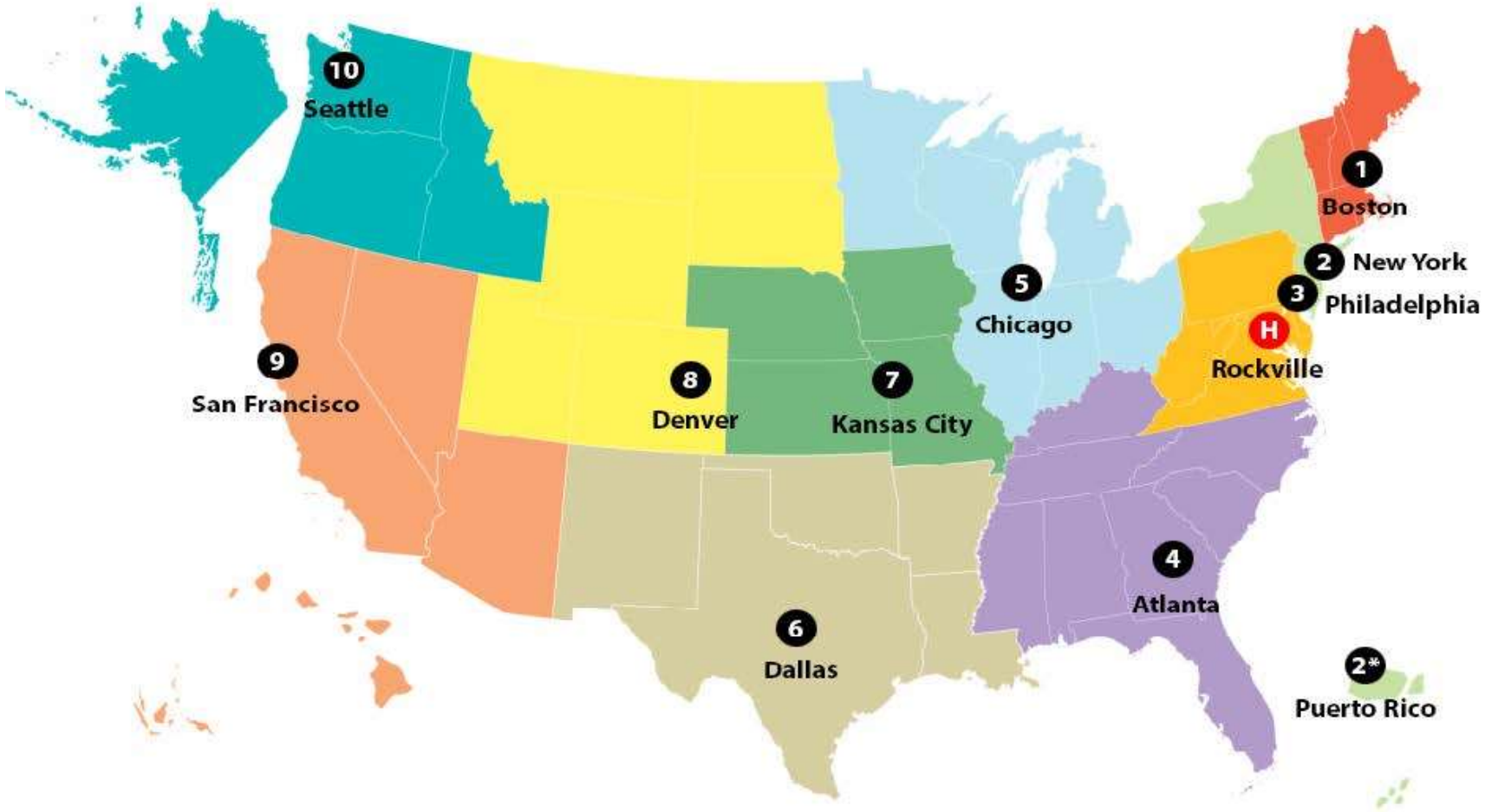
Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable.

Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

The agency funds grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

HRSA
Health Resources & Services Administration

Office of Regional Operations
Ten Regions – One HRSA



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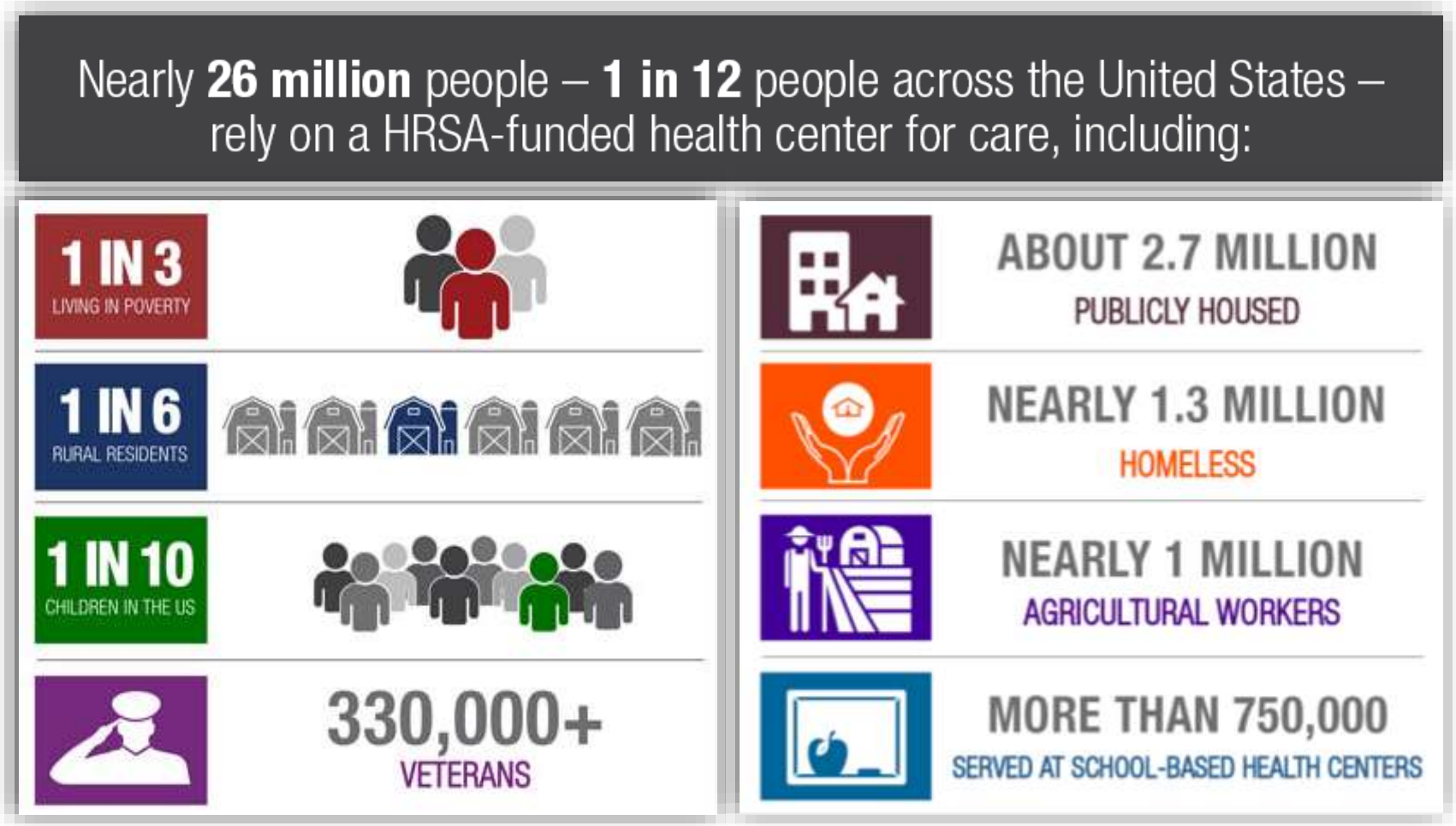
HRSA's Response to the Opioid Crisis

Expanding Access Through Health Centers & Other Primary Care Settings



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Expanding Access Through Health Centers & Other Primary Care Settings

	2014	2015	2016	2017	Δ 2014-2017
Health centers providing substance use disorder (SUD) services	838	942	961	D.N.A.	↑15% (2014-2016)
Patients receiving Screening, Brief Intervention, and Referral to Treatment (SBIRT)	229,288	457,132	716,677	1,017,249	↑344%
Patients receiving SUD services	100,238	117,043	141,569	168,508	↑68%
SUD patient visits	977,074	1,038,230	1,135,218	1,227,629	↑26%
Patients receiving medication assisted treatment	D.N.A.	D.N.A.	39,075	64,597	↑65% (2016-2017)
Providers delivering medication assisted treatment services	D.N.A.	D.N.A.	1,700	2,973	↑75% (2016-2017)

*D.N.A. – Data Not Available

HRSA Health Resources & Services Administration

Expanding Access Through Health Centers & Other Primary Care Settings

- HRSA awarded over $396 million to enable HRSA-funded community health centers, academic institutions, and rural organizations to expand access to integrated substance use disorder and mental health services across the nation
  - FY 18 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) Awards - **$7,159,898 to support 25 health centers in Oregon**
  - Rural Communities Opioid Response Program-Planning Awards - **$600,000 to support 3 health centers in Oregon**
  - Rural Health Opioid Program (RHOP) - **$499,873 to support 2 health centers in Oregon**
- Title V Maternal and Child Health Services Block Grant Program
- HRSA's 340B Drug Pricing Program supports affordable medication-assisted treatment.

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Current HRSA Grantees in Oregon

Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH)

- Adapt
- Bandon Community Health Center
- Benton County
- Central City Concern
- Clackamas County
- Columbia River Community Health Services
- Klamath Health Partners, Inc.
- La Clinica Del Valle Family Health Care Center, Inc.
- Lane County
- Lincoln County
- Mosaic Medical
- Native American Rehabilitation Association, Inc.
- Neighborhood Health Center
- Northwest Human Services, Inc.
- One Community Health
- Outside In
- Rinehart Medical Clinic
- Rogue Community Health
- Siskiyou Community Health Center, Inc.
- Tillamook County
- Umpqua Community Health Center, Inc.
- Virginia Garcia Memorial Health Center
- Wallace Medial Concern
- White Bird Clinic
- Winding Waters Medical Clinic

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Current HRSA Grantees in Oregon

- **Rural Communities Opioid Response (Planning)**
  - Lake Health District
  - Samaritan North Lincoln Hospital
  - Umatilla County
- **Rural Health Opioid Program (RHOP)**
  - Mid-Valley Healthcare, Inc.
  - Northeast Oregon Network

Connecting Stakeholders to Opioid-Related Resources

HRSA supports training dissemination and information portals that provide resources on emerging public health issues, including opioids.

TARGET Center
Tools for the Ryan White Community

RHIhub
Rural Health Information Hub

POISON Help
1-800-222-1222

NRTRC
NORTHWEST REGIONAL
TELEHEALTH RESOURCE CENTER

MCH NAVIGATOR

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Forecasted Funding Opportunities

Grants.gov → Search Grants → Opportunity Status: Forecasted → HRSA

- **HRSA-19-048**: Poison Control Support and Enhancement Grant Program
- **HRSA-19-038**: Systems-level Strategies in Response to the Opioid Epidemic for People Living with HIV and Opioid Dependency - System Coordination Providers
- **HRSA-19-085**: Opioid Workforce Expansion Program - Professional (OWEP)
- **HRSA-19-089**: Opioid Workforce Expansion Program - Paraprofessional (OWEP)
- **HRSA-19-018**: Small Health Care Provider Quality Improvement Program
- **HRSA-19-083**: Rural Community Opioid Response Program Evaluation Cooperative Agreement
- **HRSA-19-082**: Rural Communities Opioid Response Program-Implementation

Region 10 Specific Activities to Address the Opioid Crisis

Opioid Response Learning Collaborative (ORLC) Regional Meeting
August 1-2, 2018

Region 10 Upcoming Activities to Address the Opioid Crisis

- **Mental Health First Aid (MHFA)**
- **Behavioral Health Webinar Series:** February, May, and August 2019

  Topics covered:

  - Quick start solutions for integrating behavioral health with primary care
  - Expanding access to quality SUD/MH services
  - Identifying and aligning intersections of the opioid epidemic, law enforcement, social services, and public health
  - Root causes of the opioid epidemic and lessons learned

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