# Rural Faith Leaders Workshop: Empowering Faith Leaders to Help Persons with Substance Use Disorder – 12/8/2020

**Betty-Ann Bryce:** Good afternoon everyone. Thank you for joining the ONDCP's first Rural Faith Leaders' Workshop. We have a really full agenda today and I really want to make sure that all our speakers have an opportunity to present their great work to you. We have a PowerPoint presentation. One of your questions will be will it be available to you. Yes, it will be. At the end of the session, the PowerPoints will be fully loaded and you can refer to them. So with that, I wanted to say welcome, hello, good morning, good afternoon. My name is Betty-Ann Bryce.

At some point, many of you may have received an email from me. I really welcome you to this event today. We're really excited to bring it to you. I am Special Advisor for Rural Affairs within the office, the White House Office of National Drug Control Policy. The purpose behind this faith-based series is to really think about the community of folks who work in the faith community, both the pastors, the leaders, as well as the folks who are working within this community to help people.

The idea behind this workshop is this first workshop is an introduction. It's a building block. There are some issues that we should have in our back pocket as we move forward. One of those issues is what's going on in your community. How is the pandemic affecting your community and the ability to deliver services? What should you be taking away? What should you be keeping? So this workshop is organized today to give you the introduction, and we have some really amazing speakers here who are going to share with you. One of those first ones...

I'm really, really privileged to welcome Dr. Winstanley, who is joining us today, because I've asked her to do a really important task for you. I've asked her to set the framework of the pandemics, both the COVID pandemic, as well as the opioid and substance use issue in context. What is happening in rural America? What should you be thinking about? How are these pandemics... how do they overlap, and what should you take from them?

I am not going to read every aspect of her background. It's very, very distinguished. What I will say is she is the Vice Chair of Research and an Associate Professor at West Virginia University, and Dr. Winstanley, I will turn it over to you. Thank you for joining us today.

**Erin Winstanley:** Thank you so much. I really want to thank Director Carroll and Ms. Bryce, ONDCP, and everyone behind the scenes that has made this webinar possible today. I'm really thrilled to see that we have over 340 participants or attendees today. I can tell you having been conducting research on substance use disorders the past 20 years. We need your help right now, and we need all hands on deck to address this intersection of the overdose epidemic and COVID-19 in rural America.

So, just to start you off, overdose deaths are disproportionately high in rural areas. We've known this for the past several years. Of course, you may be aware of the high rate of overdose deaths in West Virginia. Preliminary data that we have, there's always a lag in epidemiological data, so based on what preliminary data we have, we do think that drug use has increased since the COVID-19 pandemic began in February 2020. We are seeing increase in the amounts of data that suggests that overdose deaths, and actually not-fatal overdoses, are increasing across the United States.

Data from early on in the pandemic, though, has suggested that COVID-19-related deaths were lower in rural areas. This, of course, might be due to geographic isolation, so there's less

probabilities of risk exposure because of the lower population density. Living in Appalachian, West Virginia, I actually can say that I am thankful for the protection that we have right in this lower density population that I live in, but we are beginning to see research that suggests that COVID-19 testing in rural areas, and obviously again, there's a lag in the data, may have been a little slower to uptake in these rural areas, so we're not sure how accurate this data is.

But I think we can all agree, though, that rural areas are incredibly vulnerable right now to the COVID-19 pandemic. And that's because in many of our states, like West Virginia, we have older populations, we have residents that have a high prevalence of chronic health conditions that make them more vulnerable to COVID-19, and we have decreased access to healthcare. I can tell you that in West Virginia, our state, our governor, and our leaders have been extremely concerned about really trying to mitigate the risk of COVID-19.

So this is a map of the United States that indicates the overdose death rates. The darker shades of red represent states with higher overdose death rates. So you can see that in 2018, across the United States we had about 20 overdose deaths per 100,000. West Virginia, for the past 20 years, has had the highest overdose death rate in the entire country.

This is just showing you circling where we are in West Virginia, and just to give you an idea of how many deaths there are, there's 51 per 100,000 in West Virginia. Approximately every single day, there are 184 deaths due to overdose, and that's really a startling number. So this is a really critical intersection of two deadly epidemics.

So there is some really important overlapping mechanisms between COVID-19 and drug use that are alarming. So, first off, COVID-19 as many of you are already probably aware is a severe acute respiratory syndrome. Also, commonly drug use is known to compromise lung function, so that might be in terms of tobacco use, vaping, vaping other drugs as a mechanism of delivery. We know that many of the patients with substance use disorders have chronic obstructed pulmonary disease, COPD. Chronic lung disease is associated with an increased risk of overdose-related deaths. Also, this is going to complicate things on a long-term management of COVID-19 is that drug use can impair the immune system and/or it causes some neural inflammation, which could decrease the advocacy of COVID-19 vaccines. We don't have that data yet, but again, making patients or people who use or people in our community who are using drugs, or even in recovery from drugs might have compromised immune systems.

The hallmark symptom of an opioid-related overdose is decreased respiration. Interestingly, if you overdose on other drugs, it infrequently causes this decrease in respiration, so it really is the hallmark syndrome of a opioid-related overdose. So, just as I showed you the concentration in the country of overdose deaths by state, I just wanted to show you the latest data from the New York Times about where COVID-19 hotspots are. I captured this map just a few days ago. It doesn't quite overlap with the overdose epidemic, but you can see there are many states that have a high density or predominantly rural... North Dakota, South Dakota. Luckily they don't have the highest overdose death rates in the country, but they are seeing incredibly high rates of COVID-19 right now, and we're beginning to see this intersection increasing. I'm not sure about your rural areas, but we are really concerned here in West Virginia. We are seeing the highest rates of hospitalization, ICU, and increasing overwhelming of our hospitals as I speak to you right now.

So in terms of substance use disorders and where the actual intersection is for COVID-19, we see that patients with substance use disorders are almost nine times as likely to be infected with COVID-19, and that may have to do with many of the factors that I previously mentioned. But

this is even higher for our patients that have an opiate use disorder, so they're about 10 times of risk at having this. Most alarmingly, patients that have African American with substance use disorders have a phenomenally high risk. So the latest data that's released that was co-authored by the Director of the National Institute on Drug Abuse, Dr. Volkow, you can see in this slide that the increased risk for Caucasians with substance use disorders, death and hospitalizations related to COVID-19 were really at significantly increased risk for African Americans with substance use disorders. This really brings attention to who the highest need is for this intersection and how we need to focus some of our efforts and do forward.

So there are overlapping mortality risk factors between our patients with substance use disorders and COVID-19. We can see that male sex is more likely to experience an overdose death and COVID-19, that there is for substance use disorders. So you think about a vulnerability, not just being people that are actively using substances, but particularly for opiate use disorders if they relapse after a period of abstinence, they can be in extremely high risk of overdose because they've lost their tolerance to those drugs. It's easy to understand that during these times, this prolonged period of social isolation, and decreased economic opportunities, and other aspects of the pandemic that could really be triggers for people to potentially relapse.

We know that people who are using alone are less likely to have someone who's available to administer naloxone, save their life, and/or bring them to the hospital so that that can be reversed. Patients that aren't using medications for opiate use disorder, these medications that are approved by the FDA include methadone and buprenorphine have been demonstrated to prevent overdose deaths. So it's really critical to ensure and help engage patients in treatment using medications that are approved. For COVID-19, we know that tobacco use, obesity, older age, and chronic health conditions make patients more vulnerable to experiencing a COVID-19-related death.

So, you can really see, though, that many of these underlying risk factors overlap in terms of race and the socioeconomic disparities that are underlying some of the deaths and keeping that in mind throughout. So healthcare in rural areas, and this really in what way are we able to respond to these intersecting pandemic of COVID-19 and epidemic of overdose deaths in the United States. So in rural areas we have fewer hospital beds, in particular ICU beds. We have fewer addiction treatment programs and syringe exchange programs.

Syringe exchange programs provide outreach to patients that are not actively engaged in treatment and can really be critical in helping to prevent hepatitis C, HIV, and overdose deaths until people are ready to get into addiction treatment programs, or able to get into addiction treatment programs. Research that we have shows that fewer than 40% of our rural areas have access to physicians that are able to prescribe people morphine, while residents may be less likely to use preventative services, and I'm not sure about your rural areas, but we definitely in West Virginia have less access to broadband, which really limits our ability to use telehealth.

As a personal anecdote, I was really shocked when I drove down to Snowshoe, our ski resort here. I couldn't believe that you could travel anywhere in the United States and not have internet access, cell phone access for three consecutive hours. It was really enlightening for me to be on the back country roads of West Virginia and see what that was like. I was just glad that we didn't run out of gas or have any needs that would require being rescued using the phone.

Due to stigma, individuals with substance use disorders might be reluctant to see healthcare and we know that's a particular challenge right now that will confound this issue. And COVID-19 has caused reductions in substance use prevention and treatment services in rural areas. Some programs were not able to transition treatment from in-person to telehealth. We do know that

the regulations, that federal regulations and local regulations, that dictate how methadone in substance abuse treatment is delivered requires some in-person visits.

We have vulnerable populations that we need to keep in mind during this time period, and those are incarcerated individuals, are individuals that are homeless and/or have unstable housing, and obviously people that are alone during this time period. They're very vulnerable. They present significant challenges to helping people, and also the challenges of preventing COVID-19 transmission in congregate living situations. We definitely have a crisis here in West Virginia, in Morgantown, the intersection of homelessness and COVID-19 overdose deaths, and it's really perplexing our local political leaders.

I think, we talk about... I've been doing this for years, the number of deaths associated with overdose, but it's really hard to actually describe the human suffering that's due to the overdose epidemic, because at the end of the day these are numbers, these are people's fathers, parents, sisters, brothers, cousins, friends, our coworkers, and our colleagues.

So, it's important to think about compassion fatigue. Our frontline healthcare workers are experiencing compassion fatigue right now that are working on the front lines in the emergency departments and hospitals right now in response to COVID-19, but our frontline healthcare workers, social service workers that have been on the front lines of the opioid epidemic in all of our rural areas are also exhausted. They know so many of these people who've died of overdose deaths and really being exposed to overdose deaths is a traumatic event. These traumatic events, where they're directly witness or not, however we come to know about them, are traumatic and they do affect us. We see that in these rural areas we have high rates of overdose and low access to addiction treatment, which really makes it difficult to understand this. And COVID-19 really might exacerbate compassion fatigue in our rural areas, in particular for our behavioral healthcare providers.

I think these are some of the challenges. It's important to think about how we can help make our communities more resilient, and I really love this. Claudia La Bianca is an artist, and a street artist in Miami, and she did this mural on Jacksonville Memorial Hospital. If you can see there on the picture, she made a real tribute to our heroes on the front lines right now, and this is a social worker. So really think about how we can really support everyone who's working at this intersection of substance use disorders and the COVID-19 pandemic, and help support them as they help provide critically needed services to this population.

And we want to build community resilience. So, future considerations, as I wrap this up, is that I think that the long-term economic consequences of COVID-19 are undoubtedly going to have a disproportionate impact in our rural communities. We're already struggling with higher unemployment, fewer social services, and certainly these create an environment that might exacerbate the risk of poor mental health and drug use in our communities. The need to expand emergency regulations regarding telehealth, as I mentioned, in our areas that don't have access to broadband, we need to be able to connect with people with the resources that they have, which often is a telephone in their own home.

We need to consider low threshold models to deliver care in rural areas. It's very difficult to open new programs, especially during a pandemic. We need to integrate how can we think about delivery of harm reduction and also preventing the transmission of COVID-19, and I can really see how community resilience is going to be critical to helping our rural areas survive these intersecting epidemics. In part, we can know that religious organizations can provide a critical link in building community resilience. So again, I thank you for your interest in this topic

and your willingness to participate today, and it underscores the importance of ONDC facilitating this event.

So what can you do in your community? You can recognize the vulnerable individuals. There are individuals that are currently struggling with substance use disorders, they might be actively using drugs, but they also might be working hard to maintain their long-term recovery during these unbelievably challenging times. We want to support their friends and family members because of the stigma and the emotional burden associated with this, and also our clinicians and other service providers. I can tell you that our clinicians and our behavioral health clinicians are not okay. I'm working actively with my colleagues and trying to do some wellness activities and supports to really help them during this time. We want to provide non-judgmental support and work to reduce stigma, and consider integrating outreach services during these extraordinary times, and whatever we can do to actually facilitate coordination of services.

And so when I talk about overdose and these challenging things in rural areas, and many of you probably already know this, I'd really like to share a few pictures of just how beautiful our rural areas are, and how much we can enjoy them even during these challenging times where we can get outside and safely enjoy our communities. Again, I really thank you for your interest in this topic, the work that you'll be doing. I am available to help support you, and contact information is here for all the wonderful work I know that you're going to be doing in your communities. And again, thank you.

**Betty-Ann Bryce:** Thank you so much, Dr. Winstanley, for your presentation. I really, really appreciate the emphasis on compassion fatigue, because I think that is a really, really... it's an issue everywhere. Our next presenter will be looking at the economic impacts. What I wanted the participants to really take away from the first two presenters is both the competing pandemics that you are dealing with on the front lines in your smaller communities, but also the economic impact of that.

For the economic impact, I've invited Vanessa Lominac Haste to join us today. She is from Fahe, which is a community bank. Why I've asked her to come and talk about this issue is a community bank is your partner. A community bank can do things that the federal government cannot do when you think about capital-intensive projects like housing, recovery supports, and things of that nature. So I want you as you listen to her, not just to listen... if you're wondering why... Vanessa will share what they're doing in their community, but more importantly, she'll share what she has seen, what her bank has seen, and how they're responding. I think that's an important context for this because that economic impact really, really is linked to recovery, and to everything that you can do with respect to recovery, especially finding jobs. So with that, Vanessa, I turn it over to you.

**Vanessa Lominac**: Thank you so much. I appreciate the invitation. My name is Vanessa Haste and I am from Fahe. I appreciate having the opportunity to speak with you today. I will discuss Fahe's role in supporting rural communities including projects and programs related to substance use treatment and recovery. I will also discuss challenges the pandemic brought to smaller communities, and in turn, the way the pandemic affected treatment and recovery efforts for those involved in the work of substance use disorder programs.

Fahe is a backbone organization, financial intermediary, and CDFI membership organization that assists individuals and communities throughout Appalachia. Fahe works with the members, local leaders and partners on community development projects and strategic planning. Whatever the community challenge may be, whether it is recovery housing, the need for recovery and treatment centers, homelessness solutions, food insecurity, veterans' programs, or other needs,

Fahe will leverage our capital and partnerships and use our knowledge of funding to change lives through community development and investments.

Fahe is a membership organization. Our members, as you can see represented by the map, allow us to cover a large footprint and achieve impact through strength in numbers. Challenges have arisen in rural communities due to C-19, affecting SUD treatment and programs as well as the local economy. The COVID-19 pandemic caused extremely serious health and economic impacts across the country. In communities across Appalachia, where the disparities existed prior to the pandemic, we see the potential for even worse outcomes than our neighbors will see in more affluent regions.

Our communities experience steeper recessions and slower recoveries than America does as a whole. Jobs proving prone to large scale layoffs, like the food and service industry, tourism, and manufacturing are found at a higher rate in Appalachia. We have seen hospitals, critical as ever during the pandemic, conduct layoffs. These jobs are the economic lifeblood of our communities in the most endangered enterprises in America. In rural communities, there is not only limited access to broadband, but also limited access to needed equipment, such as a smart phone, laptop, or tablet. This technology is vital for individuals to stay connected in a virtual world.

Fahe had to find creative solutions for clients and treatment providers who did not have access to internet or needed equipment in order to ensure clients continued to receive recovery supports. Economic downturn due to the pandemic has hit, and will continue to hit, rural areas hard. We have seen a spike in overdose follow. When you do not have treatment options in place, or post-treatment supports in place to help individuals stay in recovery from SUD, everyone in the community loses. Fahe recommends the expansion of programs that focus on increasing success of people in treatment and recovery, as well as the transition to mainstream life. Funds that support frontline organizations, delivering treatment and post-treatment transition, will ensure the necessary capacity to deliver these services.

The addiction crisis has devastated Appalachia. Fahe observed and experienced the magnitude of the impact in rural communities through our members and personal connections. Everyone in one way or another has a personal connection that has seen the impact of the SUD epidemic. It is not just one line of business or one demographic. It affects the community as a whole. We see this impact through education, healthcare, and the workforce. This in turn hinders evolution and growth in the rural community.

Fahe saw a need for treatment options and post-treatment support for individuals in rural communities. We decided to use our expertise and knowledge to attempt to be one piece of the solution. This health crisis needs to be addressed for multiple sides and angles. Fahe wants to be useful in this space and do our part to help work towards solutions.

Fahe works with partners and members to develop recovery housing. Recovery housing projects generally require multiple levels of funding. Through strategic planning and project planning, Fahe works to evaluate not only construction funding, but also operational funding for recovery centers. Hickory Hill is located in Knott County, Kentucky. That location has 68 efficiency units in two-dorm rooms for a total of 100 beds.

Sky Hope is located in Somerset, Kentucky. In a similar set up to Hickory Hill, it has 68 efficiency units in two-dorm rooms for a total of 100 beds. Odyssey House in Neon, Kentucky can house 16 men in a transitional setting. This Fahe member homes and Fahe partner addiction recovery care project was initiated through a core recovery housing grant.

Now I would like to look at some of Fahe recovery project initiatives. In 2018, through a POWER Grant, Fahe formed a recovery task force focused on rural Eastern Kentucky counties. Once that funding expired, Fahe developed a member working group, not only to continue discussion of recovery solutions, but to connect members in other states.

Kentucky Access to Recovery is a core-funded pilot program that was developed and is administered by Fahe. It is focused on providing individuals in recovery from opioid addiction recovery supports, such as housing, transportation, and child care. KATR served 1,253 clients in its first year. KATR serves 15 Kentucky counties. Fahe also has a transformational employment program. This program connects recovering individuals with meaningful employment opportunities in 12 Kentucky counties. This grant-funded program provides employer incentives to hire, employer supports through mentoring, through Rob Perez of DV8 Kitchen, and intern support through addiction recovery care.

How can you help? This, I think, the biggest question the individuals find when they are looking at these needs in their communities. There is always, always, always room to help, whether that’s through food banks, clothing banks, offering transportation to individuals to get to their meetings or recovery groups or treatment appointments. It may be connecting with your local support groups and joining a virtual meeting or making a phone call to reach out. What you see as a very small act may be just the encouragement that that individual needs to stay on that path of recovery. Thank you so much. If you have any questions, please reach out to me at any time.

**Betty-Ann Bryce:** Thank you so much, Vanessa. What I want you to take away from Vanessa's presentation, obviously is the extraordinary work that Fahe is doing in the communities and counties that they serve, but there is probably a Fahe in your backyard. The idea of looking at your locals banks as another avenue for that critical funding for, again, those capital-intensive outlays such as housing, recovery housing, and bigger pieces, is so important to the work that you are doing.

As we are going through and thinking about this work, looking at the pandemic and what's happening, you know you're going to need more strategic partners, and so thank you so much for that, Vanessa. And also, Vanessa is a great lead into the... to the next speaker who is Heidi Christensen, who is just an amazing person and a force of nature in the faith-based community. Heidi oversees many projects and you will get these slides, and you can read ad nauseam about all the work that we're all doing, but she really developed an opioid crisis toolkit that I've asked her to come and talk to you about today because it's so relevant to the faith community, and it picks up on Vanessa's point about what you can do. So with that, I'll turn this over to Heidi. Thank you again for joining us today.

**Heidi Christensen:** Thank you, Betty-Ann, and please thank Director Carroll for this invitation today, and most especially, thank all of you for being with us today. We really appreciate our rural faith leaders and your partners around the country joining this conversation. Friends, we know you are witnessing first-hand the hardship that addiction exacerbated by this pandemic, which we heard so profoundly just a moment ago. It's just this wrought on your community. We're hopeful that we'll be able to support your efforts to get folks connected to the treatment and to the ongoing care that they may need.

It may just seem overwhelming, but your community can make a difference. My role today is to talk to you about federal resources that will support those efforts, and then you'll have an opportunity to hear an exchange between Dr. Burks and Pastor Delaney on how the state of Tennessee is encouraging equipping certified recovery congregations and how our local faith leader who's gone quite national is working with communities in actionable steps towards

congregational readiness so that faith communities can better support folks in crisis in long-term recovery.

So, I'll tell you a little bit about our office. The Center for Faith and Opportunity Initiatives or the partnership center is a federal office, and we're located in the Office of the Secretary at the US Department of Health and Human Services. It was established in 2001 during the Bush Administration. While it's had many different names and leadership over the many years, it still really has the same mission, and that is to be a resource to you. The Center's primary goal is to strengthen the efforts of faith and community leaders in response to public health issues and public health crises, such as preventing the spread of COVID-19, and educating the public on this anticipated vaccine program.

We've done a lot of work in meeting the needs in those experiencing mental health challenges, and with particular focus today, supporting those with substance use disorders, especially those making the journey of recovery. We do this in a couple of ways. On a weekly and monthly basis, our team gathers up all the information and resources that HHS and her sister agencies may bring to bear that will be helpful to you and others working on the front line in communities and congregations, including those that are seen here on the screen, from NIH, NIDA, to Substance Abuse and Mental Health Administration, the Centers for Disease Control and Prevention, FDA, CMS, you name it, there's a lot of agencies, and there's a list of them at the bottom.

Through these e-newsletters, you will see the most up-to-date news, reports, e-learning opportunities, funding notices, and more, not only from these HHS entities, but also from other federal agencies that are creating tools and resources that will benefit the health and wellbeing of local communities. That will include, of course, our host OMDCP or Department of Education, Homeland Security, USDA, which I'm sure many of you know and are very familiar with. So, I invite you to sign up for this ongoing supply of information and resources at partnerships@hhs.gov, and we'll send that out.

On the next slide, our examples of the toolkits, guides, one-pagers, two-page briefs, the Center develops to equip local leaders. I'll focus on the one Betty-Ann mentioned first. It's called The Opioid Crisis Practical Toolkit for Faith... oh, no, no, go back, go back. Well, you can stay there, that's okay. The first edition was created back in 2017 and with input from our faith leaders across the country, including Dr. Burks, and of course Pastor Delaney, who helped us to understand what folks were struggling with on the ground, what was working, and what they would find helpful.

So, now in its fourth edition, the toolkit response to the question, "What do I do in the midst of this crisis?" It offers a framework for practical action depending on where the congregation is, and their readiness to step into this work. As you know, communities are in very different places. Some need to simply start by including those suffering with addiction in their congregational prayers for healing, as they would any other medical condition. And other communities are ready to jump into emergency responses and be trained on administering naloxone, the opioid reversal drug, or navigating members in the community to treat.

The toolkit is intended as a discernment tool to give local leaders a place to begin with practical suggestions and ideas fleshed out in the next presentation. Like all our publications, the toolkit is available on our website, so stay with us live if you would. You'll see these seven buckets for potential activity describing the toolkit, and you can't help but notice that it was written pre-COVID. All of the ideas for sharing space and time and opening doors to recovery support really close up and personal. That said, the basic concepts are still relevant and timely.

For instance, one of the buckets you'll see there is open your doors. It's a call to increase the number of lifelines in your community by hosting recovery support groups or connecting people to a community-based recovery support programs, right? AA, NA, Celebrate Recovery. That's still possible. Many of these recovery groups have gone virtual, and there are links to mutual support meetings and 24/7 mobile app recovery communities, as well as peer support. The ones I've mentioned, and so many more, 12stepme.org, In The Rooms, Sober Grid, R/Tribe, ReConnect, there's so many more. For rural communities, this explosion in virtual support options is sort of a bit of a silver lining in the pandemic, because no matter where you are, recovery support is available 24/7.

With it... I have a copy of it right here, Betty-Ann and her team have it, is the Partnership Center created a two-pager so that it lists just what we know of the virtual groups that are out there. This is a way you can use this tool to connect... we'll share it with you, and you'll share it with your community, connect individuals to support in this critical time.

So on the next slide, I wanted to return to this slide to say the second one in the middle, this other resource I want to bring to your attention is one that recognizes that addiction, as we've recognized throughout the presentations from my co-speakers today, disrupts lives and livelihoods. The road back to work and school can be rocky and challenging for those reentering communities from treatment programs. There may be gaps in their education, in employment histories. They could have criminal records, financial and legal complications, technological literacy and other just basic job readiness skills. The Center's Faith & Community Roadmap to Recovery Support, getting back to work speaks to the many opportunities with cases studies across the country for communities of faith to walk with people in recovery and meet some of these basic needs, and provide the kinds of valuable social supports services that can rebuild lives and their livelihoods.

And as folks in recovery will share, it's when the crisis ends that the real work of healing and restoration begins. This can be the sweet spot for communities of faith who have the people, networks, the skills and talents to be an integral part of the recovery journey. On the next slide, I want to share with you just a picture of the Center's YouTube page. All of our toolkits and resources are brought to life with webinars that illustrate the content and then feature federal subject matter experts, and also, really more importantly, our community partners who share their promising practice and models that are working in real time.

As an example, when we did the opioid practical toolkit, that was accompanied by two years of webinars. Webinars over two years, and they put a training specifically for faith-based leaders on trauma, informed care, and very first childhood experiences, and then another one, which focused on how to create a culture of compassion in communities for those who suffer with STDs. And all those recordings are available on our YouTube page. Future webinars are listed in our newsletter. We really just want to be able to get this information to you to be able to use and share in your community.

Our final slide is our contact information. Friends, the Partnership Center seeks to serve your mission to serve your community. The health challenges of today and these complex issues surrounding addiction, both acute and long-term, require the communities be equipped to participate as true agents of hope and healing, and we're eager to support that journey, and our contact information is here on this slide. Please, please be in touch. I'm going to turn this time over now to the real experts in the Zoom room, and thank you. I look forward to being in touch with all of you.

**Betty-Ann Bryce:** Heidi, thank you so much for your presentation. Again, we promise to provide you with resources. All the slides will be available on the site at the end, and also all the resources that Heidi mentioned will also be posted, so you will have access to everything that has been discussed. I encourage you to, I know the chat has really been active, and I appreciate that. If you have questions, please put them in there. I'm sure Heidi will peek in and respond to any questions as we're going along. Anything we don't get to, we certainly will follow-up with you.

The next part of this program is so intriguing, as Heidi said, we really wanted to make sure that we gave some time to two phenomenal speakers to talk about congregation readiness and what that means, because before you can start working with the faith community, you really have to get the faith community ready to work with you. I thought that this was so important as the first workshop to really have a look into this sector. And with that, I've asked Pastor Greg Delaney, who's really been a leader in this space to talk about this issue. He'll be joined by Dr. Monty Burks, who I can say now has become a really good friend, both of them.

And they will be tag-teaming on this issue, so I will turn it first over to Pastor Greg for the first introduction. Pastor Greg, the floor is yours.

**Greg Delaney:** Thank you so much, Betty-Ann. It's such a treat to be with all of you, and a privilege. I'm honored by that, and also to be on the dais with my dear friend, Dr. Monty Burks. So, as Betty-Ann mentioned, we're going to kind of go back and forth a little bit, giving you a little insight as to what has happened, both in Ohio, and in Tennessee. If you take a look at the next slide, I'll give it over to Monty really quickly, and he'll talk a little bit about the goals that they work from in the Tennessee area.

**Monty Burks:** Absolutely. And Pastor and brother, Greg Delaney and I have become really good friends, and I want to thank Heidi Christensen for introducing us together through some various works in the country. And also, thank you, Betty-Ann for inviting us to present today. Esteemed leaders, people that are listening, and people that have taken your time today, we really want to share one common thread. It's not about creating new programs, it's about partnering with existing resources, how to leverage things in your community to establish recovery communities and to build recovery capital that's going to go sustainable after all of this is gone.

So what are Tennessee's faith-based initiative goals? Our goals, we're connecting individuals struggling with addiction and mental health concerns to treatment and other types of resources, facilitate an understanding of what treatment and recovery are. Making sure that when we talk about congregational readiness, understanding that the institution jargon in the faith community can be completely different in a professional capacity than it is in the work that we work in, the substance abuse, treatment, prevention, criminal justice.

I preach the knowledge of what addiction and mental health are, understanding that behavioral health concerns affect all communities, understanding what the continuum of care is, and how the faith-based community connects in all of it: prevention, treatment, recovery, criminal justice. The faith community can imprint itself through the whole continuum and stay connected with a person from the very beginning until the very end, until that person is the one exercising their steps and going back and helping save our communities. And help understand and implement our best practice model, which I'll go over on the next slide.

**Greg Delaney:** I think I got the next one, my friend, but I'll give it right back to you. One of the things that we have done here in Ohio that mirrors all those goals that Monty and the team in Tennessee have, is we really spend a lot of time with our faith-based communities in letting them know that A) that they have a place to play in this particular space. They're valuable community members.

But also, helping them to see the "why." I like this remark, our colleague from Atlanta, Kelly, that these faith-based communities are uniquely designed to offer a repentance, honest self-assessment without judgment, and responsible living with spiritual devotion, and because it intertwines with recovery, because it's a holistic process.

And so one of the things we focus in here on Ohio often, is helping faith-based communities, churches, congregations, those leaders understand that they need to have a calling to this space, but we can also help to validate their 'why' because some of the things they do inherently are excellent for this particular population and how we can serve them. And so I'll give it back over to you, Monty, and let you take that even further.

**Monty Burks:** Absolutely. With respect, we wanted to make sure we connected our mosques, our synagogues, our temples, our groups, not just the traditional faith-based institution, not just the four walls, but all of the people in the community that serve their community, that have been there for decades long before any state government resource was there, and long after any of all of our faith-based conversations may cease, we wanted to make sure that we reached out and leveraged those communities and partnered them together.

So we started with our community anti-drug coalitions or our substance abuse prevention coalitions, knowing that they serve and connect with 12 sectors of the community, and the faith community's already one of their sectors, but let's enhance that sector. Let's get our congregational readiness to not only be part of the conversation, but be part of the work that's in progress in the community. Our treatment and recovery courts, formerly known as drug courts, I'm a fan of not calling it drug court any longer, because when you say drug and you associate it with court, sometimes people unintentionally associate criminality with people that are in recovery. Everybody that has had a path to travel, that's an old them. We're talking about the new them.

Addiction and recovery program, these are called different things in every one of our states, but existing programs that provide recovery support services, if a program exists, that program is what you consider recovery capital. We may not necessarily understand how the program works, but we live in the age of the internet. It's time for us to look up what the program does and see how we can partner with those programs, and again, leverage all those resources, Health Departments, Health Educators, local law enforcement, colleges and universities. The progeny of our faith-based initiative is our collegiate recovery initiative, so our faith-based communities are working with our collegiate community to provide outside recovery support services for our young people that are in college that may need to go to a recovery meeting that's off campus because we understand the stigma associated with the disease of addiction, and a mental health concern can cause a person to not seek adequate help.

**Greg Delaney:** So one of the things that we echo with what Tennessee does and how we approach it here in Ohio when we're having those conversations, is really simplifying it and say, "Don't reinvent anything until you've had the opportunity to research what's available in your local community as well as the state level and the national level." Because what we're starting to see is that often, it's not a case of not having enough resource, it's more about having information about where those resources are, and how I can potentially connect to them.

And so to echo on the next slide, we kind of take the faith community down this road that regardless of your faith tradition, we're all in that boat of helping our neighbor, of serving our neighbor, whether that's in the Torah or in the New Testament where I hang out, we kind of use that as the cause to sit in the middle. But what you see there on that slide is actually the recovery-oriented system of care from SAMHSA. They have invited the faith community to this,

and what we tried to do with this particular visual is to say, "You're part of a grander effort. We need you kind of understand where and how those things can fit in with what you do, but even more importantly, how you communicate to them on how you can assist them."

So it becomes this really amazing collaborative work. Going back to that little bit that's on the left-hand side of the slide, from my perspective is this why, how, and what kind of approach. Often, we'll get a church or a congregation will say, "Hey, I want to go do something. I want to go do this." And before we get there, we want to take them back to why do you want to engage the population, and then we can help them with how to engage the population using some of these principles in terms of collaborative work. And then we'll get to the what.

The good news is, is there's a lot of what's, and there are a lot of great what's. Often, they don't have to take on a brand new what because we'll be able to bring them into alignment with somebody who might be doing something exactly the same, but in a different region of the state, or maybe something that we maybe need to tweak a little bit based on some principles that are already in place.

Kind of coming back to what Monty said, it's helping the faith community understand that you have a role, you have a place to play, but we really need you to get outside those four walls, as he mentioned, and find out how do I integrate, and the best way to integrate is to research with what you have so that you're not duplicating... that's a big thing, but also that you are providing a more holistic process for that person that's in the middle. Because at the end of the day, it's the individual and their family that's the most critical piece of the puzzle. And so how are we serving them, and serving them well? How are we loving, and loving them well?

The best way to do that is to say, "We're going to surround you with not only access through our faith portal, perhaps, but we're going to give you the tools and the connections that you're going to need in terms of be successful on your recovery journey and on your re-assimilation back into society. So, on the next slide, Monty's going to take you through a couple things on the Faith Based Engagement Process. If you go to the next one, he can kind of give you a visual of what's going on in Tennessee.

**Monty Burks:** Absolutely. And right now, we have some of our Faith Based Community Coordinators are on this Zoom. I would ask that the Faith Based Community Coordinators drop your contact information in the chat section for anybody that wants to talk to you about the kind of work you do, because I won't have time to go deeply into it. But our first level of faith-based engagement is our Faith Based Community Coordinators. They're a group of individuals with lived experience. Their job is to recruit, train, and certify congregations as recovery congregations.

We're trying to pull our congregations into the fold, into the mix with equal information, just like we do with our treatment programs, our housing programs, et cetera. There has to be a conduit of consistent information to our congregations for two things. One is all congregations do not have the strategical or logistic capacity to have a meeting, but they don't have to. We're trying to help every congregation become recovery-friendly according to their culture, which means that they may be from a different religion, a different belief, a different cultural environment, a different socioeconomic environment.

Our coordinators' job is to connect with them, meet them where they are, and figure out how to get them to utilize tools that are already available in their community. Here's, on this slide, the contact information for all of them is available. They're going to drop their contact information again in the slides. Next one, please.

So we have built a Best Practice Model that our Faith Based Coordinators utilize to work with our congregations to become a certified recovery congregation again. Our conversations with our congregations have nothing to do with religion or religious perspective. They have to do with recovery, treatment, and access to resources. So 1) provide spiritual or pastoral support according to the congregation's culture. Again, understanding that leadership in the faith community is the driving force behind whether congregations will usually get involved in recovery support ministries or recovery support work. Deal with addiction by its definition as a treatable disease. We're looking at the health model, the medical perspective, treating the person, getting resources to the person.

If all of our congregations became mini-hospitals to get a person to the other hospital, probably most of us would run out of a job. Embrace and support people in recovery and walk with them all their journey, fellowship with people no matter what their religious tradition or perspective is. We have over 12,000 congregations in Tennessee. Our goal is to reach all 12,000 and to somehow know how to utilize resources that exist. Disseminate recovery information. Our coordinators can provide that. Host to refer individuals to recovery support meetings. Listen to all of my congregational leaders, you do not have to have a meeting in your store house to know about the meeting down the street, and to utilize that meeting as a resource, and to partner with that meeting.

Again, it's not my job to get into the culture of the congregations, but it is to provide tools to all congregations and to all belief systems. Congregations that follow that Best Practice Model that just partner with us, we recognize them as Certified Recovery Congregations.

So right now we have 736 recovery congregations. We've actually connected with well over 2,500 different faith and spiritual and recovery institutions in the state to build this robust network of congregational support. We provide an educational forums at all 95 of Tennessee's counties, and here's a QR scan that we use for our faith communities. Everywhere we go, we put this in every room, we hold this up on every board, this is outside. All of our faith communities may not openly say they want to start a meeting or connect to resources, pick your phone up, do the QR scan, a box will pop up, it will connect you to our office and we will send that information to our Faith Based Coordinators and they will reach back out to the congregation, and if for nothing else, there may be an opportunity to refer someone for an assessment, get a person into treatment, get a person to a hospital, get a person some type of housing.

We've increased awareness of recovery support resources nationwide, and I'm thankful Pastor Greg Delaney and I have become brothers. We've traveled parts of the state . . .parts of the country just to reiterate and to wear this message out that partnerships are the key, collaboration is the key.

So some of the types of ministries that have been created with our recovery-friendly congregations, relapse prevention, housing, education, childcare, transportation... there's a little slick saying, we call it the Chubers, the Church Uber, the white van that's only used two days a week is an awesome opportunity for people to take someone to and from a treatment facility, to a recovery meeting, to IOP, to the grocery store. People in recovery don't have access to traditional transportation sometimes, because we burned every bridge possible, and I'm a person in long-term recovery. I get it. I've knocked down more bridges and more walls in my path than probably most people that you know.

I also know that I needed to reiterate myself, put my feet on solid ground, and not involve myself in things that would get me back in trouble. So transportation to meetings, housing

assistance, relapse prevention, marital and family counseling, childcare when we go to and from meetings.

**Greg Delaney:** So, what we took from the way we approach it here in Ohio is we had hundreds of forums. They were in conjunction with our Attorney General's office, now with our governor's office, and they're also just come up on their own. One of the things we really tried to focus on is how do we create congregational readiness. Monty calls it to be a Certified Recovery Congregation. We look at it as how do I best equip a congregation. So we kind of took this approach that we knew we had some things right off the jump that we needed to cover and take care of within the faith community. I think I saw Michael S. come up in the chat and talking about how difficult it is to get faith communities to embrace the idea of addiction is a disease.

We have a lot of wonderful tools that help to get the light bulb to turn on and really kind of change the perspective that folks within the congregation may have about addiction. So one of those things is really to start to de-stigmatize addiction as an approach that we take. And then we kind of go through this group of these boxes and take it down to helping them understand what an empathetic response is. It's a little different. We may not have shared experience inside that congregation, but we all have stuff, and so how can I create avenues of connection with those people that I may not have as much in common with, but I probably have more in common with than I think.

So, as we move through there, we really spend our time, kind of spending it in an educational format, in an educational way. So the next slide will give you a feel for how we go about doing this, and it really is an idea of going and getting the best possible education from a variety of sources and begin to synthesize and distill that down, and customize it to the congregation that I might be working with. I might have a little bit of a different language in a Catholic setting than I might in the Evangelical setting, but at the end of the day, we're trying to give them as much information as possible about who it is that they're going to be serving. And then going into those things that we've talked about before, how it is that they could potentially serve with the understanding that I don’t want . . . if I have a Celebrate Recovery that's going on in my town on a Tuesday night, and the congregation begins to feel, "Well, this is the direction that we want to take."

We come and say, "Hey, don't do it on Tuesday. If you want to do one, do it on a Thursday. We'll help you with that. We'll get it set up for you there," because now we have two places for this group to go over the course of a week that are safe and recovery-focused and faith-focused. So that's part of the process that we've taken in terms of how do we get our congregations ready, and then once they're ready, then we can give them ideas on how to go about what we're going to talk about next on the next slide, and that's implementation of a program or an opportunity within their congregation.

**Monty Burks:** Absolutely. So the implementation process, and first off I want to say Drew Brooks, I see you. Drew Brooks has been doing this work for a lot longer than a lot of us can even imagine. Drew Brooks is a wealth of information, knowledge, and resources in and of himself. Also, Uplift Appalachia is on here, Dr. Amy Clement from ETSU, who has done a lot of great work in East Tennessee, West Virginia, North Carolina and those surrounding areas. Elizabeth Tomey, when we talk about recovery, we talk about all recovery.

Gambling addiction, pornography addiction, anything that pulls a person away from their family or from resources or spirals them negatively out of control, and they need help. So we're talking about connecting resources to get people that are recovery-friendly. Recovery-friendly is not

just one thing, it's all things geared towards helping serve the person. Thank you for asking that question.

So what is the Lifeline Peer Project? We also have some of our Lifeline Peer Project Coordinators here on this call. Please drop your contact information in the chat box so if people need to ask you some questions about the type of trainings you provide, they can. The Lifeline Peer Project was established to reduce the stigma related to the disease of addiction. We have 17 individuals that are in long-term recovery that travel around the state of Tennessee and till the soil to help communities, not just their communities, all communities understand that they're a part of the recovery process. They've helped influence policy and helped change conversations in communities. Where we would have closed door conversations around addiction, now we have open town halls where people give their testimony. So they can show people that this is what the other side of addiction looks like. This is what recovery looks like.

There are 17 Coordinators, each one are housed in our Substance Abuse Prevention Coalition. To date, they've provided 6,000 recovery trainings, almost 6,100. They've referred almost 14,000 people to treatment in other recovery sources. The majority of their referrals have come from the pews of our sanctuaries. Let me say that again: the majority of their referrals have come from the pews of our sanctuaries, which means our pastors, our imams, our rabbis, our bishops, our clergy now have a resource that they're connected to where they can make that call themselves.

And listen, clinicians, we're not trying to take your place. We're trying to get people to you. We're using the recovery community to create an access point to get people to get to you, because sometimes it takes a person out of a suit and tie, it takes a person in Chuck Taylors, holey blue jeans and a tee-shirt to get someone to open up about issues that's hurting them. They’ve also started, that number's low they started well over 700 recovery meetings and connected the dots between communities so that people can reach out and have more of those resources, like Pastor Delaney said, "Seven days a week there should be one meeting somewhere in a community." Unfortunately there's not, but that doesn't mean that there can't be.

Some of the trainings they provide are addictive brain, mental health 101, trauma-informed congregation, person-first language, religion versus spirituality in recovery. These are all things in our Lifeliners and our Faith Based Coordinators provide to our faith community across our state. Here's the map of the Lifeliners again. This will all be available to you. This is their contact information.

**Greg Delaney:** So, kind of building on what Monty said, from an implementation perspective here in Ohio, once somebody has found their 'what,' then we begin to provide an assessment of how they're going to do that what. And as a person who's done a few what's, I started a meeting in my hometown probably eight years ago, and I'm also a person in long-term recovery. Out of that, we created a hub for services. Out of that we created a home for men. So we have great folks in the state who are willing to serve and willing to share how they did things with someone else who wants to do something similar.

The way that we're structured here in Ohio is we have 55 mental health and recovery boards, per se... that's not naming for all of them, that serve our 88 counties. So part of our strategy is always to make sure that those faith communities and those faith congregations that want to get engaged, that we also engage all of those resources and all of those capabilities that are within that board, because that board often has the direct connection to our providers. That

board often has potential resources through our state agency in Ohio Mental Health and Addiction Services. It's critical that we create this collaborative work between the two of them.

But the really, really neat part about this from my standpoint is there is no limit to creativity. There is no limit to creativity. We had an organization in Green County, Ohio that was seeing women that didn't have a place to go in crisis. And so they opened the very first contemplative house that we have here in the state of Ohio, and they're serving women and then sending them off to deeper levels of treatment, deeper opportunities for long-term recovery. But it was all out of a need, and even though we didn't have that thing done yet, we had an awful lot of people who had done something similar and we were able to educate them, fund them, get them up and running. Now they're in the process of serving women on a daily basis, and also being a connected part of the rest of the community.

So, while ours is a little bit different in that we kind of go from the bottom up, where Tennessee's had a top down, the real benefit of it is we've been able to learn from one another, and been able to say, "Okay, where's the best way to go? Could we use the toolkit that Monty has available that will share with you, or is there something we can pull from this education and this hands-on training that we've had here in Ohio to push it up and provide assistance for those who want to engage?"

So the next slide is just my contact information and Monty's contact information. We went through this super quick. We're at 2:15, so we're done. But my whole approach, and if anybody's ever worked with me, I'm here to serve you. I've been blessed by given a chance at life. I should not even be here on this call from the consequences of my addiction. So I see every day as an opportunity to serve and I'm grateful for it. Feel free to contact me. I'll get on the phone with you. I'll jump on a Zoom. One of these days I'll jump back in a car and come see you, whatever. Just want to make sure that's clear, and I want to thank you again for allowing me to share.

**Monty Burks:** And thank you again for my... Thank you, Betty-Ann. Thank you for putting this together, and thank you all for the questions and the comments. I'm going to try to respond to everything that you've asked that I can. Thank you.

**Betty-Ann Bryce:** Thank you, guys, for really comprehensive presentation. The next slide is me if you're curious as to... if you want to know more about me than you need to, you're happy to read this slide. I'll go to the next slide please because I didn't want to leave without talking about your favorite, favorite subject, which is data. I know everyone is chomping at the bit to talk about data, but I do think it's important for you... I didn't want to have this meeting without at least mentioning why you need to at least use data to level set and increase your understanding of what's going on in your community.

I'm going to run through this quickly. This is a data tool that's very much still available to you, but I want you to just follow with me quickly on why you need to understand and look closely at data, and how it's going to help you respond to everything that Heidi, Monty, Pastor Greg, Vanessa, and Dr. Winstanley has shared with you thus far.

So, early in pre-COVID, which is how we refer to our lives now, but in February of this year, the ONDCP released this product, Rural Community Action Guide. It's available on the toolbox, and I'll share you where it is in a moment. Within the Community Action Guide, which I welcome you to download and look at, I'm going to zero in on one chapter, which is exactly three and a half pages long, so it should be really quick for you to get through. It really talks about how data can help you, how data can help you respond to the big questions that you have right now, what

perpetuates the problem, what makes you vulnerable to the crisis, how to understand how the crisis is changing, the face of it, what impact it's having on your community, identify prevention treatment and recovery models that work.

And also look at the socioeconomic and demographic information, and how those local factors may be having an effect on what you are doing. So here I pulled from the tool, and I'm showing you three things that I think are relevant and will make a case for data. One is if you look at the drug overdose mortality trends over time, using counties, and this is CDC mortality data that's built into the tool, I used. . . I just pulled a couple of counties to provide an example. This is we provided a tool giving you information over 10 years, broken up in five-year tranches. You can see how the work that you're doing may be changing the community.

If you look at these counties over that 10-year period, the red box implicates the first five years, and the green, the latest five years, you'll see that they've been able to hold stable for 10 years in terms of mortality. What questions does that raise for you? What are they able to do? Are their prevention, treatment, and recovery programs working together, and what's going on there?

Now, let's look at some counties where that is not the case, where over that same 10-year period, and that is leading up to 2018, which reveals the latest data, you'll see that they are experiencing an increase in overdose mortality. Now keep in mind this does not take into account what the Director and Dr. Winstanley said, which is what we know that mortality has changed quite a bit during COVID. So you'll see that these are counties that have experienced and increase. This doesn't mean that they don't have prevention treatment and recovery activities going on, but it could indicate that there is a disconnect between their policy trends or that there's a delay in the impact of what they're doing.

Now, let's look at the reverse. Let's look at counties that over that 10-year period have seen a drop in mortality, and it's the same question. Now looking at Pike County you may say, "95 is still high," but look where it's coming from. So, whatever policies, prevention, treatment, recovery, community, it's starting to take effect. If you look at Pipe County on a map, you're going to say, "Oh, it's dark, dark blue," meaning it still has problems. But it is managing those problems. So, when you look at the data, it helps you to get a really good sense of what's going on in your community. It's a really important starting point. Now let's keep going.

The economic factors are just as important. You've heard a lot of my colleagues talk about broadband infrastructure. What's going on in the community, what's driving the clients to you, what's driving overdose data, so we can't not look at access to broadband, poverty rate, unemployment rate and what's going on there. So, just using a county again, Fayette County, this is all public... this a public tool that you have access to, so you can look at whatever aspects you want, but just looking at this small rural county, and then looking at just how the differences are in terms of their access to broadband at 37% when the actual state average is 87. That's really indicative of what they maybe have been able to do during the pandemic.

Also, a slightly higher unemployment rate, which may have changed again because of the pandemic. So these are just things that you should not lose sight of because they will always affect the work that you're doing.

I wanted to zero in on the two things I just mentioned. I used Indiana, and I wanted to showcase a couple of things. One here is that when you pull out the poverty rate for Indiana, you see that the average rate is 14.1%. So you'll see the below the poverty rate and above poverty rate. So the question is how much does poverty impact what you're seeing among your clients. That's for

you to answer, but we want you to be aware that there is probably a correlation where you have high poverty and the work that you're doing.

Also, broadband connectivity, which comes up quite a bit, so zeroing in here on broadband access. We're using again Indiana, and I apologize, Indiana, it was just easier for me to pull at the time. But you look at the average broadband access rate connectivity's at 92.9%, but here are some communities and counties in Indiana that are not experiencing that 92.9% rate, right? So, their ability to pivot, to take advantage of the telehealth changes or virtual dynamic that has been underscored throughout the pandemic, it varies. And this is across the board in a number of your states that while some parts of your communities may enjoy a high access rate, some communities don't. So it becomes, "What are we doing about that?"

Because as you hear, there is a lot that can be done, but where you have challenges with access to broadband, access to rural transportation, access to housing, access to all the other dynamics that you need, it will affect your ability to be successful.

The other thing that I wanted to point out to you, which is also part of the tool, is your vulnerability, or you can think about this as your recovery capital. So, what makes a community vulnerable to some of the things that you're seeing? And this is also built into the tool. This came out of questions that we got from the community when we traveled around. "Why is this happening to me?" Maybe these are some of the data that you don't like to look at, but you have to have some awareness of it, because it is impacting the work that you do.

So where you're in a community that is more vulnerable, and the higher the score here, as we rated it you are more vulnerable, your ability to recover may be slower than a community with a risk-resilience score of one. And that's something to take away. Now, I've done this really quickly. This is something that I work with communities on, and I'm happy to do the same with you. I would love for this community to have some awareness of it, because as you're going in and saying, "I need this grant. I need this solution. I need this," it's important to make sure that you're building it around the strategic framework that takes into account what's going on in your community on the ground.

So, here we come to the Rural Community Toolbox. It was mentioned earlier. Some of you are aware of it because maybe you've come on the page. But the Rural Community Toolbox is basically where you go when you know what kind of funds you need. 17 federal agencies got together, as the Director said, and put it all together. You'll notice this is the screen shot of the first stage. At the bottom, you'll see the Community Assessment Tool, which I referenced. You can go in there and take a look at the data points that I just raised for your community.

Next to it, you'll see the Rural Community Action Guide. Again, you're welcome to take a look at that. Here it's about funding. I need an iPad. I need expand broadband infrastructure. I need information on housing, food. So we built this tool not just about prevention, treatment, and recovery, but about how to make your community whole, because that is just as important.

As you're thinking about this and building your strategic partnerships, you're thinking, "Okay, my broadband infrastructure is weak. What are the agencies that can help me with that." That is the FCC. That is USDA. Those are some... HUD, Department of Housing may have some stake in this as well. So, we wanted to build a place for you to go in one place to then think about all the other places . . . all the agencies that can help you. And again, if you're confused, if you need more information, I am happy to walk you through this or to think with you strategically about some of the issues you may have.

But I wanted to at least give you a sense of the toolbox and what you'll see. As you go in, I stuck with funding because most questions come about funding. What type of funding are you looking for takes you to this screen. Click on it, it takes you to the information that's there. Two things to be cognizant of, and my partners in this, I'll introduce in a minute, is active and inactive. When you have 17 federal agencies, we're on different funding cycles. So at any given point, when it's active, it means the grant opportunity's open or the funding opportunity's open. When it's inactive, it's closed.

This is not a page that you visit once. This is a page that you bookmark and you visit often, because funds are going to open up and close to different cycles. For example, the FCC opportunity for infrastructure is going to open on the 4th of January, it's probably only going to be open for two months. Right now if you go and click on it, it's not open, so it's inactive.

The way to use these pages, you have webinars, you have information. Prepare for the grant. Don't wait until the window opens because the first complaint we hear is that, "The cycle was short and I wasn't ready." The purpose of putting it all together is so you can get ready for whatever you're interested in, and you can build strategies that could lead you to what Pastor Greg Delaney, what Monty, what Heidi, what everyone has been talking about.

The next slide just gives you another view of what I just said, so it really is on you to take a look at this page, and tweak it and play around with it. I just wanted to, I think I gave you a snapshot of treatment and services as well, so you have funding, you can enter if you're looking for treatment and services, if you're looking for information, if you're looking for a video to watch. And by the way, the videos from this will be uploaded to this page, so this is one way to force you to become familiar with this tool. We will link to all of the resources that were mentioned today.

So I wanted to introduce Kristine Sande. In addition to all her other talents, they are my partners in crime behind the Rural Community Toolbox, which means I'm a figurehead and a puppet, because her team keeps it updated. They do a very amazing job. We partnered with them to build a tool, and now they keep it updated and keep all the grants and activities that you have in there live and well. I partnered with them because they already had an amazing site that you should be aware of, if you're not already aware of, which is Rural Health Information Hub, and I'm going to ask Kristine to take a few minutes to tell you about that. Kristine, the floor is yours.

**Kristine Sande:** Thanks, Betty-Ann. I'm just going to spend a couple of minutes telling you about the Rural Health Information Hub or as we call it RHIhub. I think it's a great resource for rural communities as you're looking to improve and maintain both rural healthcare, but also the health of the population in rural communities. That's where faith communities come in. The RHIhub is funded by the Federal Office of Rural Health Policy, and that's within the Department of Health and Human Services. We are located at the University of North Dakota Center for Rural Health. Most of our activity takes place here in Grand Forks, North Dakota, but we're surveying the whole nation.

I'll spend a little bit of time on our website, which is the most popular thing that we do probably, because the information is available 24/7. The website address is there on the screen. It's ruralhealthinfo.org. If you google, you'll find us as well. So, we have a team of information professionals who scour the whole universe every day looking for new resources, new funding opportunities, events, news and the like that are produced by organizations and agencies all across the country that pertain to rural health.

The items that they find during that activity are then indexed on our website and can be found in our online library section of the site. The extensive funding section within that online library is particularly popular as you might imagine. It includes opportunities related to substance use and misuse, as well as a lot of other areas that come into play when trying to serve people with those substance use disorders.

Our website also hosts about 20 evidence-based toolkits that help rural communities design and implement programs, walk you through the steps and the things you need to think about when designing those programs. That includes a toolkit on the Prevention and Treatment of Substance Use Disorder, and also contributing to the evidence base of what works in rural communities is our Models and Innovation section on the website. In that section, you can find over 300 examples of successful programs that have been implemented in rural communities all across the country.

We also have more than 50 Topic Guides covering issues including substance abuse and the rural response to the opioid crisis, as well as many other rural health topics obviously. And those guides just serve as a primer about those issues as well as giving links to resources and funding and models specific to that topic. You'll also find State Guides covering issues in each state, rural data visualizations with county-level data, our online magazine, The Rural Monitor, and much more.

Then on a weekly basis, we send out our weekly newsletter RHIhub This Week. That comes out on Wednesdays and includes new original content from RHIhub as well as alerts about rural relevant news, events, resources, and of course, funding. Always have to remember funding. You can also sign up to receive our custom alerts which allow you to choose specific topics or states that you're interested in information about.

If you find yourself needing help finding information or whether it's about you need statistics or you're looking for funding on a specific thing in a specific area, or you need to find an expert who can help you think through something, you can contact our Information Specialists and they can provide you with free customized assistance. The contact information for that is on the next slide, so info@ruralhealthinfo.org is the best way to connect with the Information Specialists, since we're all working from home right now.

I hope that you will take the opportunity to visit us on the web. We also have social media accounts there that you can check out. Thanks so much for having me on today, Betty-Ann, and I'll turn it back to you.

**Betty-Ann Bryce:** Thank you so much, and thank you to all our speakers today. Really appreciate you taking the time. My contact information is on the screen, if you have any questions specific to me, to the toolbox, or to just anything else. I know we're at time, so unfortunately we will not be able to take any live questions. We're five minutes over. But I will say that we will copiously monitor the chat, and if anyone has not gotten back to you, we will follow up with you via email.

Regarding next steps, this was the first one. I really want you to keep in mind everything that you heard. The next faith-based series will start to drill down on prevention and connecting faith to prevention, so the conversation will focus just on that. If you have any questions, feel free to reach out to me by email. Any follow-up thoughts, you will have the PowerPoint, so you can reach out directly to any of the speakers if you have specific questions for them or feel free to send it to me, and I can connect you.

So once again, thank you, everyone for your attention today. I can't wait to read the chat. I see it's been really active all day. I hope you enjoyed this. Feel free to reach out to me with your thoughts. Please enjoy the rest of your day. Thank you.