COAST TO CASCADES COMMUNITY WELLNESS NETWORK
Corvallis, Oregon
SELF-ASSESSMENT
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Grantee Organization	Mid-Valley Health Care, Inc.
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FY 2018-2020 Rural Health Opioid Program (RHOP)
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I.Executive Summary

The STARS Rural Outreach project used a combination of evidence-based strategies. It expanded access to treatment for Opioid Use Disorder using a Hub and Spoke model. Treatment and recovery services were fully supported by peer support specialists in the service area. Community and provider education were implemented and supported by targeted distribution of Naloxone. All project activities were supervised by a consortium called the Coast to Cascades Community Wellness Network.

Despite significant disruptions caused by COVID-19, staff vacancies, and a change in program coordinator, the Rural Outreach program had some notable successes. The number of individuals identified with OUD and in treatment for OUD appeared to increase over the grant period. Community partnerships appear to be stronger and galvanized around a common purpose. The Sweet Home community seems to have made significant progress in awareness of OUD as an issue and in lessening the stigma around substance use disorders and treatment. Individuals receiving direct services report being pleased with the support they are getting. At the conclusion of Year 3 of the grant, foundational activities were in place, seem to be functioning well, and will be carried over into the No Cost Extension period. These activities include the Hub and Spoke model, offering MAT and peer support through the spokes, structured community activities like Community Court, and solid relationships with key community partners. Key informants continue to be enthusiastic, and each noted that significant improvements in services and community attitudes have been made over the duration of the grant.

When grant funds were awarded in 2018, Linn County had one of the highest rates of opioid-related deaths among Oregon counties and one of the highest hospitalization rates for heroin-related and other opioid-related use in the state. The rate of opioid prescriptions filled in Linn County continues to be higher than the statewide rate (200 vs. 167 per 1,000 residents, respectively). Although the state's Prescription Drug Monitoring Program (PDMP) has led to a reduction in opioid prescriptions, this has not translated into a reduction in opioid addictions. To the contrary, local law enforcement reports that there is both high availability and high use of heroin within the region. Additionally, since 2020 when COVID-19 began spiking, we saw an unfortunate increase in individuals using fentanyl which consequently led to a rise in overdoses.

II.Background and Purpose

The overall purpose of the Samaritan Treatment and Recovery Services (STARS) Rural Outreach project is to reduce morbidity and mortality of opioid use disorder (OUD) in rural east Linn County, Oregon. To accomplish this, the program established new services for OUD beginning in the fall of 2018, using the following evidence-based strategies: A. using a community consortium for project governance and oversight; B. establishing and expanding opioid use disorder (OUD) treatment and recovery services in rural east Linn County through a Hub and Spoke model; C. community education and naloxone distribution; and D. utilizing peer support specialists. Below are brief descriptions of the primary strategies implemented by the program:

- The Coast to Cascades Community Wellness Network (CCCWN) provided oversight and supervision to the STARS Rural Outreach project. Using a consortium or community coalition to provide leadership within a community has long been a recommended strategy to combat substance abuse. The National Rural Health Association ([NRHA]; Gale, 2016)

recommends developing broad community coalitions in order to deepen the community's capacity to address OUD locally. Throughout implementation, the consortium provided a formal structure for key stakeholders to coordinate and supervise program implementation. The consortium also identified and leveraged community assets, assisted in moving initiatives forward, and ensured that the project met grant requirements.

- The project expanded Opioid Use Disorder (OUD) treatment and recovery services into rural East Linn County using a Hub and Spoke model. The Hub and Spoke model has been offered as a promising practice in rural areas where typical outpatient treatment services are unavailable or not feasible to serve the needs of the population (Chou et al., 2016). Samaritan Treatment and Recovery Services, located at the Lebanon Community Hospital, served as the hub. They provided comprehensive and intensive outpatient services until the opening of the residential treatment center in early 2020. Primary care clinics in Sweet Home and Brownsville were the spokes; several primary care physicians began supervising outpatient medication-assisted treatment (MAT) in 2018.
- Peer support specialists (PSS) began working in the spoke clinics and (under the auspices of the grant) within the community to connect individuals to care and facilitate recovery activities in the second year of the grant. Peer support is an evidence-based practice (see evidence summary by Mental Health America, 2018).
- The Centers for Disease Control and Prevention (CDC, 2018) and the National Institutes of Drug Abuse (NIDA, 2017) recognize targeted distribution of naloxone as an evidence-based practice. The project distributed Naloxone directly within the community, and also to emergency responders in the program area.
- Project activities also included community and provider education about OUD and services available; outreach and education often addressed the stigma of SUDs.

The evaluation plan had multiple process and outcome objectives, listed and organized here by project goals.

Goal 1: Coast to the Cascades Community Wellness Network (CCCWN) Consortium members work together to expand delivery of opioid related health services in east Linn County.

Process Questions:

1. Did the supervisory function of CCCWN operate as expected?
2. How did the consortium contribute to the expansion of opioid related services?

Outcome Question:

1. Have community supports related to OUD treatment and recovery increased as a result of the CCCWN's leadership?

Goal 2: Establish STARS Outreach to deliver a comprehensive program that features best practices for opioid treatment programs, including MAT, behavioral counseling, and peer support activities.

Process Questions:

1. Did capacity to deliver MAT increase?
2. How many screenings were conducted?
3. How many activities and services were added for treatment or recovery?
4. To what degree are evidence-based practices being carried out with fidelity?
5. To what degree are people with OUD engaged in the full spectrum of medical, behavioral and counseling services that are available?
6. What factors facilitate or impede access to the full spectrum of MAT, behavioral and peer support services?
7. Is STARS rural outreach reaching its intended audience?

Outcome Questions:

1. Has the number of individuals screened of OUD increased?
2. Has the number of individuals with OUD in treatment increased?
3. Has the number of individuals participating in recovery support activities increased?
4. How has the mortality rate changed since the implementation of the STARS rural outreach program?

Goal 3: Conduct OUD education and outreach activities in east Linn County that include community distribution of naloxone rescue kits by rural clinics and first responders supplied through Samaritan Lebanon Community Hospital (SLCH) pharmacy services.

Process Questions:

1. How many naloxone kits were distributed?
2. What factors facilitate or impede community education efforts?
3. Who are we reaching through education and outreach efforts?
4. Who and what are the natural community supports within the service area?

Outcome Questions:

1. How has the morbidity rate of OUD changed since the implementation of the STARS rural outreach program?
2. How has knowledge and awareness of OUD increased among community members as a result of STARS education and outreach efforts?
3. How has the support system for families of individuals with OUD changed, and to what degree is it self-sustaining?

Goal 4: Extend the reach of STARS Outreach into outlying rural areas by utilizing the services of a trained Peer Support Specialist

Process Questions:

1. How has the rural PSS affected referrals made for OUD assessment and treatment?
2. How has the PSS identified and increased use of recovery assets within the community?
3. How has the PSS increased support for friends and family members of individuals with OUD?

Outcome Questions:

1. How has the number of individuals initiating treatment for OUD from rural East Linn changed?
2. How has the number of individuals participating in recovery support activities in rural East Linn changed?
3. How has the support system for individuals with OUD changed in the service area, and to what degree is it self-sustaining?

Statement of Need

When grant funds were awarded in 2018, Linn County had one of the highest rates of opioid-related deaths among Oregon counties at 4.9 deaths per 100,000 population over the years 2015-2017; in 2019, that rate had decreased to 3.16 per 100,000 (OHA, n.d.). Hospitalization rates for heroin-related and other opioid-related use in 2017 were also among the highest in the state (2.4 and 27.2 per 100,000 population, respectively). In August of 2018, East Linn County saw a rash of overdoses, up to 6 a week showing up in the ED due to Fentanyl and Carfentanil being used with other street drugs. Rates of opioid prescriptions have been decreasing across Oregon since 2015, but the rate of opioid prescriptions filled in Linn County continues to be higher than the statewide rate (200 vs. 167 per 1,000 residents, respectively). Although the state's Prescription Drug Monitoring Program (PDMP) has led to a reduction in opioid prescriptions, this has not translated into a reduction in

opioid addictions. To the contrary, local law enforcement reports that there is both high availability and high use of heroin within the region.

III.Self-Assessment Methods

The performance monitoring and evaluation plan used both qualitative and quantitative data from multiple sources. Primary data collection included (1) tracking of program activities; (2) observation of program activities; and (3) semi-structured key informant interviews. The evaluation used secondary data from the following sources: (the Oregon Prescribing and Drug Overdose Data Dashboard, from CCCWN Regional Mental Health/Substance Use Disorder Coalition meeting minutes, and from EPIC, SHS's electronic health record. Key informant interviews were conducted with key program stakeholders yearly. Interviewees included project staff, CCCWN Mental Health/Substance Use Disorder Coalition members, healthcare providers, community partners, and east Linn County residents receiving STARS services. The evaluator recorded notes for each interview; statements from interviews were then used to provide further context to the relevant evaluation questions.

Project staff maintained records of program activities and contacts using a program tracking database. The database (developed by Samaritan's Research Development Office) was the intended source of data for the following measures: number of individuals screened for OUD; number of individuals identified as having OUD, number of individuals referred to medical, behavioral, and counseling services; persistence in treatment; number of naloxone kits distributed; and number and descriptors of community education participants, according to the project's assessment plan. CCCWN Mental Health/Substance Use Disorder Coalition agendas and minutes were reviewed quarterly and yearly by the evaluator to describe the amount and nature of feedback provided to STARS by the Committee. To address the morbidity and mortality measures of opioid-related overdoses and deaths during the project period, the evaluator used two data sources. First, Sweet Home Police Department (SHPD) shared overdose and fatality numbers. Second, the report presents relevant figures from the Oregon Prescribing and Drug Overdose Data Dashboard.

Data challenges/limitations included: inconsistent coding within EPIC; consistent data entry by program staff; issues with confidentiality requirements; and obtaining adequate time with stakeholders to complete interviews. Another limitation to making inferences about the program's overall impact is that there are separate, ongoing OUD programs occurring locally, thus some outcome indicators cannot be solely attributed to STARS program activities. Data provided by SHPD and the Oregon Prescribing and Drug Overdose Data Dashboard have some notable limitations. First, figures from the SHPD report heroin overdoses and fatalities specifically; the time frame of the reported numbers follows the calendar year (January – December) rather than the project period. Second, the Oregon Prescribing and Drug Overdose Data Dashboard has a significant lag in updating data, and no information is available regarding opioid-related fatalities for the current project period. Moreover, these data represent Linn County as whole and cannot be specified to the service area.

IV.Results Discussion

Goal 1 of the program plan states, "Coast to the Cascades Community Wellness Network (CCCWN) Consortium members work together to expand delivery of opioid related health services in east Linn

County." Below are the results for the two process and one outcome evaluation questions related to Goal 1.

Did the supervisory function of CCCWN operate as expected? (1.1)

Reviews of the CCCWN Mental Health/Substance Use Disorder Coalition meeting minutes and key informant interviews, the CCCWN continued to execute its supervisory responsibilities throughout the duration of the grant period. In September of 2021 the Coalition voted to expand its efforts in Linn County to include Lincoln County, the RAID Planning Steering Committee, and Regional Measure 110 Committee. Due to the heightened need for substance use services and the severity of complications brought about during COVID-19, the coalition went from meeting every other month to monthly. This allowed for broader insights into regional trends, collaboration for consistent SUD and OUD messaging, and increased resources for the target population. The coalition addressed needed improvements and problem solved solutions regarding new services and grant activities.

How did the consortium contribute to the expansion of opioid related services? (1.2)

Key informant interviews and meeting minutes provided insights into the CCCWN's role in expanding services. In Year 1, the coalition fostered teamwork and convened partners from multiple agencies and service providers. This has led to more identified opportunities within the service area as well as elevated awareness of multiple, correlated issues to OUD. In Year 2, the coalition again supported the convening of partners and specifically helped to overcome bureaucratic barriers related to Narcan distribution. In Year 3, COVID-19 significantly impacted the further development of community partnerships. The committee also heavily discussed the State of Oregon Measure 110 for expanding SUD treatment. During the No-Cost Extension period the coalition worked collectively to address the increased rate of overdoses across the region.

Have community supports related to OUD treatment and recovery increased as a result of the CCCWN's leadership? (1.3)

Key informants noted the CCCWN's leadership role, over the duration of the grant, in galvanizing support among community partners and in decreasing SUD stigma. Changes in attitudes locally were the most frequently mentioned contribution in this area.

Goal 2 states that STARS will establish "a comprehensive program that features best practices for opioid treatment programs, including MAT, behavioral counseling, and peer support activities." This section addressed the six process questions and four outcome questions related to this goal.

Did capacity to deliver MAT increase? (2.1)

The greatest improvement in MAT delivery occurred during Year 1, when internal policies and procedures were formalized and implemented. Introducing the HUB & SPOKE Model allowed for increased collaboration between substance use professionals and the medical team, structured coordination of care, and warm hand-offs with the patients. Our HUB was the Recovery Clinic in Lebanon, Oregon where the Medical Director of Samaritan Treatment and Recovery Servies (STARS) and one other Provider held X-waivers and initiated the process of stabilization for patients transitioning onto Medication-Assisted Treatment. The first two SPOKES were readily available in the Sweet Home Clinic and Brownsville Clinic, totaling four Providers with their X-waivers in Year 1. MAT was supported by the opening of residential treatment in Year 2 and by having program staff regularly available in the clinics for warm hand-offs. The Medical Director and Project Coordinator

worked together to educate medical professions on MAT and X-waivers. This resulted in an additional two SPOKES, one more in Lebanon and one in Albany. By Year 3, interviews with program and clinic staff suggest that capacity to deliver MAT has been realized, and that MAT services are operating well in the service area. The successes of the HUB & SPOKE Model were gaining recognition among Providers and two additional SPOKES in Lebanon and the Toledo Clinic became X-waivered. Finally, during the No-Cost Extension period we welcomed an additional four X-waivered Providers in; Albany, Lincoln City, and two more in Lebanon. Our HUB assigned a MAT Care-Coordinator who facilitated weekly virtual staff meetings where X-waived Providers, substance use professionals, and peer support specialists all worked to increase patient access to care and decrease barriers.

How many individuals were screened for OUD? (2.2)

Table 1. OUD Screening and Treatment	First Year	Second Year	Third Year	No-Cost Extension
Number of individuals screened for OUD using the tracking database	40	24	55	77
Number of individuals screened for OUD using EPIC records of SBIRT flowsheet	3735	2992	4059	3878
Number of individuals, who, after being screened for OUD, were identified as having OUD	32	14	250	59
Number of individuals with OUD who were referred by one provider to another provider for the treatment of OUD	30	14	41	59
Number of individuals with OUD, who, after receiving an initial consultation with a treatment provider, started the treatment process	22	9	41	36

How many activities and services were added for treatment or recovery? (2.3)

In Year 1:

- Gender-specific intensive outpatient programs in Lebanon
- Three-year operations certification from the Oregon Health Authority
- Mindfulness-based recovery support group
- Collection of referral options currently available within the larger service area
- Provision of MAT within Spoke clinics

In Year 2:

- PSS doing outreach within the community to identify individuals with OUD, in partnership with Sweet Home Emergency Ministries (SHEM)
- PSS doing outreach to unhoused individuals, in partnership with the Family Assistance Center
- A 6-8-week course entitled Parent Café was planned, but cancelled due to COVID-19
- Community Court had a planned launch earlier in the year but was delayed until 9/23/20 because of COVID-19.

In Year 3:

- Community Court launched in September of 2020. PSS and project staff attend each session and are instrumental in interviewing/assessing and in connecting individuals to services.

- An open recovery support group was added in the Sweet Home area by the PSS.
- DUI outpatient groups opened at STARS

No-Cost Extension:

- Family Tree Relief Nursery (FTRN) opened two new offices for PSS in Sweet Home.
- A women's recovery house, The Hope Center, began accepting women into the house offering a "Harm Reduction" approach with grant Peer Support Specialist on site.
- PSS worked in partnership with Harm Reduction Specialist providing education, outreach, and Narcan at two community sites in Sweet Home and Lebanon on a weekly basis.

To what degree are people with OUD engaged in the full spectrum of medical, behavioral and counseling services that are available? (2.5)

Progress toward this objective were initially hampered by unfiled staff positions in Year 1; program and clinic staff supported individuals with a client-led approach. Specific, reliable data about the number of individuals who have engaged with the full spectrum of medical, behavioral, and counseling services is not available; key informants indicated that there is variation with how individuals choose to engage. Key informants also indicated that engagement overall tends to be challenging. One key informant estimated that out of ten referrals, one or two individuals will engage in services of any kind. The Project Director discussed one possible challenge, being the way individuals define their own recovery process.

What factors facilitate or impede access to the full spectrum of MAT, behavioral and peer support services? (2.6)

The factors that facilitate or impede access, apart from how the program functions, have not significantly changed over the last three years of the grant funded project. Key informants noted that transportation continues to be a significant barrier; COVID prevented PSS from providing some transportation support during year 3. Family life and social networks can also create more stress or obstacles, or they can support someone in successfully accessing and continuing with treatment and recovery services. A provider noted that many individuals presenting at the clinic have complex co-morbidities, which can limit treatment options. COVID-19 continued to impede access over Year 3 of the grant and into the No-Cost Extension. The STARS residential program was urged to close its doors for several months while the outpatient services were interrupted by numerous cases and exposures of COVID-19 resulting in weeks of no treatment. This was a "hard time for everyone" said one individual who had been receiving services at the STARS facility. Overall key informants, including patients, generally spoke positively about referral procedures, and technical aspects of making referrals and coordinating care between providers. PSS are often available and immediately responsive to providers' requests. Communication and referral have continued to improve over time.

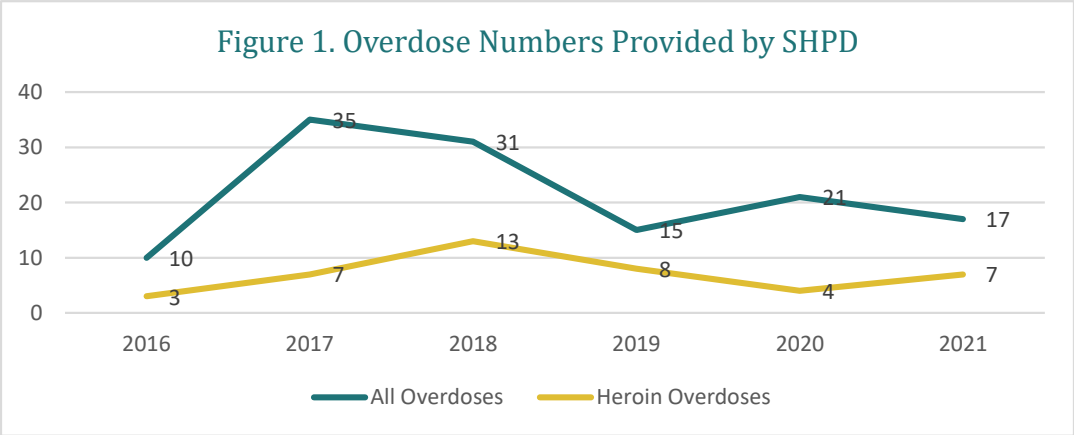
Is STARS rural outreach reaching its intended audience? (2.7)

Table 2 represents demographic variables of individuals identified with OUD through the STARS Rural Outreach program. Project staff are confident that they are reaching the intended audience, even if numbers remain small. PSS keep a consistent and robust caseload.

Table 2. Demographics (Individuals Receiving Treatment for OUD)	First Year	Second Year	Third Year
Race			
American Indian/Alaska Native	1	0	0
White	23	13	40
Unreported	8	1	1
Ethnicity			
Hispanic/Latino	0	0	0
Non-Hispanic Latino	26	13	40
Unreported	6	1	1
Age Group			
Adolescents (13-17)	1	0	0
Adults (18-64)	26	13	37
Elderly (65+)	5	1	4

Changes in Outcomes (2.8 – 2.11)

For changes in the number of individuals, screened, identified, referred to treatment, and in treatment, please refer to Table 1 above. We have two sources of data to assess the mortality rate over the time period of the grant. The Sweet Home Police Department (SHPD) has been keeping records of drug-related overdoses and fatalities since 2016. After highs in 2017 and 2018, the number of overdoses overall appear to be decreasing. However, this downward trend may have been interrupted by COVID-19. According to preliminary data published by the Centers for Disease Control (2021), drug overdose deaths in Oregon increased by 40% between March 2020 and March 2021. The Oregon Prescribing and Overdose Data Dashboard publishes county-wide figures. No new data has posted to the dashboard since the Year 2 Evaluation report. Using data from the Medical Examiner, there was a slight (but probably not statistically significant) decrease in the mortality rate for Linn County as whole between 2018 and 2019 (data for 2020 is not yet available). According to Medical Examiner data, there were 4 opioid-related deaths in Linn County in 2018, with a mortality rate of 3.27 deaths per 100,000 population. In comparison, there were 4 opioid-related deaths in 2019, with a mortality rate of 3.16 deaths per 100,000. The No-Cost Extension period, following the more severe months of COVID-19 saw another spike in overdoses. In 2022 between the months of January and June, 75 overdoses were reported by Samaritan Lebanon Community Hospital (SLCH) Emergency Department in Linn County. This is not to say whether these were fatal or non-fatal overdoses. Additionally, SLCH began tracking the number of Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS) babies born. Between January and June, 15 babies were born to NAS/NOWS.



Goal 3 of the STARS Rural Outreach project is to "Conduct OUD education and outreach activities in east Linn County that include community distribution of naloxone rescue kits by rural clinics and first responders supplied through Samaritan Lebanon Community Hospital (SLCH) pharmacy services." There are four process questions and three outcome questions under Goal 3.

How many naloxone kits were distributed? (3.1)

According to the tracking database, 353 units of Narcan were distributed during the No-Cost Extension. (As a reference, the total of naloxone kits that were distributed during Year 3 was 174, during Year 2 was 79, and during Year 1 was 145.)

What factors facilitate or impede community education efforts? (3.2)

Interviewees provided a number of perspectives on community education efforts. In Years 2 and 3, COVID-19 disrupted all services, including education and outreach efforts. The program staff shifted to webinars or online education and published several articles in the Sweet Home newspaper, The New Era. There is sense from key informants and program partners that it was necessary to first concentrate on building and refining the systems of support for individuals with OUD, before engaging in broad community outreach. Still, key informants generally agree that the narrative around OUD has shifted in comparison to three years ago. There is a broader awareness of OUD as an issue and the attitudes (particularly attitudes consistent with stigma) have slowly shifted. Some noted successes in the area of community education, including the education of the Sweet Home City Council and the Sweet Home Health Committee. The efforts extended towards educating providers on the benefit of obtaining an X-waiver showed in the increase of X-waivered providers across the region from originally 4 to now 10. The weekly virtual meetings dedicated to MAT, HUB & SPOKE providers, substance use professionals, and peer support specialists have allowed for ample education on the importance of each role in the team. Additionally, education for residents has been an opportunity to provide insight as to how MAT helps substance users gain success in their lives.

Who are we reaching through education and outreach efforts? (3.3)

Table 3 presents the number of individuals reached through direct (e.g., presentations, consultations, webinars, online modules) and indirect (e.g., flyers, newsletters, mailings, and other

mass media) over the grant period. Education efforts include in-person classes and events, webinars, newsletters, flyers, and Community Court.

Table 3. Direct and Indirect Community Education	First Year	Second Year	Third Year	No-Cost Extension
Children (0-12)	0	0	0	0
Adolescents (13-17)	0	0	0	11
Adults (18-64)	4	22	41	132
Elderly (65+)	1	0	0	11
Unknown Age	0	0	6000	6000
Estimated Reach for Indirect Communication	110	3100	6041	6104

Who and what are the natural community supports within the service area? (3.4)

The first two years of the grant period focused on identification of specific services and supports. One key informant characterized Sweet Home as an "underprivileged community," observing that, "they don't have a whole lot." More resources (especially support group meetings) are available within Lebanon, if individuals have transportation available. Project staff also identified local faith-based services such as Celebrate Recovery and Country Counseling to which they can refer individuals with OUD. Clinic staff identified community institutions (e.g., clubs, civic groups, churches) that provide volunteer support to local causes as possible assets. Key informant interviews in Year 3 emphasized how conditions in the service area have changed over the duration of the grant and that partnerships are stronger.

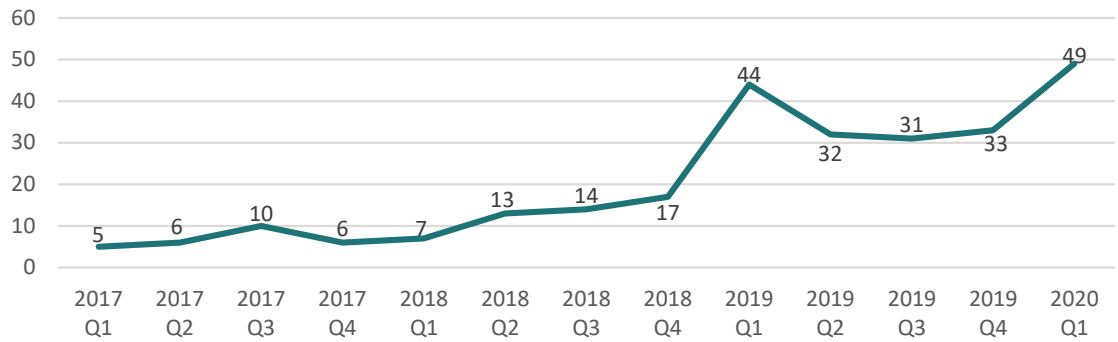
"We have more people working on OUD than we had in the past. This includes recovery supports, like Country Counseling and Exodus Recovery in town, and having James and the peer supports is more than we've had in town in the past. The focus on Narcan and MAT is also good."

How has the morbidity rate of OUD changed since the implementation of the STARS rural outreach program? (3.5)

The true prevalence of OUD in east Linn County is not known. Prior to the initiation of the Rural Outreach Program, Linn County's hospitalization rate for use of any opioid in 2017 was among the highest in the state (37 hospitalizations; 29.6 hospitalizations per 100,000 population) according to data from the Oregon Prescribing and Overdose Data Dashboard. The number of opioid-related hospitalizations decreased slightly in 2018 for the county (29 hospitalizations; 22.8 hospitalizations per 100,000 population). Although reported in last year's evaluation report, these are still the most recent data points available. Naloxone administrations using EMS data is another measure that can be used to better understand morbidity. Figure 2 depicts the trend of EMS naloxone administration

in Linn County, using the most recent data available from the Oregon Prescribing and Drug Overdose Data Dashboard. (Please note that data have not been updated since Q1 2020.) In the beginning of 2022, the Harm Reduction Coalition along with the CCCWN Mental Health/Substance Use Disorder Coalition worked together with local law enforcement to support the work of more coordinated data collection for overdoses. Linn County subscribed to ODMAPS, a centralized system for collecting overdose data. Samaritan Health Services also recognized the need for this data and began collections for all 5 hospital emergency departments. In the Samaritan Lebanon Community Hospital 75 overdoses were reported between January and June while 15 babies were born to NAS/NOWS.

Figure 2. Number of EMS Runs with Naloxone Administration in Linn County, 2017-2021



These figures represent Linn County as a whole and are not specific to the service area of the Rural Outreach Program. The number of naloxone administrations should be interpreted with caution; proliferation of naloxone in the service area could have increased its use, whether or not the rate of OUD changed during the same time frame.

How has knowledge and awareness of OUD increased among community members as a result of STARS education and outreach efforts? (3.6)

Key informants generally agreed that awareness of OUD and stigma around OUD has improved over the grant period. However, as one partner noted, there are still areas where more education and support in the community will be needed.

How has the support system for families of individuals with OUD changed, and to what degree is it self-sustaining? (3.7)

Supports for families of individuals with OUD has been long established through the Family Tree Relief Nursery. The Project Director and PSS collaboratively worked to sustain and pass off to community members, a virtual Nar-Anon Family Group. The Family group was originally going to be facilitated in-person at the STARS location in Lebanon, however this was interrupted by COVID-19. Presumably other local service providers are also offering family support. Key informants generally noted that this was an area in which they wanted to grow or expand efforts.

Goal 4 of the STARS Rural Outreach Program is to "Extend the reach of STARS Outreach into outlying rural areas by utilizing the services of a trained Peer Support Specialist." The evaluation questions listed under Goal 4 include:

How has the rural PSS affected referrals made for OUD assessment and treatment? (4.1)
How has the PSS identified and increased use of recovery assets within the community? (4.2)
How has the PSS increased support for friends and family members of individuals with OUD? (4.3)
How has the number of individuals initiating treatment for OUD from rural East Linn changed? (4.4)
How has the number of individuals participating in recovery support activities in rural East Linn changed? (4.5)
How has the support system for individuals with OUD changed in the service area, and to what degree is it self-sustaining? (4.6)

From interviews in Year 3, Key informants viewed peer support specialists as very knowledgeable, available, and filling in gaps that cannot be addressed through traditional medical services – gaps like transportation, home visits, assessments, and support groups. Peer support continues to help individuals to effectively access and navigate services. A number of individuals are actively participating in recovery support activities, but STARS staff also noted that some individuals in the service area must be creative about finding meaningful social supports and activities, especially in the context of COVID-19 restrictions. This may continue to be a challenge.

Peer support specialists also serve a vital role in connecting with members of the community. As one peer support specialist noted, "The more we're out here, the more we're engaging in community things, we're present in Community Court, people know where we're at and how to get a hold of us." Patients, likewise, praised the fantastic job that PSS are doing:

"I've been working with Josh . . . it's good to see him a few times a week and to call him when I need to. I know that I can call him, if I was to relapse, and it could be in the middle of the night. I don't feel judged, I feel like I can tell him anything."
"I feel like they [STARS] really do try to go above and beyond. Even in the very beginning I didn't have a phone or have an email that hooked up to my phone. They found alternative ways for connecting."

The total number of individuals receiving direct services from STARS staff for OUD increased in Year 3 and in the No-Cost Extension as compared to Years 1 and 2.The figures for Years 1 and 2 came directly from the program database, whereas in Year 3 and the No-Cost Extension, we populated a list of individuals identified with OUD within the service area, and then asked the STARS staff to review and report how these individuals engaged in treatment.

Table 4. Individuals with OUD in Treatment	First Year	Second Year	Third Year	No-Cost Extension
In treatment 0-2 months without interruption	4	6	9	33
In treatment 3-5 months without interruption	4	3	9	28
In treatment 6-12 months without interruption	1	0	4	13
In treatment 1 year + without interruption	9	10	3	11
Referred, but not yet started treatment	10	0	6	3
Discontinued treatment	4	5	10	9

V.Communications/Dissemination Plan

With guidance and direction from program staff and the CCCWN advisory committee, the evaluator recommends that the following steps be taken for communication of evaluation findings for Year 1-3:

Step 1: Discuss evaluation findings internally and identify needed or desired adjustments to program plans and activities.

Step 2: Identify audiences and opportunities to communicate evaluation findings.

Step 3: Work with SHS marketing/communications to create specialized media tools for communicating with these audiences (e.g., newsletter story or PowerPoint presentation).

Step 4: Create a list of audiences, a timetable for presentations and publications, and make plans to complete them.

VI.Conclusions and Recommendations

Despite significant disruptions caused by COVID-19, staff vacancies, and a change in program coordinator, the Rural Outreach program had some notable successes. The number of individuals identified with OUD and in treatment for OUD appeared to increase over the grant period. Community partnerships appear to be stronger and galvanized around a common purpose. The Sweet Home community seems to have made significant progress in awareness of OUD as an issue and in lessening the stigma around substance use disorders and treatment. Individuals receiving direct services report being pleased with the support they are getting.

At the conclusion of Year 3 of the grant, foundational activities are in place and seem to be functioning well. These activities include the Hub and Spoke model, offering MAT and peer support through the spokes, structured community activities like Community Court, and solid relationships with key community partners. Key informants continue to be enthusiastic, and each noted that significant improvements in services and community attitudes have been made over the past three years.

Recommendations

Although the Rural Outreach Program will continue for another year of funding, there is an opportunity to have meaningful and purposeful discussions around how to move from an implementation phase into a maintenance phase of operations. According to Aarons, Hurlburt, and Horwitz (2011), the following contextual factors should be considered when a program that is using evidence-based practices shifts from implementation to sustainability:

- Executive leadership demonstrates a commitment to continue implementing evidence-based practices.
- The organization also has policies that support continued use of evidence-based practices.
- The program receives consistent, ongoing funding to the level that is needed to keep service delivery at a high quality.

- There is continued collaboration with community partners and stakeholders that is characterized by trust and frank discussion of concerns.
- Day-to-day programmatic leadership espouses team participation and psychological safety.
- There is a critical mass of expertise on the staff who is implementing the evidence-based practices.
- The program continues to assess fidelity requirements of implementing the evidence-based practice.
- The program maintains adequate staffing.

Although all the bulleted items above are important, the STARS Rural Outreach program may benefit from specifically discussing these factors specifically:

1. How can the Rural Outreach program achieve consistent **funding** so that the same level of services can continue in the service area after grant funds have been exhausted?

2. Considering that STARS and the PSS refer individuals to treatment services outside of the Samaritan system (and based on client needs and preferences), how can the program, or program leadership, continue to build on the relationships currently in place? A **Collective Impact Model** (Kania & Kramer, 2011) could be beneficial in further galvanizing partners around common goals and increasing information sharing across client-serving organizations. In a collective impact model, partners establish a common agenda, agree to measure progress the same way and to share data, coordinate their activities with each other, and continuously communicate.

3. Without a full-time program coordinator dedicated to implementation of the program, how can the program maintain an adequate level of **staffing** to ensure that relationships are maintained, and that activities are being implemented with fidelity?

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