Section A: Population of Focus and Statement of Need

A. 1

The project is a statewide effort with several targeted populations. According to the 2020 United States Census, Arkansas's population is 3,011,524, making it the 33rd most populated state. Of the 75 counties in Arkansas, 55 are considered rural. Among rural counties, nearly 60 percent have fewer than 20,000 people. Arkansas is in the bottom third in terms of population per square mile at 57.9 compared to the District of Columbia at 11,280.0 and Alaska at 1.3 per square mile. The majority of Arkansas's population is White (78.5%) followed by Black or African American (15.6%), Two or More Races (2.4%), Asian (1.8%), American Indian and Alaska Native (1.1%), and Native Hawaiian and Other Pacific Islander (0.5%). Hispanic or Latino ethnicity is 8.6% of Arkansas's population.[1] Arkansas has a slightly higher proportion of females to males than the United States, with 50.6% and 50.4%, respectively.[2]

A. 2

Rural Areas

The Social Vulnerability Index (SVI), developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is a powerful tool for identifying and assessing communities facing social vulnerability. This comprehensive index and mapping application takes into account a range of demographic and socioeconomic factors, such as poverty, limited access to transportation, and crowded housing. By analyzing 16 variables from the 5-year American Community Survey (ACS), the SVI can highlight communities in need of support both before and after disasters. The SVI considers themes like socioeconomic status, household characteristics, racial and ethnic minority status, and housing type and transportation, and combines them to provide an overall measure of social vulnerability. County scores ranging from 0.75 to 1 indicate high vulnerability, scores from 0.5 to 0.75 indicate medium to high vulnerability, scores from 0.25 to 0.5 indicate low to medium vulnerability, and scores below 0.25 indicate low vulnerability. For example, in Arkansas, 18 out of 75 counties, mainly in the delta region, fall into the highest vulnerability category, exhibiting characteristics such as lower socioeconomic status, a higher percentage of single-parent households, a larger proportion of minorities, and more vulnerable housing types.

In Arkansas, according to the 2023 County Health Ranking & Roadmaps, 82% of households had a broadband internet connection. This ranged from 58% to 91% of households across counties in the state, which contributes to an increase of tele-health services available in the hard-to-reach areas.

Underserved populations

Startlingly, the CDC's data from 2020 reveals a grim reality: counties with greater income inequality witnessed overdose death rates for Black Arkansans more than double those in other counties. Among older Black men across the United States, the overdose death rates were nearly seven times higher than those for older White men. This disparity is further exacerbated by U.S. Census data, which shows that 16.8% of Arkansas residents live in poverty, a figure higher than

[1] United States Census Bureau. (2021). Arkansas: 2020 Census. Retrieved from United States Census Bureau: https://www.census.gov/library/stories/state-bystate/arkansas-population-change-between-census-decade.html
[2] United States Census Bureau. (2020). QuickFacts. Retrieved from United States Census Bureau: https://www.census.gov/quickfacts/fact/table/US,AR/AGE775222

the national average of 11.5%. The highest poverty rates are concentrated in the Delta and southern regions of the state, where CDC findings suggest an increased potential for overdose death rates among minority populations with greater income inequality.

The data for total drug overdose deaths in 2022, sourced from the CDC WONDER Online Database for Arkansas, was 21.7 per 100,000, lower than the national rate of 32.6 per 100,000. The overdose rate for white Arkansans was 24.2 per 100,000, lower than the national rate of 35.6 per 100,000. The overdose rate for black Arkansans was 22.0. Arkansas's Naloxone Reporting tool, which collects all grant-funded naloxone administrations, reveals a significant disparity: since 2018, 85.8% of naloxone administrations were to white Arkansans, and 12.0% were to black Arkansans. This stark contrast underscores the urgent need for targeted interventions and data collection focusing on health protective measures and overdose rates among racial and ethnic minorities.

Lastly, results from the 2021 and 2022 NSDUHs indicate that homosexual and queer minorities are more likely than their heterosexual counterparts to use substances, experience mental health issues, including major depressive episodes, and experience severe thoughts of suicide. The findings in this report particularly underscore how these issues affect sexual minority groups, who face unique challenges. Data on minority populations, a rising proportion of the state's population, are needed to ensure substance use/misuse interventions account for cultural, racial, and ethnic differences.

Maternal Health

According to the 2023, Arkansas Maternal Mortality Review (AMMR) Committee legislative review, 92% pregnancy related deaths were considered preventable. The AMMR recommended that facilities implement guidelines for assessing the needs of pregnant and postpartum women with complex medical or social issues. It would be beneficial for hospitals to consider employing a social worker or case manage primary role to conduct a psychosocial needs assessment, including social determinants of health, prior to the discharge of delivering women. This could help in identifying potential barriers to care and connecting women to resources and postpartum case management. Educating providers about the importance of a timely social work assessment can ensure better access to health care services for women. Additionally, getting case management involved in all substance use cases and screening for substance use or alcohol use at each visit could be helpful.

The taskforce on maternal health 2024 publication of the *National Strategy to Improve Maternal Mental Health Care* agreed that the perinatal period provides a great opportunity to engage individuals in discussions about their mental health and substance use, as well as other risk factors affecting their overall health and well-being. It's important for pregnant and postpartum women to receive support from healthcare systems and providers to enhance not only their physical health but also their mental well-being. This engagement, with the support of SOR funding, could lead to prevention efforts that are culturally relevant and sensitive to the needs of pregnant and postpartum women, particularly those from under-resourced communities who are at high risk for maternal mental health conditions and substance use disorders. It's crucial to provide patient education and connect individuals to resources and referrals, as this support could potentially change the lives of both the mother and child.

Given that Arkansas has the highest maternal mortality rate in the United States, the following data focus on maternal and child health. While many of the risk factors below are not necessarily directly related to drug overdoses, they can contribute to conditions that increase the

likelihood of substance abuse and overdose incidents. The United States Maternal Vulnerability Index (MVI) identifies counties where mothers are vulnerable to poor health outcomes based on six themes associated with maternal health outcomes.[3] Congenital syphilis is a disease that occurs when a mother with syphilis passes the infection on to her baby during pregnancy. Arkansas experienced a 392% increase, from 13 cases to 64 cases of congenital syphilis from 2017 to 2023. During this time 19 infants died. From 2020-2023 and there were 17 syphilitic stillbirths. In 2023, CDC released US county-level syphilis rates for 2021 which showed Arkansas having 5 of the top 20 counties nationwide for rates of primary and secondary syphilis among women ages 15-44 years. After this report was issued, the Office of the Assistant Secretary of Health with the US Department of Health and Human Services formed the National Syphilis and Congenital Syphilis Syndemic Federal Task Force and named Arkansas a priority jurisdiction of concern. From 2021-2023, there have been 183 congenital syphilis cases with 30% of moms having a positive toxicology screen. Whereas the same time frame there have been a total 626 pregnant women with syphilis. Of those women 9% self-reported drug use during pregnancy.

The Arkansas Department of Human Services (DHS) Division of Children and Family Services (DCFS) keeps track of newborns effected by illegal substances that fall under the State's Garrett's Law. According to DCFS, Garrett's Law added two additional conditions that met the conditions of child neglect: 1) the presence of an illegal substance in a newborn's system due to the mother's knowing use of the substance; 2) and a newborn having a health problem due to the mother's usage of illegal substances prior to birth.[4] In 2023, there were 1,525 Garrett's Law Referrals. Though this continues the decreasing trend from a high of 1,619 in 2021, it still has a significant impact on the child welfare system with 44% of children entering foster care being placed due to parental substance abuse. It is the second highest placement reason.

The rate of neonatal abstinence syndrome (NAS), NAS diagnosis (withdrawal) in Arkansas increased close to seventeen-fold between 2000 and 2021. After decreasing in 2018 and 2019, the NAS rate increased to 3.7 per 1,000 births in 2020. In 2021, the increase continued to a new high of 5.1 per 1,000 births. The overdose death rate was 6.9 deaths per 100,000 mothers in the first six months of 2018 and increased to 12.2 deaths per 100,000 mothers in the latter half of 2021. (ACHI) Due to the alarming intersection of high rates of drug use and syphilis and congenital syphilis cases, neonatal abstinence syndrome (NAS), and overdose deaths among pregnant women in Arkansas, we must prioritize collaborative interventions. Since such a high percentage of women depend on state funding for these services, DHS programs funded through SAMHSA are crucial. 9.6% of women reported not having insurance during postpartum, which is higher than the national rate (6.3%). By fostering partnerships across state agencies and other invested agencies, we can effectively address broader health challenges, issues related to coverage, and a (w)holistic approach to wellness faced by these vulnerable populations, ensuring comprehensive care and support for mothers and their infants.

Co-occurring Disorders and Medicaid

When it comes to individuals with mental health needs including substance use disorders (SUD), more than 380,000 Arkansans (roughly 12% of the total population) had at least one

[3] Surgo Ventures. (2022). The US Maternal Vulnerability Index. Retrieved from Surgo Ventures: https://mvi.surgoventures.org/

[4] Division of Children & Family Services Policy & Procedure Manual. https://humanservices.arkansas.gov/wp-content/uploads/Policy-Manual-March-2024.pdf

medical claim with a primary diagnosis of a mental health condition in 2019.[5] This is over 10% lower than the national average of adults with mental illness, suggesting there may be sizable portion of adult Arkansans going completely without diagnosis and treatment or not able to access services for mental health and SUD.[6] According to the Arkansas Center for Health Improvement (ACHI), Commercially Insured Beneficiaries had the lowest percentage of 30-day Emergency Room and Inpatient Readmissions for those with a primary diagnosis of substance use disorders from 2020-2022 with 11.7% respectively, and Medicaid PASSE had the highest with 30.5% respectively.

Medicaid beneficiaries with co-occurring mental health/SUD conditions, may not be able to access the full continuum of care. A barrier is that traditional Medicaid beneficiaries aged 21 to 64 cannot currently received Medicaid-funded residential substance use disorder treatment, many of them instead visit hospital emergency rooms, seek no treatment, or end up involved in the criminal justice system because of their SUD. Arkansas has requested a waiver of federal rules preventing Medicaid payment for this service through the Centers for Medicare and Medicaid Services and expects to receive approval in Spring 2025.

With a waiver, the landscape for care may shift in Arkansas. Inpatient services for SUDs would be available to Medicaid beneficiaries. Arkansas Medicaid also plans to build out the SUD continuum of services for which Medicaid funds can be used. To support this, OSAMH's focus now becomes getting SUD providers ready to enroll as Medicaid providers and provide reimbursable services through Medicaid. Another requirement to ensure fidelity and authorization of services is American Society of Addiction Medicine (ASAM) criteria. The ASAM criteria is widely utilized and provides comprehensive standards for placing, continuing service, and transferring of patients with addiction and co-occurring conditions. Previously referred to as the ASAM patient placement criteria, it was developed through a collaboration that commenced in the 1980s to establish a national set of criteria for delivering outcome-focused care in treating addiction. This SOR grant serves an opportunity to educate and assist providers in enrolling as a provider and using ASAM criteria before the waiver is approved.

One of the goals of DHS's "Roadmap to a Healthier Arkansas" is to connect populations and individuals to the healthcare resources and services available across the continuum of care. One strategy to achieve this would be to engage peer recovery specialists for OUD patient follow-up. Thirty-day readmission rates in both emergency department and inpatient settings were higher among Medicaid populations. Ensuring patient follow-up and aiding in scheduling primary care appointments could help reduce these 30-day readmissions. Closed-loop referral software tools are available to support the engagement of peer recovery specialists for OUD patient follow-up.

Justice-Involved

According to the Prison Policy Initiative, Arkansas releases roughly 132,988 men and 47,413 women from its prisons and jails each year, and the risk of overdose death is more than 10-fold higher among adults released from prison relative to the general population. The rate of

[5] Arkansas Center for Health Improvement. Arkansas Behavioral Health Landscape Preliminary Analysis. 7/1/2022 p.6.
[6] Arkansas Center for Health Improvement. Arkansas Behavioral Health Landscape Preliminary Analysis. 7/1/2022 p. 56.

opioid overdose is markedly elevated after prison release, particularly in the first two weeks.[7] In women, the higher rate of opioid overdose is mediated by a more significant mental health burden. These complex conditions can be compounded when a person is under criminal justice/correctional supervision or sent to a forensic psychiatric institution. In 2020, the SMI/SED population comprised only 17.5% of Medicaid-enrolled adults and children receiving behavioral health support in Arkansas. Yet, it was and remains one of the highest-cost groups. It is crucial to recognize the need for more support initiatives to ensure successful community reintegration. For those with more intensive behavioral health needs and/or justice-involved individuals with co-occurring conditions, DHS is heavily investing in more stabilization/recovery initiatives in the care continuum to prepare individuals better to transition back to their communities successfully.

In an annual report from the Division of Youth Services, the number of youth (ages 12-21) receiving criminal drug charges has increased dramatically. In 2023, there were 258 criminal drug-related charges among youth, a 24.6% increase from 2022 (n=207). The Arkansas Department of Human Services (DHS) and OSAMH aims to expand the accessibility of evidence-based interventions for youth incarcerated for drug-related crimes. Prevention experts suggest that upstream prevention strategies for opioid misuse should begin with underage drinking prevention programs. Strategically working to delay the age of first alcohol use among students may help prevent the development of opioid use disorders before they start. School-based alcohol prevention programs and early opioid education are ultimately needed to continue the downward trend in substance use among this age group.

Youth and Young Adults aged 16-25

In *2021, Young Adult State of Wellbeing* publication from the Arkansas State Epidemiological Outcomes Workgroup (ASEOW), the population between 18 and 29 years of age represents 15.9 percent of the Arkansas population, which decreased slightly from 16.2 in 2020, and is now like the U.S. distribution (16.1%). According to ASEOW, the percentage of males among both the U.S. and Arkansas the young adult population is slightly higher than that of females. In addition, there is a higher percentage of those aged 18-24 years than 25-29 years. This could be indicative of the fact that up to 33 percent of students enrolled in Arkansas universities and colleges are non-residents, inflating the proportion of the population in the 18-24 age group. Additionally, most graduates from Arkansas colleges and universities, those aged 25-29, tend to relocate to major cities outside of the state. U.S. percentages of young adults are slightly higher across sex and age relative to Arkansas data. According to a 2024 report published by the National Survey on Drug Use and Health (NSDUH), approximately 33.7 percent of young adults aged 18 to 25 had any mental illness (AMI) in the past year. This percentage was higher than that of adults aged 26 to 49 (28.1 %) and adults aged 50 or older (15.0 %). Regardless of age group, females were more likely than males to have AMI, serious mental illness (SMI), or major depressive episode (MDE); however, the gender gap was most apparent among young adults aged 18 to 25.

[7] Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction (Abingdon, England)*, *105*(9), 1545–1554. https://doi.org/10.1111/j.1360-0443.2010.02990.x

According to the Arkansas Prevention Needs Assessment[8] (APNA) an annual survey measuring substance use among children ages 12-17, in 2023, among 12th graders specifically, lifetime prescription drug misuse was notably high at 8.5%. Encouragingly, the APNA report showed that young Arkansans' rates of both lifetime and past 30-day use across all the aforementioned substances fell below national averages in 2023. According to APNA, the majority of 12th grade students perceived that both heroin (81%) and methamphetamine (79.8%) are "likely to cause great harm." These rates for 6th graders were only 57.1% and 56%, respectively. This difference suggests that the age at which students receive education about these substances may coincide with a change in perception. Therefore, younger students' perception of harm could be increased by introducing opioid education at an earlier age. Despite the overall decrease in youth opioid misuse, overdose deaths among young people remain a significant concern. In 2021, the Arkansas Department of Health reported 16 overdose deaths in youth ages 11 to 20, and 121 between the ages of 21 to 30. In 2022, people aged 15-24 made up 7.6% of total overdose deaths[9].

Several issues of concern remain: First, while the overall un-insured rate in the state was 8.7 percent, rates for young adults were nearly double overall at 15.3%, largely driven by males. Second, for young adult rates were significantly higher for minorities. Hispanics had an un-insured rate of 27.7% and 20.2% of Black young adults lacked insurance. Third, while Native Hawaiian and Pacific Islanders represent only 0.35 percent of the Arkansas population, the rate of uninsurance in the 19-25 age group is higher than any other group at 69.4%. Finally, un-insurance rates in 2021 fell from 2020 in the young adult population driven largely by increases in Medicaid and Marketplace coverage related to the pandemic. Remaining uninsured is an issue for providers to effectively target and serve this age group without a funding source. Therefore, OSAMH with the help of partnerships with service provider and the support of the peer network can assist young people getting enrolled in ARHOME. The ARHOME program uses Medicaid dollars to buy private health insurance for youth and includes SUD residential coverage.

Naloxone Distribution

In May of 2023, the OSAMH allocated $2.5 million to saturate Arkansas with Naloxone. This project concluded April 1st, 2024, achieving 100% saturation in 61 of the state's 75 counties. These efforts have contributed to Arkansas' steeply declining opioid-related overdose rate (-13%). OSAMH will continue this vital work through proven methods, expanding through a comprehensive training program and increasing targeted reach to rural populations through mail-order services.

[8] https://arkansas.pridesurveys.com/regions.php?year=2023
[9] https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html

SECTION B: Proposed Implementation Approach

B. 1

Goal 1: Strengthen prevention infrastructure, focusing on underserved communities with high substance misuse risks.
Objectives:

1. By 09/29/2025, and annually thereafter, regional capacity to implement data driven prevention strategies as measured by number of sub-grantee prevention contracts and monthly activity monitoring of activities delivered in high-need communities.
2. Collaborate with Prevention Regions with identified underserved communities with high substance misuse risks to develop and disseminate state-of-the-art, culturally relevant substance misuse prevention and treatment resources.
3. By 09/29/2025, improve access to culturally and linguistically appropriate prevention education trainings as measured by development of standardized opioid response training curriculum in English and Spanish. By 09/29/2026, provide translated curriculum materials in Vietnamese and Marshallese.
4. Partner with an outside entity to distribute and train counties across the state as well as identify interested parties in receiving naloxone based on the distribution plan to meet the need of 100% saturation across all 75 counties throughout the grant period. 75% of participants will report increased confidence related to identifying signs and symptoms of opioid misuse as evidenced by post-training surveys.
5. By 09/29/2025, and annually thereafter, improve capacity of regional prevention providers to identify communities in need of naloxone as measured by maintenance of OSAMH Naloxone Distribution map and program documentation of naloxone distributed to targeted communities as a result.
6. By 09/29/2025, and annually thereafter, increase regional capacity to implement data driven prevention strategies as measured by number of sub-grantee prevention contracts and monthly activity monitoring of activities delivered in high-need communities.

Goal 2: Maximize positive health behaviors and substance use prevention outcomes throughout each region of the State of Arkansas.
Objectives:

1. By the end of the project period in 2028, coordinate with an outside entity to utilize prevention strategies recommended by the Center for Substance Abuse Prevention (CSAP) to reduce underage drinking by 3%, as measured by the Arkansas Prevention Needs Assessment (APNA).[10]
2. By the end of the project period in 2028, coordinate with outside entities to increase opportunities for school-based pro-social involvement by 20% (as measured by APNA) in high-poverty areas and those counties with the highest rates of substance misuse to support and engage youth ages 12-25.

[10] https://arkansas.pridesurveys.com/

3. By the end of the project period in 2028, contract with an outside entity to create educational opportunities to train counselors at participating schools to utilize the Screening, Brief Intervention, Referral and Treatment (SBIRT) method to promote annual screenings of students for opioid, stimulant, and prescription drug misuse and to implement evidence-based universal prevention interventions.
4. By the end of the project period in 2028, collaborate with participating schools in the Arkansas Collegiate Network to develop and disseminate prevention resources to their students.
5. By the end of the project period in 2028, increase collegiate recovery programs in the state by at least one.

Goal 3: Enhance the knowledge base for the workforce to better support individuals at risk or with an OUD, families and the community in prevention, treatment, and recovery support through trainings, consultation and evaluation.
Objectives:

1. Modernize providers (prevention, treatment, and recovery) by training on the latest evidence-based techniques, skills, and assessment tools including ASAM to develop a more advanced workforce to combat substance use disorders and co-occurring disorders.
2. Develop a toolkit in collaboration with the Arkansas Department of Health to screen and treat STI, HIV, and other chronic illnesses associated with high-risk behaviors and SUD for funded providers to utilize.
3. Establish a quarterly meeting with stakeholders to discuss and educate providers and stakeholders on the importance of data collection best practices and ways to improve services based on data.
4. Contract with an outside provider to gather GPRA survey intake and follow-up data to improve the state's report to SAMHSA regarding progress toward grant requirements.
5. Identify the barriers in accessing MOUD treatment services for youth and young people through assessment and evaluation and develop a plan to mitigate these barriers.

Goal 4: Move towards ongoing sustainability for substance use disorder services along a full continuum of substance use disorders for the State of Arkansas.
Objectives:

1. Create a toolkit for interested service providers to use as they engage with Medicaid toward becoming a new provider.
2. Establish regularly scheduled meetings led by a project management team with stakeholders and subject matter experts to develop a timeline for enrolling subgrantees as Medicaid providers.
3. Identify barriers to the enrollment process and make necessary revisions to the enrollment toolkit.
4. Develop educational opportunities with the Recovery Community Organizations (RCOs) to utilize Medicaid for reimbursable peer recovery support services.

5. By January 30, 2025, OSAMH will have a meeting with the Department of Health and other interested state entities to explore opportunities for braided funding to achieve goals and objectives.
6. By the end of the project period in 2028, increase the number of SUD treatment providers enrolled in Medicaid and increase utilization of Medicaid services.
7. Create educational opportunities to equip youth and young adults (16-25) with skills to navigate services and enroll in benefits including insurance.

Goal 5: Expand rural access to treatment for OUD and other concurrent substance use disorders.
Objectives:

1. Collaborate with subject matter experts and external consultants to develop a hub and spoke model for access to FDA-approved medications for the treatment of SUD for hard-to-reach populations and rural areas.
2. Provide innovative telehealth strategies in rural areas to increase the capacity of support services for OUD/stimulant use disorder prevention, treatment, and recovery.
3. Improve access to health care utilizing mobile units to reach rural areas.
4. By the end of the project period in 2028, a low-barrier Buprenorphine treatment program will be piloted in the state.

Goal 6: Decrease severity of social determinates of health which negatively impact overall wellness of mothers, pregnant women, and their children in Specialized Women's Services programs.
Objectives:

1. Contract with an outside entity to provide specialized maternal health services to pregnant women in SWS programs and to pregnant women at risk of needing SWS programs.
2. Identify pregnant women in collaboration with an outside entity working with justice-involved mothers, family court cases, or other entities to enroll them into services related to prenatal care and system navigation.
3. Develop a toolkit to educate providers in reducing discrimination for mothers and pregnant women needing SWS services.
4. Increase current admissions to SWS treatment by 10% through increasing accessibility of childcare services for mothers which is a deterrent to women admitting to SUD treatment.
5. Contract with an outside entity to assess and evaluate the effectiveness of SWS services in meeting the needs of mothers and pregnant women.

Goal 7: Work with DCFS to develop braided funding for Substance Use Services programs.

Objectives:

1. Establish regularly scheduled meetings with stakeholders from DCFS, OSAMH, SUD treatment providers, and other interested parties to examine the data regarding unmet needs of pregnant and parenting women, families, and youth in care with SUD-related services and develop a collaborative resource network to address barriers.
2. Review and align contract language by both DCFS and OSAMH for contracts providing SUD-related services to pregnant and parenting women, families, and youth in care to produce a more collaborative, evidence-based, and relevant care plan by the end of the project period.
3. By the end of the project period in 2028, OSAMH will establish a working partnership with an early childhood development entity to address childcare, child development, parenting needs, and other services for pregnant and parenting women in SUD-related services.

Goal 8 – Reduce relapse and overdoses for the justice-involved population.
Objectives:

1. Collaborate with stakeholders to develop a roadmap for justice-involved individuals to receive the full continuum of care including MAT treatment.
2. Increase the number of active participants receiving justice-involved peer recovery support services in specialty courts as recorded on Goodgrid by 10% as an avenue towards recovery resources and referrals.
3. Implement a centralized reporting and management program in conjunction with an outside entity for justice-involved peer recovery support specialists as they work in specialty courts.

Goal 9: Work towards RCOs being the centralized custodians for the peer recovery support workforce in the community.
Objectives:

1. Establish regularly scheduled meetings led by a project management team with the RCO leaders to develop strategies to encourage current employers of peer recovery support specialists (PRSS) to adopt RCOs as the custodians and develop a timeline for centralizing the peer recovery support workforce.
2. By January 30, 2025, OSAMH will facilitate a community forum with healthcare providers, law enforcement agencies, justice services, community partners and other interested stakeholders to collaborate on the process of converting RCOs as the overall custodian of PRSS and develop a comprehensive referral system for recovery services through the RCOs.
3. OSAMH will plan, with or without outside entities, technical assistance on best practices for RCO development and management to increase capacity of peer recovery support services in underserved and/or rural areas.

Goal 10: **Advance peer recovery support services to provide evidence-based services to families in the continuum of care.**

Objectives:

1. By the end of the grant period, OSAMH will contract with an outside entity to develop and provide specialty training of recovery support services for pregnant and parenting women with substance use and related issues as well as a specialty training for family support services.
2. Increase the number of NARR certified recovery residences including residences specifically tailored to accommodate families including pregnant women and children and/or individuals with co-occurring disorders.
3. OSAMH will outsource the peer certification process including applications, testing, training, and ethics enforcement to a nationally recognized credentialing entity.
4. Partner with an outside entity to schedule, plan, and implement core, advanced, and supervisor training for the continuation and growth of the PRSS workforce.

Number of Unduplicated Individuals to be Served with Award Funds				
	Year 1	Year 2	Year 3	Total
Prevention	1750	1750	1750	5250
Treatment Services	400	400	400	1200
Recovery Support Services	400	400	400	1200
GPRA/SPARS Target	800	800	800	2400

B.2

The Office of Substance Abuse and Mental Health proposes to add new programs and support and/or enhance existing services to bridge service gaps in prevention, treatment, and recovery, addressing critical health disparities for underserved groups across the state.

Reaching Underserved Populations

OSAMH will partner with the Overdose Response Network (ORN) to train service providers in skills necessary to address the intersecting layers of discrimination associated with SUD and other marginalized identities[11], improving the quality of care and treatment outcomes for minority racial and ethnic demographic groups and sexual and gender minorities. OSAMH will create and maintain advisory committees to meaningfully involve members of these groups in the planning and delivery of service provider education initiatives. At the end of each federal fiscal year, allocated funding will be set aside specifically for the development of culturally relevant substance misuse prevention and treatment resources.

During year 1, OSAMH will support the development of coalitions to assess the specific services needs of ethnic and racial minorities as well as sexual and gender minorities. Working to provide these populations with culturally appropriate prevention, treatment, and recovery services will require OSAMH to develop relationships with key community stakeholders to overcome cultural and linguistic barriers. These assessments will inform appropriate adaptations to traditional prevention, treatment, and recovery services to create the best fit for these groups in years 2 and 3. OSAMH will increase access to educational materials for linguistic minority groups.

Additionally, OSAMH will utilize "Hub and Spoke models" of care for recovery and treatment throughout the state to reach underserved communities whose difficulties are compounded by living in high poverty rural areas. Investments in telehealth technology as well as regional mobile care will greatly increase rural Arkansans' access to care, particularly in the Delta and southern regions.

Prevention

OSAMH will implement the six Center for Substance Abuse Prevention (CSAP) strategies: *Dissemination of Information*, wherein we will provide information about the nature of drug use, misuse, addiction and the effects on individuals, families and communities. *Prevention Education* will be used by two-way communication between an educator and participants that follows a curriculum aimed at affecting critical life and social skills, including decision making, refusal skills and critical analysis. *Community Based Processes* will be used to enhance the ability of the community to more effectively provide prevention and treatment services for drug misuse disorders by planning, organizing and enhancing the efficiency and effectiveness of service implementation, building coalitions and networking. We plan to use *Environmental Approaches* to establish or change community standards, codes, and attitudes that influence the incidence and prevalence of substance misuse in the general population.

The Arkansas Collegiate Network, the state's collegiate substance misuse prevention coalition comprising 23 institutions of higher education, will equip school counselors to utilize the Screening, Brief Intervention, Referral and Treatment (SBIRT) method on campuses to screen for opioid, stimulant, and prescription drug misuse. Furthermore, qualitative studies will provide more robust information on collegiate substance misuse to include students identified as at-risk for substance use disorder through SBIRT, and schools who have not participated in the statewide survey, ACSUA.

[11] https://connect.springerpub.com/content/sgrlgbtq/2/2/125

Treatment

OSAMH will implement direct services through contracts to treatment providers who meet licensing requirements and show regulation compliance. Treatment providers in Arkansas's 7 OTPs (6 fully licensed and 1 under provisional license) as well as all other treatment providers funded through the SOR grant will meet the MATE ACT Training Requirements as delineated in Section 1263 of the Consolidated Appropriations Act, 2023. Treatment services may include MAT such as MOUD, individual counseling, and group counseling in residential and outpatient settings. MAT Therapy Services and MATRIARC programs are in service to populations throughout the state through the Hub and Spoke model and recruit and support new MAT providers using all FDA-approved medications to treat OUD and other SUDs. The goal is to increase the number of providers to reach the underserved rural populations as well as utilizing mobile units and innovative telehealth strategies.

OSAMH will collaborate with the Arkansas Department of Health in providing testing and treatment of STI, HIV, and other chronic illnesses associated with SUD high-risk behaviors. A toolkit will be developed for funded treatment providers in accessing these services through the Health Department including warm hand-off referrals to treatment when needed. Treatment providers will also be educated on providing vaccines and resources for blood testing needs for potential health complications from SUDs.

OSAMH will focus on the treatment needs of mothers and pregnant women with SUDs through collaboration with outside entities to identify pregnant women with SUDs and getting them enrolled in services related to prenatal care and system navigation. Providers will be educated on how to reduce stigma for mothers and pregnant women needing SWS services to encourage earlier participation in treatment efforts. Braided funding opportunities with DCFS will be explored to increase service efficacy and decrease childcare issues as a deterrent for mothers entering and remaining in treatment as well as aligning contract language with both entities in establishing substance use services for this population. Protocols will be established to ensure pregnant women receiving substance use disorder treatment also undergo routine screening for syphilis and other STIs. This initiative aims to detect syphilis early in pregnancy or during the postpartum period allowing for timely treatment and management. By integrating these services, the hope is to improve health outcomes for pregnant women and their unborn children in uterus by addressing multiple social determinates simultaneously.

Other treatment factors including barriers in access to MOUD treatment services for youth and young adults (16-25), protocols for continuum of care for soon-to-be released incarcerated individuals, improvements in data collection to measure quality of services, and the establishment of a pilot program for low-barrier buprenorphine treatment will be addressed through stakeholder meetings and in partnerships with collaborating entities. For health protective measures in preventing fatal overdoses, OSAMH will work with an outside entity to distribute naloxone and lifesaving tools for people re-entering their communities upon discharge from treatment or institutions. These efforts for health protective measures may be partnered with other state agencies, mobile health units, or nationally recognized groups specializing in the best practices of saving and protecting lives.

OSAMH, in collaboration with an outside entity, will provide opportunities to modernize the provider workforce by covering topics on the latest evidence-based techniques, skills, and

assessment tools including ASAM criteria. When and where appropriate, these training opportunities will utilize resources from the Tribal Opioid Response (TOR) Technical Assistance about evidence-based practices to healthcare workers providing OUD services to minorities. To move towards ongoing sustainability for the full continuum of care in SUD services, OSAMH will develop a toolkit and timeline for enrolling subgrantees as Medicaid providers. In partnership with an outside entity, OSAMH will develop opportunities to utilize Medicaid for reimbursable peer recovery support services as well as educate youth and young adults (16-25) on enrollment in Medicaid for substance use services.

Recovery

SOR funding has a long-standing tradition of supporting the peer recovery workforce, providing training, credentialing, and facilitating the hiring of workers across various agencies. In this grant period, our aim is to expand this workforce and build sustainability and capacity. With the support of SOR funding, OSAMH is eager to create a collaborative, intentional, and educational forum with Recovery Community Organizations and other qualified interested parties. This forum will be a space where all voices are heard and valued, contributing to the development of an action plan that centralizes the employment of peer specialists. The forum's agenda may encompass the establishment of a toolkit, educational training for hiring and retaining peer specialists, advocacy, addressing barriers, and building support around the peer recovery workforce.

Arkansas is committed to fostering a working relationship with a national credentialing body for peer certification. This partnership will not only include a robust process for ethical review and testing but also the utilization of an online supervision database for peers during their certification journey. This commitment to ethical standards and professional development is a testament to our dedication to the integrity and quality of our peer recovery workforce.

Specialty court peers provide a necessary bridge for individuals with SUD and mental health challenges to access resources. They also offer the individual an introduction to their area's recovery community. These actions are uniquely provided in a peer role without judgment or stigma. Breaking down barriers to resources and advocating for the individuals they provide services to are the primary actions of a PRSS in the justice-involved setting. The empowerment of historically underrepresented groups is a significant outcome of their work. In collaboration with the Arkansas Model of Peer Recovery and an outside entity, peer specialists may advocate with the individuals they serve, and offer a voice to these groups. This outside entity will provide oversight of employment and payment of peers within the courts, in line with their purpose of responsibility for the administration of the non-judicial business of the judicial branch. PRSS working within the court setting will engage in resource brokering, community outreach, and connect the justice-involved populations to housing, employment, health resources, and transportation.

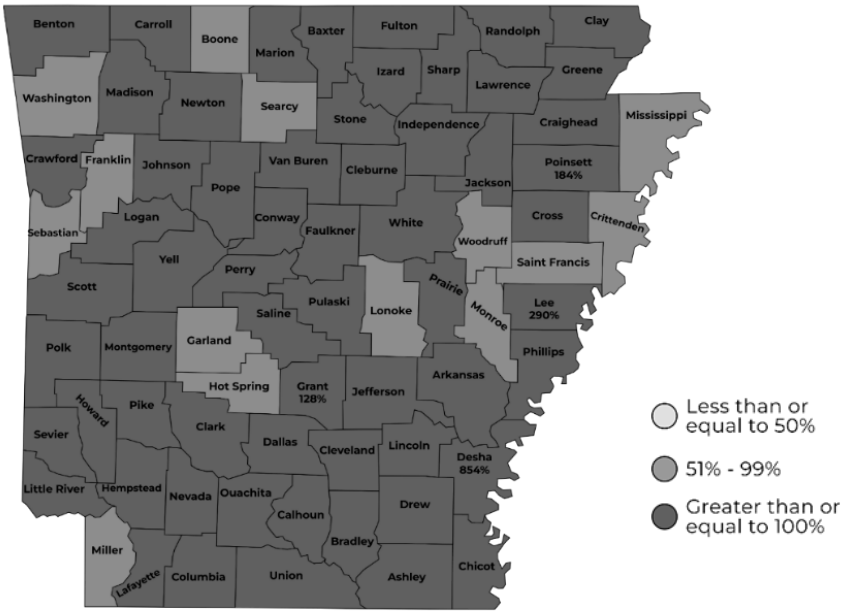
Naloxone Distribution

Arkansas’s current distribution plan utilizes a heat map to illustrate naloxone saturation by county. OSAMH will partner with an outside entity to supply, train, market, and plan distribution in collaboration with the prevention provider network. Distribution to counties that are currently

below 100% saturation will be prioritized. To ensure ongoing, comprehensive coverage and service provision across the entire state of Arkansas, the OSAMH, in coordination with a selected vendor and the state's Regional Prevention Provider system, will focus distribution of Naloxone to at least 25 counties annually while continuing to provide to other counties when in need. This strategy will ensure that all 75 counties in Arkansas receive Naloxone over a span of three years. Regional Prevention Providers will continue to implement evidence-based strategies within their regions, including education about the harms of opioid and stimulant misuse and Naloxone training. By adopting this approach, all 75 counties in Arkansas will receive prevention resources, effectively saturating the state's diverse regions and communities to decrease medical emergencies due to substance use, while decreasing opioid misuse overall.

OSAMH will partner with the Arkansas Department of Health to standardize and continually improve an official overdose recognition and reversal training, optimized for accessibility and relevancy. OSAMH's approved training will contextualize the opioid epidemic through visualizing current data trends, emphasizing the importance of reporting both fatal and non-fatal overdoses and Naloxone administrations, and incorporating interactive educational components to maximize its impact. This training will be updated annually, available both online and in-person, and translated into ethnic minority languages.

Key personnel providing essential community-based resources including regional prevention providers, peers, first responders, military, and other professionals likely to encounter an overdose will be trained as trainers. Once trained, these stakeholders will be authorized to implement this training in their local communities and professional networks, expanding the reach of bystander intervention initiatives. OSAMH will support the development of peer health educator programs in colleges and universities, and other settings wherein peer leaders may effectively promote community change.



SECTION C: Proposed Evidence Based Practices

C. 1

Medication Assisted Treatment (MAT) combines pharmacological interventions with substance abuse counseling and social support for individuals with an opioid use disorder. SAMHSA recommends MAT due to outstanding results found in individuals with an OUD. Reduces potential relapse and overdose. Ensuring that 100% of the OSAMH contracted providers has FDA approved medication available to individuals with an opioid use disorder and have a trained prescriber on staff or contracted.

Screen, Brief Intervention, Referral and Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. Increase treatment linkages for individuals with an OUD or Stimulant Use Disorder (SUD) through potential referral sources such as emergency departments, child welfare and others.

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change. MI is applied to a wide range of problem behaviors related to SUD, as well as health promotion, medical treatment adherence, and MH issues. As of 2013, MI is implemented at more than 30,000 sites in all 50 states and around the world, with an estimated 3 million clients (SAMHSA). Increase successful outcomes by increasing treatment admission and retention through positive regard and support of the MI mode.

Matrix Model (MM) provides a framework for engaging individuals with a stimulant use disorder (e.g., methamphetamine and cocaine) and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. The Matrix Model Curriculum provides for types of groups identified in SAMHSA Tip 42: Medication Assisted Treatment as being most commonly used in successful MAT programs and stimulant used disorders. Ensure all SOS contracted providers have this curriculum available to individuals served with an OUD or SUD and reduce use of opiates and/or stimulants.

Contingency Management (CM) is a voucher or prize-based incentive-based program and involves individuals potentially earning tangible rewards to reinforce positive behaviors such as abstinence. According to Nation Institute on Drug Abuse (NIDA), research has demonstrated the effectiveness of treatment approaches using CM principles Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective. Outcomes: Increased engagement and retention in treatment services.

Seeking Safety (SS) is an evidence-based model to help survivors with co-occurring trauma and SUD. It stays in the present and teaches an array of safe coping skills. SS approach has been successfully implemented with a wide range of populations including both males and females; adolescents; military and veterans; homeless people; survivors of domestic violence; criminal

justice and racially/ethnically diverse populations; individuals with substance use disorders; and clients in all levels of care. Outcome: Increase safety skills in dealing with trauma.

Cognitive Behavioral Therapy (CBT) is a widely recognized, evidence-based treatment for substance use disorders. This therapeutic approach focuses on identifying and modifying dysfunctional thinking and behavior patterns that contribute to substance abuse. By helping individuals understand the connection between their thoughts, feelings, and behaviors, CBT aims to develop healthier coping mechanisms and reduce reliance on substances.

Peer Recovery Support Services is an evidence-based practice that includes individuals with a shared history of being a person in recovery from mental illness and/or substance abuse disorder, who has been trained to work with others on an individualized road to success and recovery. Outcomes: Increases engagement and retention in recovery.

The Hub and Spoke Model is an innovative and effective approach to delivering behavioral health services designed to reach and support hard-to-reach populations. This model creates a network of care that ensures comprehensive and continuous support for individuals with complex health needs, especially in underserved or rural areas.

Centralized Hub: The hub is a central facility, often a specialized treatment center, that provides intensive and specialized services. It typically offers comprehensive assessments, initial treatment plans, and specialized care for complex cases. The hub has multidisciplinary teams, including doctors, psychiatrists, psychologists, and other healthcare professionals.

Spokes: The spokes are community-based healthcare providers such as primary care clinics, community health centers, or local behavioral health providers. These spokes deliver ongoing care, support, and monitoring to patients in their local communities. They ensure that patients have access to continuous care close to their homes.

Integrated Care Coordination: The hub and spoke model emphasizes seamless communication and coordination between the hub and the spokes. This integration ensures that patients receive consistent and well-coordinated care across different service providers, reducing gaps in treatment and improving outcomes.

Accessible and Localized Care: By leveraging local providers as spokes, the model makes it easier for hard-to-reach populations to access care without needing to travel long distances. This is particularly important for individuals in rural or underserved areas who might otherwise face significant barriers to accessing specialized care.

Comprehensive Services: The model offers a full spectrum of care, including prevention, early intervention, treatment, and recovery support. This holistic approach addresses the multifaceted needs of individuals with behavioral health issues, including those with co-occurring conditions such as substance use disorders and mental health disorders.

Focus on Continuity and Relapse Prevention: The ongoing support provided by the spokes helps in maintaining long-term recovery and preventing relapse. Continuous monitoring and regular follow-ups ensure that patients stay engaged in their treatment plans and receive timely interventions when necessary.

C. 2

To ensure the fidelity of EBPs and evidence-informed and/or promising practices, common standards or guidelines in provider training and program implementation will be identified. These standards will include program oversight, provider development and evaluation, and outcome evaluations. During the evaluation process, the process and outcome data will be collected regularly to monitor the quality of provider training and program implementation and effects. Information gathered from these data will support continuous quality improvement efforts by identifying any necessary changes to program implementation strategies.

SECTION D: Staff and Organizational Experience

D. 1

The Arkansas Department of Human Services (DHS) is Arkansas's largest state agency, with approximately 6,600 employees working in nine divisions headquartered in Little Rock and 80 county offices. The DHS OSAMH is the State Opioid Treatment Authority and serves as the Single State Agency to distribute grant funds and oversee community treatment centers. The previous SOR/STR was managed by DHS. OSAMH has experience with coordinating with subgrantees on previous grant programs and ensuring service delivery to the populations of focus. OSAMH staff are familiar with the Arkansas cultures and customs of the underserved population of focus and have experience working with communities at the grassroots level. Several staff members of OSAMH also have lived experience in recovery from substance misuse and/or mental health challenges.

D. 2

Partnering organizations (to be finalized upon award) include:

- Arkansas Department of Health (ADH) is a government entity for public health to protect and improve the health and well-being of all Arkansans with more than 100 services provided statewide by public health professionals. ADH has vast experience in providing more than 100 services statewide by public health professionals. Currently, they are the CDC grant recipients of the Arkansas Overdose Data to Action in States grant – working with similar goals to address the opioid crisis through a public health lens.
- The University of Arkansas Medical Services Center for Addiction Services and Treatment (UAMS) provides medication-assisted treatment to treat OUD which. combines the use of medications (e.g., Suboxone, buprenorphine, Vivitrol, methadone) and individual and group therapy to treat opioid detoxification, withdrawal, and cravings.

This program is experienced in working with underserved populations and OUD treatment.

- Medication Assisted Treatment Recovery Initiative for Arkansas (MATRIARC) is a partnership with the UAMS Psychiatric Research Institute and the DHS designed to expand evidence-based treatment for opioid use disorders by making free-of-charge consultations available to medical professionals providing medication-assisted treatment. This group is experienced in utilizing telehealth and other avenues to reach rural areas for treatment.
- Arkansas Community Corrections (ACC) is a division of the Arkansas Department of Corrections, is the state agency that implements probation, parole, and re-entry programs, and supervises specialty drug and mental health courts. For this project, they administer FDA approved medication for MAT/MOUD to the justice involved population. Previously, they have only offered injectable naltrexone, but recent strides have been made to offer other medications as well in the future after contract alignment with the medical contractor, WellPath. Arkansas Medicaid covers all MOUD/MAUD medications. This program has experience in working with justice-involved populations.
- Arkansas Administrative Office of the Courts (AOC) oversees and manages specialty courts and implement best practices strategies to assist families and people affiliated with their county courts in conjunction with ACC. AOC works in collaboration with OSAMH to develop a model to supervise and support peer recovery specialists walking alongside people enrolled in specialty courts, and act as navigators through the services available. This program has experience in working with justice-involved populations.
- Arkansas Collegiate Network (ACN), a coalition of students, faculty, and institution staff leaders networking and communicating with a shared goal of addressing substance misuse. This group is experienced in working with college students.
- Arkansas Foundation for Medical Care (AFMC) is a nonprofit organization with a mission to promote excellence in health and health care through education and evaluation. Through a highly trained staff, AFMC has nearly five decades of health care experience working with the state Medicaid programs, the Centers for Medicare & Medicaid Services, health departments, hospitals, clinicians, long-term care facilities and private insurers. AFMC has experience in helping educate providers and individuals about Medicaid.
- The UALR MidSOUTH Center for Prevention and Training, which has 47 years of experience training addiction professionals and paraprofessionals on evidence-based practices related to substance misuse and mental health challenges. This program has experience in disseminating information.
- CHESS Health is a mobile solution via smart phone to amplify impact to those in need, along with reaching and engaging those who use drugs and need support outside of traditional treatment modalities. These resources are available 24/7/365, and peer support specialists offer services within their scope through CHESS. This technological program has experience in accessing individuals to encourage their compliance with treatment.

- The Opioid Response Network (ORN) is a free technical assistance network that specializes in assisting states, groups, agencies, and other stakeholders in developing evidence-based plans for prevention, treatment and recovery. The ORN has thousands of subject matter experts and disseminates information through technology transfer centers. This group has vast experience in providing education in many topics related to OUD and SUD.
- The End Overdose program's vision encompasses a society that prioritizes health, compassion, and evidence-based solutions to address the drug overdose epidemic. End Overdose is a 501(c)3 non-profit organization based in California with a national reach working to end drug-related overdose deaths through education, medical intervention, and public awareness. Besides having experience in disseminating information, this program is well-versed in the provision of naloxone distributions and health protective measures.
- Arkansas AWARE is a project funded through the Substance Abuse and Mental Health Services Administration RFA-SM-22-001 AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grant to support districts in efforts to provide mental health awareness and trauma informed practices. This program has experience in working with youth which is a population of focus.
- River Valley Medical Wellness is an independently owned practice that encompasses a wide range of services aimed at treating substance use issues. With the addition of two mobile units, this program has experience treating rural populations.
- Upon award, OSAMH will contract with a Data Evaluator, the Wyoming Survey & Analysis Center (WYSAC) of the University of Wyoming (UW), which has the latest statistical analysis software tools for managing and analyzing data, as well as access to the UW facilities and research library. Its staff hold advanced degrees in statistics, economics, political science, psychology, sociology, and computer science. The WYSAC team is led by Senior Research Scientist, Rodney Wambeam, PhD. who has served as lead evaluator on numerous SAMHSA-funded projects including Arkansas's Federal Prevention Block, Strategic Prevention Framework-Partnership for Success, and Emergency COVID-19 grants.

D. 3

All personnel for the positions below will be required to have a minimum one year of experience with the OUD and SUD populations and working with the underserved populations in Arkansas including mothers and pregnant women, rural populations, justice-involved populations, and other minority populations. All personnel will understand the National Culturally and Linguistically Appropriate Services (CLAS) standards as prescribed in the SAMSHA – HRSA Center for Integrated Solutions.

State Staff	Role	Qualifications	FTE
Program Director (Key Personnel)	Coordinates and collaborates with other state-level opioid initiatives attempting to align initiatives; represents the state at national meetings as required; maintains primary oversight on all aspects related to the SOR-IV grant including funding allocation, contracts and implementation of program goals and objectives.	Masters in a behavioral health field with emphasis on substance use; managerial experience; administrative grant-related experience; five-year related experience.	1.0
Program Coordinator (Key Personnel)	Works under the direction of the project director; Monitors performance and progress of all SOR-IV grant goals and objectives; ensures all day-to-day grant required activities are completed and serves as primary contact for treatment providers and collaborating agencies.	Masters in a behavioral health field with emphasis on substance use; managerial experience; administrative grant-related experience; five-year related experience.	1.0
2- Data Coordinators (Key Personnel)	Works under the direction of the project director; Collects and evaluates data to update the OSAMH and treatment agencies on outcome adherence; Monitors data collection for the GPRA and other required data requests for SAMHSA.	Bachelor's degree or equivalent experience One year of experience in data collection and analysis.	1.0
Point of Contact for Financial Matters (Key Personnel)	Works under the direction of the project director; Performs as primary contact for all financial communications involving the SOR-IV grant and invoicing by contractors	One-year experience in grant budgeting, invoicing, and managing financial issues; One year of experience in administrative duties.	1.0
Women's Services and Youth Services Coordinator	Works under the direction of the project coordinator; Provides training and technical assistance to treatment providers involved in SWS services; and monitors contract compliance, outcomes, progress toward goals.	Bachelor's degree or equivalent experience; One year of experience working with women in SUD programs.	0.5

Peer Recovery Director	Works under the direction of the project director; Coordinates and collaborates with other entities that employ peer recovery support specialists; Monitors performance and progress of SOR-IV grant goals and objectives related to recovery.	Bachelor's degree or equivalent experience; Certified Peer Recovery Support Specialist; One year of managerial experience; Five-year related experience with SUD population.	0.75
Peer Role Developer	Works under the direction of the peer recovery director; Collaborates with other entities to coordinate on-going sustainability for the advancement of peer recovery support specialists in all phases of the SUD continuum of care.	Certified Peer Recovery Support Specialist; One year of related experience with SUD population; One year of administrative experience.	0.5
Peer and Peer Youth Training Coordinator	Works under the direction of the peer recovery director; Provides training and technical assistance to peer recovery support specialists and coordinate training opportunities for youth peer recovery support specialists.	Certified Peer Recovery Support Specialist; One-year related experience with SUD population; One year of administrative experience.	0.5
Recovery Community Organizations and Residences Coordinator	Works under the direction of the peer recovery director; Monitors performance and progress of SOR-IV grant goals and objectives related to recovery community organizations and recovery residences.	Certified Peer Recovery Support Specialist; One year of related experience with SUD population; One year of administrative experience.	0.5
Prevention Collegiate Coordinator	Works under the direction of the project director; Provides training and technical assistance to collaborating agencies related to collegiate populations; Monitors contract compliance, ensure prevention and promotion progress toward goals related to prevention.	Bachelor's degree or equivalent experience; One year of related experience working in prevention programs.	1.0
Prevention Opioid Reversal	Works under the direction of the project director; Provides training and technical assistance to collaborating agencies for	Bachelor's degree or equivalent experience; One year of related	1.0

Agent Coordinator	the distribution and saturation of opioid reversal agents; Monitors contract compliance, ensure prevention and promotion progress toward goals related to prevention.	experience working in prevention programs.	
Prevention Support Coordinator	Work under the direction of the project director; Provide support to prevention team in monitoring contract compliance, ensure prevention and promotion progress toward goals.	Bachelor's degree or equivalent experience; One year of related experience working in prevention programs.	0.5

D. 4

Tauria Lewis will be the Point of Contact for financial management. Jennifer Shuler will be the Point of Contact for oversight of the award.

SECTION E: Data Collection and Performance Measurement

E. 1

The Wyoming Survey & Analysis Center (WYSAC), the Evaluator/Data Contractor in collaboration with OSAMH will collect and analyze data relevant to overall program evaluation as necessary from agencies and entities that receive current SOR funding. This data will be used to assess outcomes for required evaluation measures. WYSAC will conduct evaluation processes and provide reports that include information requested by SAMHSA and/or OSAMH, as well as indicators related to a) utilization of FDA-approved medications by providers for treatment of OUD; b) utilization of evidence-based treatments, practices, and interventions appropriate to the treatment of OUD and stimulant use disorders; c) process and primary outcomes for subgrantees who receive non-treatment SOR funds; and d) summary of processes and outcomes for other prevention, harm reduction, treatment, and recovery support projects that address the opioid epidemic in the state of Arkansas, as available and appropriate. WYSAC will design an evaluation plan that includes developing and identifying performance measures for evaluating program success in implementing SAMHSA's required activities for the current SOR goals listed. This evaluation plan will assess outcomes for required performance measures using the CSAT-GPRA treatment data collection tool at intake, six months post intake, and discharge, as well as for individual projects or programs. For example, SOR prevention funding will continue to be used to focus on opioid-related prevention in high-needs communities such as rural areas and minority populations of African Americans, Hispanics, and Marshallese. Periodic data-driven selection/adjustment of target areas will be made based on factors such as the size of additional communities, area demographics, opioid prescribing rate, opioid-involved medical episodes, OUD treatment accessibility/treatment admission volume, and health literacy distribution capacities.

Data on naloxone training, distribution, and administration within targeted communities will continue to be compiled by community service and evaluation contractors. Additionally,

WYSAC will identify data sources, including national, state, and individual program administrative data, for the evaluation and draft and prioritize key evaluation questions for each program based on objectives. As part of data collection and performance measurement procedures, WYSAC's IT Specialists will collaborate with OSAMH and sub-grantees to modify, enhance, and/or expand online reporting tools developed for the SOR grant and used throughout the state-supported Peer Recovery Support network. These tools allow individuals receiving PRS services to be entered into a centralized database on WYSAC's secure server system. Data include demographics, various assessment tools, and documentation of service provision events (i.e., "sessions" or discrete encounters/contacts in which PRS services are provided). WYSAC will work with data source entities to ensure the timeliness of available data and overcome any barriers to data sharing.

WYSAC will collaborate with OSAMH to create appropriate data collection procedures. A secure data exchange protocol will be established between each SOR-funded program and WYSAC as needed, using data transfer methods such as email encryption or File Transfer Protocol (FTP). Data will be stored on a secure server, and paper documents will be stored in locked filing cabinets separate from any other collected data and/or documentation to protect confidentiality. Access to project data will be restricted to evaluation team members by username and password. Data analysis and visualization of program data will include using SPSS, R, Stata, Excel, Tableau, NVivo, and other appropriate software. Finally, as a department of the University of Wyoming, WYSAC will comply with all Institutional Review Board (IRB) procedures and receive IRB approval from the University before any data collection. In-person or virtual site visits will be conducted with subgrantees to gather progress information for inclusion in evaluation reports as appropriate.