

OVERDOSE RESPONSE AND LINKAGE TO CARE: *A Roadmap for Health Departments*



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Commonly Used Acronyms

Acronym	Meaning
ASAM	American Society of Addiction Medicine
BJA COSSAP	Bureau of Justice Assistance Comprehensive Opioid, Stimulant and Substance Abuse Program
CCAR	Connecticut Community for Addiction Recovery
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CSAT	Center for Substance Abuse Treatment
CSTE	Council of State and Territorial Epidemiologists
DEA	Drug Enforcement Administration
ED	emergency department
EHR	electronic health record
EMS	emergency medical services
FDA	U.S. Food and Drug Administration
FQHC	federally qualified health center
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIDTA	High Intensity Drug Trafficking Area
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
LOFRT	local overdose fatality review team
MAT	medication for addiction treatment
MOUD	medications for opioid use disorder

Acronym	Meaning
NACCHO	National Association of County and City Health Officials
NaRCAD	National Resource Center for Academic Detailing
NASTAD	National Alliance of State and Territorial AIDS Directors
ODMAP	Overdose Detection Mapping Application Program
OEND	overdose education and naloxone distribution
OFRT	overdose fatality review team
ONC	Office of the National Coordinator for Health Information Technology
OTP	opioid treatment program
OD	opioid use disorder
PCSS	Providers Clinical Support System
PDMP	prescription drug monitoring program
PSS	peer support services
PWSUD	person/people with substance use disorder
PWUD	person/people who uses drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR/STR	State Opioid Response grants/State Targeted Response grants
SSP	syringe services program
SUD	substance use disorder
XR-NTX	extended-release injectable naltrexone

Introduction

For more than two decades, communities across the U.S. have faced an overdose crisis resulting in nearly 450,000 opioid-involved overdose deaths between 1999 and 2018.¹ Additionally, stimulant-involved overdose deaths have risen at alarming rates.² Since the onset of the COVID-19 pandemic, unintentional overdose and overdose death rates have increased substantially.³

Despite the high rates of overdose across the nation, substance use-related harms, including overdose and overdose death, are preventable. Evidence-based practices exist across a continuum of care for people at risk of overdose, including medications for opioid use disorder (MOUD) and harm reduction services.^{4,5} However, people at risk of overdose often face significant challenges accessing treatment and navigating systems of care. Local and state health departments are uniquely well-suited to better link people at risk of overdose to services and care to prevent overdose and support long-term recovery.

WHAT IS IN THIS ROADMAP?

This roadmap provides local and state health departments with information, resources and tools to implement effective strategies to support linking people who are at risk of opioid overdose to care. Organized by seven strategies aligned with health department essential functions, each strategy offers actionable steps, real-world examples, checklists, tools and resources informed by the latest research, subject matter experts and experiences from diverse settings across the U.S.

Examples of some of the tools and resources in this roadmap include:

- Links to guidance from local, state and national public health agencies.
- Free training resources.
- Sample forms and templates.
- Monitoring and evaluation metrics.

HOW TO USE THIS ROADMAP

This roadmap is organized into seven strategies to improve linkage to care activities across a range of health department services. To help health departments identify opportunities to improve linkage to care activities, we provide an organizational checklist in [Appendix A](#).

We recommend organizations complete the organizational checklist prior to reviewing the seven strategies. The strategies do not need to be implemented in the order they are presented, nor are they mutually exclusive. This roadmap provides an overview of several different types of strategies that can be considered for implementation by health departments depending on each unique health department and community's resources and needs. Additionally, many strategies can be implemented in partnership with other organizations and stakeholders. Within each strategy, there are several guiding elements to inform planning and implementation efforts as described in Table 1.

Table 1. Elements of the Roadmap

Strategy Areas		Critical strategies to consider when exploring opportunities to improve linkage to care.
Action Steps		Planning and implementation steps that appear at the beginning of each strategy area.
Tools and Resources		Tools and resources to guide implementation efforts.
Checklists		Checklists of items that facilitate implementation for each strategy area.
Quick Tips		Information and quick insights into approaches and ideas for planning and implementation.
Examples from the Field		Real-world examples of how strategies are being implemented in the field.

DEFINING LINKAGE TO CARE

One universal definition of “linkage of care” does not currently exist, as the meaning is often context-specific and dependent on each unique setting.⁶ For the purposes of this roadmap, linkage to care for people at risk of overdose is defined as:

Connecting people at risk of overdose to evidence-based treatment, services and supports using a non-coercive warm hand-off that helps people navigate care systems and ensures people have an opportunity to participate in care when they are ready.

A key aspect of this definition is the broad use of the term “care.” Not limited to medical treatment for opioid use disorder (OUD), it includes services and supports that reduce risk of overdose and other substance use-related harms and facilitate access to treatment, such as harm reduction services, housing, food and transportation.⁷ A second key aspect of the definition is that linkage is specified as a “warm hand-off,” meaning that the act of linking people to care is more than offering information or referrals. It is the “compassionate and non-coercive accompaniment to an appropriate care provider.”⁸ Warm hand-offs happen transparently and include the person receiving services as a valued part of the care team.⁹ This definition assumes there is no single best time or place to engage people in care, and linkage to care can be offered multiple times and in many places.

HOW CAN HEALTH DEPARTMENTS SUPPORT LINKAGE TO CARE?

Health departments have an important role in ensuring people at risk of unintentional opioid overdose are linked to care. Building upon the essential public health services,¹⁰ this roadmap identifies seven strategies health departments can implement to improve linkage to care for people at risk of opioid overdose. Regardless of geographic location, size or capacity, all health departments can strategically implement or improve policies, plans and activities that enhance linkage to care efforts. While some of the following strategies may require additional funding, staff or other resources, many strategies can be implemented without additional investments.

- 1. Collect data and conduct surveillance.** As government bodies charged with monitoring health status to identify preventable community health problems, health departments can conduct surveillance and provide data integral to determining who is at risk and where interventions can occur.
- 2. Develop a public health workforce that supports linkage to care.** Health departments are also responsible for a competent, informed and culturally sensitive public health workforce that can be enhanced to specifically address substance use-related challenges.
- 3. Increase overdose awareness among providers and community members.** As credible government messengers, health departments can inform and educate the public about preventing opioid overdose and engage community organizations in overdose prevention and linkage to care activities.
- 4. Support cross-sector collaboration and partnerships.** Health departments are key community conveners able to foster meaningful, goal-driven coalitions and workgroups comprised of diverse groups across multiple sectors.
- 5. Provide linkage to care services directly or by funding community partnerships.** Some health departments may provide services directly or fund organizations to provide linkage to care services to people at risk of opioid overdose.
- 6. Promote policy that enhances linkage to care.** Health departments can contribute to the development of policies, including laws and regulations, that support increased access to care and services for people at risk of opioid overdose.
- 7. Evaluate linkage to care initiatives.** Health departments have a responsibility to evaluate the effectiveness and quality of existing health services and research for innovative solutions to ensure people at risk of opioid overdose are linked to care.¹¹

Both state and local health departments can implement each of the seven strategies; however, some activities within the strategies may be better suited for implementation at the local level, while others may be better suited for state level implementation. Table 2 identifies some examples of activities state and local health departments can implement across the seven strategies.

Table 2. Examples of State and Local Health Department Linkage to Care Activities^{12,13,14}

Strategy	State Health Department Activities	Local Health Department Activities
Collect data and conduct surveillance	<ul style="list-style-type: none"> • Establish and enhance statewide data collection and surveillance systems. • Develop data sharing agreements and templates. • Review new Office of the National Coordinator for Health Information Technology (ONC)/ Centers for Medicare and Medicaid Services (CMS) interoperability rules¹⁵ and plan how to utilize the new rules to enhance information exchange in surveillance and harm reduction efforts. • Support local health departments and response efforts by disseminating data in a timely manner. • Support local health departments by increasing their capacity to collect and analyze data and offering guidance. 	<ul style="list-style-type: none"> • Establish and enhance local data collection and surveillance systems. • Support community-based response efforts by disseminating relevant data in a timely manner. • Establish and lead local overdose fatality review teams.
Develop a public health workforce	<ul style="list-style-type: none"> • Ensure the state public health workforce receives training and education to competently respond to overdose. • Promote the adoption of evidence-based practices among local health departments, community-based organizations and provider organizations through training and education. • Develop resource guides and technical assistance tools to support local health departments and community-based providers implement programs and policies. • Encourage the use of non-stigmatizing, person-first language among state health department staff. 	<ul style="list-style-type: none"> • Ensure the local public health workforce receives training and education to competently respond to overdose. • Host training and education opportunities for staff at community-based and provider organizations. • Encourage the use of non-stigmatizing, person-first language among local health department staff.

Strategy	State Health Department Activities	Local Health Department Activities
Increase overdose awareness among providers and community members	<ul style="list-style-type: none"> • Implement culturally appropriate and relevant statewide overdose awareness and education campaigns. • Provide overdose education and naloxone to directly run and funded state institutions and to local health departments to distribute to their partner providers. • Facilitate automatic notification to an individual’s health care provider following overdose visit to emergency department (ED) or hospital admittance. 	<ul style="list-style-type: none"> • Implement culturally appropriate and relevant community-based overdose awareness and education campaigns. • Provide overdose education and naloxone to clinics, community-based organizations and other entities that may come in contact with people at risk of unintentional opioid overdose.
Support cross-sector collaboration	<ul style="list-style-type: none"> • Lead coordination of and participate in state-wide overdose response efforts. • Collaborate with harm reduction providers, SUD treatment providers, health systems and local health departments to inform state policy and practice. 	<ul style="list-style-type: none"> • Establish community-based coalitions or workgroups to develop and implement coordinated response plans. • Convene diverse stakeholders to identify opportunities for partnership and coordination.
Provide linkage to care services directly or by funding community partnerships	<ul style="list-style-type: none"> • Coordinate funding and resources between federal, state and local agencies. • Develop initiatives to increase access to harm reduction services in the state. • Develop initiatives to increase access to MOUD in the state, including by addressing state policy barriers. • Share funding opportunities with local health departments and leverage funding and resources to support local efforts. 	<ul style="list-style-type: none"> • Support existing community-based linkage to care efforts through funding or other resources. • Develop initiatives to increase MOUD availability in the community. • Develop initiatives to increase access to harm reduction services in the community.
Promote policy that enhances linkage to care	<ul style="list-style-type: none"> • Evaluate state policies to identify opportunities to increase access to care and services. • Educate policymakers to encourage changes that will result in improved care for people who use drugs (PWUD). 	<ul style="list-style-type: none"> • Evaluate local policies to identify opportunities to increase access to care and services. • Educate policymakers to encourage changes that will result in positive outcomes.
Evaluate linkage to care initiatives	<ul style="list-style-type: none"> • Evaluate state overdose response and linkage to care initiatives. • Provide support to local health departments to evaluate their linkage to care activities. 	<ul style="list-style-type: none"> • Evaluate local overdose response and linkage to care initiatives.

CONTINUUM OF OVERDOSE RISK

Using a social determinants of health lens to describe the factors that contribute to overdose and how to effectively reduce risk of overdose, Ju Nyeong Park, PhD, and colleagues developed the Continuum of Overdose Risk (COR) Framework.¹⁶ The COR Framework describes five key stages to implement interventions for reducing risk of overdose: 1) drug initiation, 2) active drug use, 3) addiction, 4) nonfatal overdose and 5) fatal overdose.¹⁷ These five stages are not always followed in order or at all by PWUD. Not all PWUD develop a substance use disorder (SUD) or require SUD treatment.

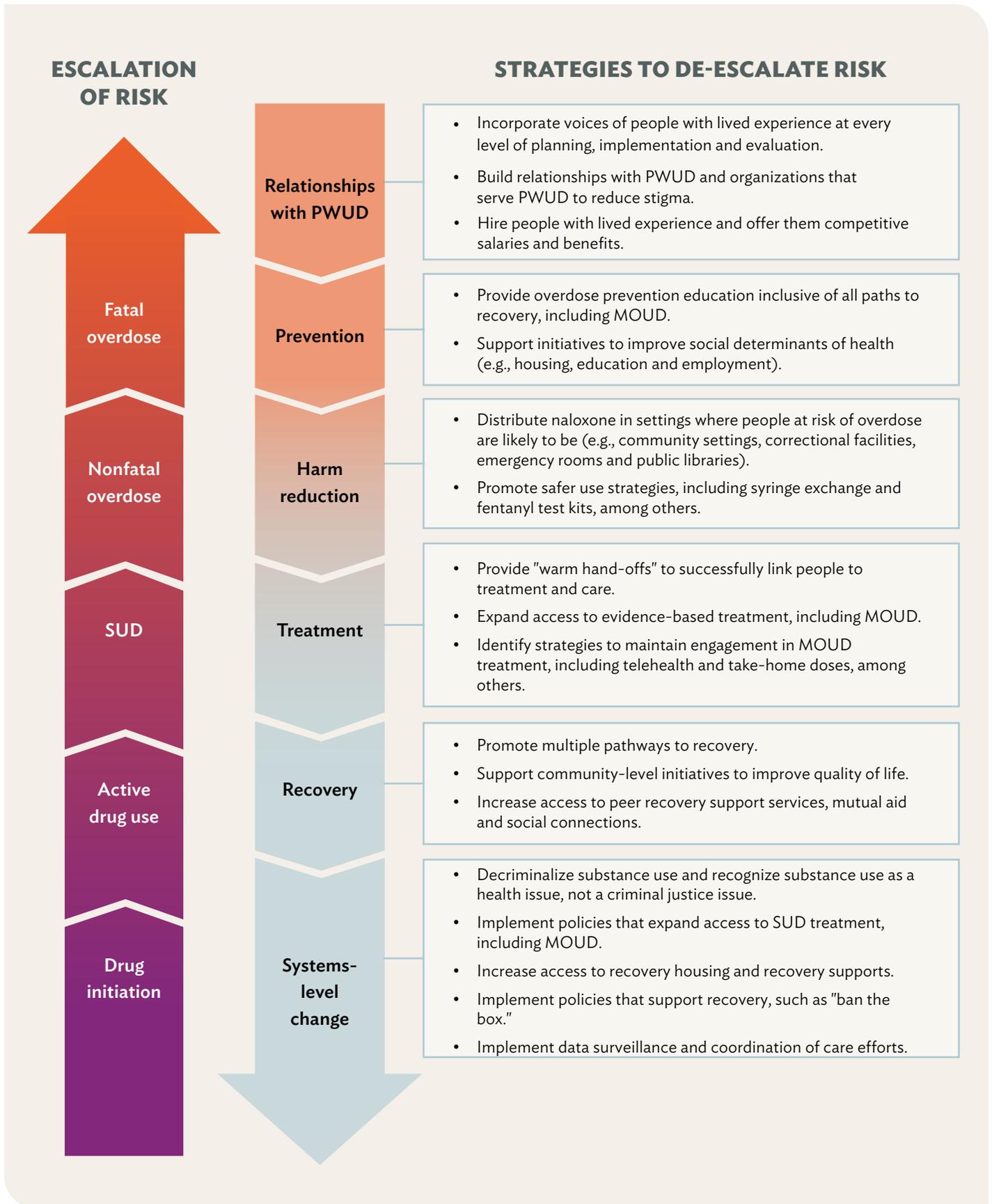
Risk factors and the levels of risk for overdose at each stage vary. For example, nonfatal drug overdose is a significant risk factor for fatal overdose; people who have experienced at least one overdose are more likely to experience a subsequent overdose.^{18,19,20} A study conducted between July 2015 and January 2018 of more than 4,000 people who experienced opioid overdose in western Pennsylvania found that 15% had a repeated overdose. Nearly 30% of the repeated overdoses occurred within 30 days from the index overdose case.²¹ Additionally, interventions and supports may vary depending on whether an overdose was accidental or intentional.

A study of drug overdose deaths in North Carolina in 2012 found that intentional overdose deaths were more likely to involve having a controlled substance prescribed and dispensed in the weeks before death and involve antidepressants as a contributing cause of death, presenting an opportunity for providers to not only reassess their prescribing practices, but also implement or enhance self-harm and suicide screenings.²² Unless otherwise noted, this roadmap primarily aims to address unintentional overdose, though many strategies and activities discussed address both unintentional and intentional overdose. Understanding the factors and conditions that lead to higher risk of opioid overdose are important to inform the development of linkage to care strategies.

Additionally, racial and ethnic disparities in access to health care further drive overdose risk. One study of patients with bone fracture or chronic pain syndrome found that among patients prescribed opioids for pain management, African American patients were significantly less likely to receive a naloxone prescription, while Native American and Hispanic patients were more likely to receive naloxone prescriptions and less likely to receive opioid prescriptions.²³ A study of drug overdoses in Pennsylvania between January 2018 and December 2019 found that White females received an overdose response more frequently than Black or Hispanic females.²⁴ While there was a significant racial disparity in fatal overdose when naloxone was not administered, there was no racial or ethnic difference in survivorship when naloxone was administered, demonstrating the critical importance of equitable emergency medical services to prevent fatal overdose.

Dr. Park and colleagues also describe six strategy areas to reduce risk of overdose and improve health at the individual, community and systems levels, including: 1) partnerships with PWUD, 2) prevention, 3) harm reduction, 4) treatment, 5) recovery and 6) reversing the criminalization of PWUD.²⁵ Figure 1, adapted from Park, illustrates the escalation of risk stages and de-escalation of risk strategies, including examples of activities for each strategy.

Figure 1. Continuum of Overdose Risk²⁶



IMPACT OF THE COVID-19 PANDEMIC ON OVERDOSE

The COVID-19 pandemic and subsequent policy responses have caused unprecedented disruptions to daily life, including increased social isolation, loss of employment, loss of housing and decreased access to health care and social services.^{27,28,29,30} People who use drugs and people with substance use disorders (PWSUD) are at greater risk of health, social and economic harms, which also exacerbate risks related to substance use.^{31,32} Preliminary data show the COVID-19 pandemic has led to alarming outcomes among PWUD and PWSUD, including significant increases in unintentional overdose and overdose death.^{33,34,35} Nationwide, reported overdose death rates are estimated to be nearly 30% higher in the 12-month period ending November 2020 compared to the 12-month period ending November 2019.³⁶

The pandemic has also challenged existing overdose prevention and response efforts among health departments, SUD treatment providers, harm reduction organizations, health care providers and other community-based organizations. Many health departments had to reassign resources and staff to address the pandemic. Direct services for PWUD and PWSUD were fundamentally changed during the pandemic and, in some cases, suspended due to risk of COVID-19 transmission.^{37,38,39} Many changes implemented in response to the COVID-19 pandemic are likely to continue well into the future. Information for this roadmap was collected during the COVID-19 pandemic at a time policies and practices were rapidly evolving to address the pandemic and the overdose crisis. Resources and tools specific to assisting PWUD and preventing overdose during the COVID-19 pandemic are included in [Appendix C](#).

EVIDENCE-BASED TREATMENT AND SERVICES

Evidence-based treatment and services that reduce opioid overdose risk and improve health outcomes among PWUD and PWSUD are available, including MOUD, harm reduction services and behavioral therapies when offered with medication, among others.⁴⁰ Additionally, integrating these services with other health care services is another evidence-based strategy to improve health outcomes for PWUD and PWSUD.^{41,42,43} Integrated care may include primary care, psychiatric care, emergency services, prevention and treatment services for infectious diseases and care coordination services, among others. By integrating and coordinating care, providers are not only able to better address comorbid conditions as a team, but also can better manage an individual's prevention, treatment and recovery plan related to substance use and overdose. Addressing harmful social and structural determinants of health is a critical component of care for PWUD and PWSUD. By reducing barriers, such as transportation, housing, food insecurity and income instability, people can access and engage in treatment and services more easily.^{44,45}

Medications for Opioid Use Disorder

Evidence-based MOUD are the most effective available treatment for individuals with OUD. This treatment modality is also referred to as medication-assisted treatment or medications for addiction treatment (MAT). There are three U.S. Food and Drug Administration (FDA)-approved medications currently used to treat OUD: methadone, buprenorphine and extended-release injectable naltrexone (XR-NTX). Each type of MOUD differs pharmacologically and is governed by different regulations:

- **Methadone** is only provided by Substance Abuse and Mental Health Services Administration (SAMHSA)-certified and Drug Enforcement Administration (DEA)-regulated opioid treatment programs (OTPs).⁴⁶
- **Buprenorphine** can be prescribed for OUD by physicians, advanced practice registered nurses and physician assistants without additional training if they are treating up to 30 patients at any one time.⁴⁷ Providers who plan to treat more than 30 patients at any one time must obtain a SAMHSA waiver (commonly known as the “x-waiver” or “buprenorphine-waiver”) by completing a requisite number of training hours specified for each provider type.⁴⁸ Qualified providers can offer buprenorphine for OUD in non-specialty settings, including primary care settings, emergency departments (EDs), mobile clinics and correctional settings.⁴⁹
- **Extended-release injectable naltrexone** can be prescribed by any clinician who is licensed to prescribe medication.⁵⁰ Unlike methadone and buprenorphine, both opioid agonists, XR-NTX is an opioid antagonist and not a controlled substance.

All three forms of MOUD are effective in reducing return to illicit opioid use; however, efficacy of the three medications vary.^{51,52,53} Methadone is the most commonly used and studied type of MOUD worldwide and clinical trials have demonstrated that it reduces illicit opioid use, treats OUD and retains patients in treatment better than placebo or no medication.⁵⁴ Buprenorphine studies show it is effective in retaining patients in treatment and reducing illicit opioid use.⁵⁵ Extended-release naltrexone has demonstrated efficacy in reducing return to illicit opioid use and reducing opioid craving once initiated.^{56,57} Research suggests it is more difficult to initiate patients onto XR-NTX compared to buprenorphine.⁵⁸ Rates of overdose associated with XR-NTX have been shown to be higher than buprenorphine at four weeks post-medication discontinuation.⁵⁹ National data show that buprenorphine is the most commonly prescribed type of MOUD in the U.S., followed by methadone and XR-NTX. In 2018, in the U.S., 648,864 people received buprenorphine treatment for OUD, 450,247 people received methadone and 73,260 people received naltrexone (study authors did not specify whether naltrexone was in oral or XR-NTX form).⁶⁰

Low-threshold or low-barrier MOUD models prioritize providing access to evidence-based treatment as quickly as possible and without restrictions or ancillary requirements, while honoring patients’ choices.⁶¹ Historically, some SUD treatment models have only provided MOUD in conjunction with behavioral therapies, such as counseling or contingent on other requirements. Additionally, federal regulations require OTPs to provide access to behavioral therapies.⁶² When possible, a robust continuum of services and care for people with OUD should be available; however, access to MOUD should not depend on receiving or participating in behavioral therapies or other services.⁶³ For more guidance about MOUD treatment, see the American Society of Addiction Medicine’s (ASAM) [National Practice Guideline For the Treatment of Opioid Use Disorder](#).

Harm Reduction Services

The National Harm Reduction Coalition defines harm reduction as “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.”⁶⁴ While organizations that provide harm reduction services vary in the scope and types of services provided, they share common values based on engaging and supporting PWUD regardless of individuals’ readiness to stop using substances or to engage in treatment. More simply stated, the goal of harm reduction is to “meet people where they’re at, but not leave them there.”⁶⁵

Examples of harm reduction strategies to address substance use include, but are not limited to:

- Outreach and education.
- Overdose education and naloxone distribution (OEND).
- Syringe services programs (SSPs), also referred to as syringe exchange programs, syringe access programs or needle exchange programs.
- Agonist-based MOUD.ⁱ
- Wound care and prevention services.
- Fentanyl and other drug checking technology.
- Peer support services (PSS).
- Screening for suicide risk and co-occurring mental illness.
- Linkages to social, economic and housing supports.
- Linkages to SUD treatment programs.⁶⁶

Most harm reduction organizations are low-barrier, community-based providers that have gained the trust of PWUD by adopting principles that put the interests of PWUD first (see [Appendix E](#)). Furthermore, people personally impacted by substance use lead many harm reduction organizations. To learn more about harm reduction strategies, visit the [National Harm Reduction Coalition](#).

ⁱ Agonist-based MOUD refers to methadone and buprenorphine, which bind to the brain’s opioid receptors, the same receptors activated by opioids like heroin and morphine, to reduce withdrawal symptoms and cravings. Naltrexone is an opioid antagonist, meaning it blocks activation of the brain’s opioid receptors and produces no rewarding effects, nor does it control withdrawal and cravings. Naltrexone requires a person to be abstinent from opioids for at least seven to 10 days and, therefore, is not identified as a harm reduction strategy.

Behavioral Therapies

In combination with medication, behavioral therapies can help treat people with OUD. Specifically, behavioral therapies can improve medication adherence and address social influences, stress and other aspects of the disorder unaffected by MOUD. There are several modes of behavioral therapy used to treat OUD. Those with the strongest evidence supporting their effectiveness include contingency management, cognitive behavioral therapy and motivational interviewing.⁶⁷ For more information about behavioral therapies, see [Principles of Drug Addiction Treatment: A Research-Based Guide](#) by the National Institute on Drug Abuse.

Contingency Management

Contingency management, also known as motivational incentives, is a behavioral therapy that provides tangible incentives and rewards to help people reach their treatment or recovery goals.⁶⁸ Contingency management is an evidence-based intervention for treating SUDs and has primarily been used to reduce substance use among participants.⁶⁹ A recent systematic review of 27 contingency management studies found the intervention has broad benefits, including reduced substance use, increased utilization of other treatments and services and reduced risky sexual behavior.⁷⁰ Additionally, evidence supports that contingency management is the most effective treatment currently available for methamphetamine use disorder.⁷¹ For more information on contingency management, see [Promoting Awareness of Motivational Incentives](#) from the Addiction Technology Transfer Center Network.

Cognitive Behavioral Therapy

Cognitive behavioral therapy for SUD treatment is an evidence-based psychosocial intervention that assists people with recognizing, avoiding and coping with situations they are most likely to misuse substances and with changing harmful beliefs and behaviors. Cognitive behavioral therapy can be offered as an individual treatment or offered in combination with MOUD, contingency management or other evidence-based treatments.⁷² For more information on using cognitive behavioral therapy to treat SUDs, see the Providers Clinical Support System's (PCSS) free training module, [Behavioral Interventions for MAT: Improving Outcomes](#).

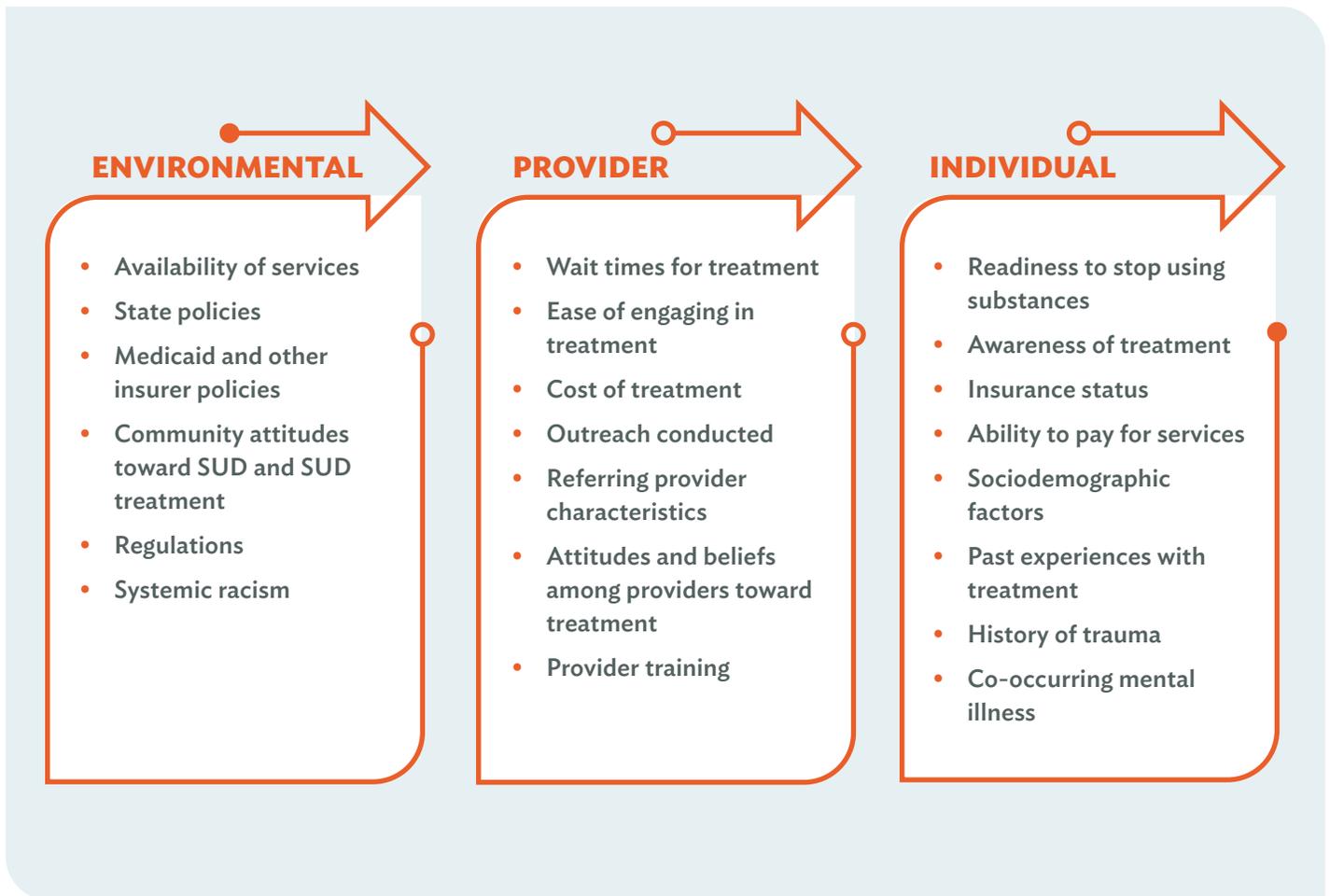
Motivational Interviewing

Motivational interviewing is a person-centered counseling approach used to help people strengthen their motivation and commitment for change. Motivational interviewing can also be used to encourage people to engage in treatment or support services.⁷³ Centered on principles of collaboration, autonomy and “drawing out” ideas, rather than forcing them, motivational interviewing supports individuals in finding their own motivation for change and supporting their self-identified goals. With training and education, motivational interviewing techniques can be used by a range of care providers, including peer support workers, treatment providers and outreach workers. For more information and examples of motivational interviewing sessions, see PCSS' [Motivational Interviewing: Talking with Someone Struggling with Opioid Use Disorder](#).

INITIATION AND ENGAGEMENT IN TREATMENT

Despite the availability of evidence-based treatment and services for SUDs, approximately 80% of people who need SUD treatment do not receive it.⁷⁴ In 2020, 41.1 million people aged 12 or older needed SUD treatment; however, only 4.0 million people received it. Among 2.5 million people who had OUD in 2020, only 11.2% received MOUD.⁷⁵ There are numerous factors that impact access to and engagement in SUD treatment and services, including at the individual, provider and environmental levels (Figure 2).^{76,77,78}

Figure 2. Factors that Impact Initiation and Engagement in SUD Treatment^{79,80}



Understanding barriers to treatment and care is important for ensuring that linkage to care efforts are successful. For example, among people who felt they needed SUD treatment but did not receive it, nearly 40% reported that they were not ready to stop using substances.⁸¹ Because many people who need SUD treatment might not be ready to stop their substance use, people should be offered harm reduction services and supports. Abstinence-only care models exclude a large percentage of people who could benefit from a range of services and supports, even if they continue to use substances.

Disparities in SUD Treatment Access

Groups that have been marginalized face greater gaps in SUD treatment largely due to historic and contemporary systemic racism and discrimination. In 2019, 90% of African American people,⁸² 92% of Hispanic people⁸³ and 87% of lesbian, gay and bisexual adults with SUDs who needed treatment, did not receive treatment.⁸⁴ Additionally, African American people are significantly less likely to receive buprenorphine for OUD compared to White people.^{85,86} Pooja A. Lagisetty, MD, MSc, and colleagues found that White people are nearly 35 times more likely to have a buprenorphine-related SUD treatment visit than African American people.⁸⁷

Racial and ethnic segregation has also been correlated to disparate treatment patterns resulting in reduced access to buprenorphine treatment in predominantly African American and Hispanic/Latino counties.⁸⁸ Treatment providers that explicitly serve American Indian or Alaska Native communities had lower rates of agonist-based MOUD maintenance (methadone or buprenorphine).⁸⁹ Additionally, the criminalization of substance use has long impacted the health, social and economic outcomes of PWUD, resulting in disproportionate harms to Black, Indigenous and other communities of color.^{90,91,92}

Individuals with co-occurring mental health and SUD experience further disparities in access to SUD treatment services due to a variety of individual and structural barriers. On an individual level, co-occurring mental illness, such as schizophrenia and psychosis, may lower motivation, create psychosocial instability or impair cognition, all of which may impact an individual's motivation and ability to seek treatment for their SUD.⁹³ On a structural level, availability of services to treat co-occurring disorders, insufficient provider training and service provision challenges were cited as significant barriers to access to treatment, among others. Individuals with co-occurring disorders are more likely to receive mental health treatment only, but not treatment for their SUD, with less than one third of individuals reporting receiving treatment for both conditions.^{94,95}

Further, racial and ethnic disparities are prevalent in access to treatment for individuals with co-occurring disorders. Eunji Nam, PhD, MA, and colleagues found that Black and Latino individuals with co-occurring mental illness and substance use disorders were less likely to receive treatment for both conditions compared to their White counterparts.⁹⁶ Another study found that while Native Americans had the highest prevalence of mental illness, they received mental health assessments least frequently, and of those who were assessed only 20% were referred to mental health services; however, they were most frequently assessed for substance use, which may reflect stereotypical assumptions around substance use rates among Native Americans.⁹⁷

Systemic racism and discrimination, provider bias and a lack of culturally responsive services, among other factors have led to disparate treatment systems and options for different populations;^{98,99} therefore, linkage to care efforts must strive for equity. Recommended action steps to address disparities in access, engagement and outcomes related to SUD care can be found in the strategy areas. Additional tools and resources can also be found in [Appendix B](#).

STRATEGY 1:

Collect data and conduct surveillance.



The first essential public health service is to “assess and monitor population health status, factors that influence health and community needs and assets.”¹⁰⁰ To fulfill this duty, health departments can use surveillance data to identify individuals, populations and geographic areas at high risk for opioid overdose. Having a dedicated data analyst or data team is ideal to ensure that data can be efficiently pulled and analyzed, as well as regularly shared with community partners.



Action Steps

- ❑ Identify and collect key data metrics to understand trends, identify key populations at risk and inform strategy development.
- ❑ Establish data sharing processes with community partners and other government health and social service agencies.
- ❑ Implement data management protocols and data use agreements to ensure patient confidentiality.



IDENTIFY AND COLLECT KEY DATA METRICS TO UNDERSTAND TRENDS, IDENTIFY KEY POPULATIONS AT RISK AND INFORM STRATEGY DEVELOPMENT.

This section details some of the key types of data that can be collected, including both case-level and aggregate population-level data: mortality data, morbidity data and service utilization data.

Mortality Data

Many health departments systematically monitor mortality data for overdose trends. Mortality data is a standard way to describe and better understand substance use and overdose in a jurisdiction. Additionally, it can help raise awareness of geographic areas or clusters of heightened overdose mortality rates, so that health care and related services can be prioritized. Overdose mortality data can also be used to identify the types of drugs and drug combinations being used, which can help inform prevention efforts and consider the needs of populations most at risk for overdose death. Overdose deaths should be stratified, where possible, by intentionality. Key participants in these activities include staff from surveillance epidemiology, mental health and substance use agencies and the medical examiner's or coroner's office.



Mortality Data Epi Tool

An electronic tool developed by the CSTE Overdose Subcommittee aims to make monitoring death certificate data less labor intensive. The program “searches the electronic version of the literal text for references to specific drugs and other words of interest that are included in the cause of death statement and the ‘how the injury occurred’ text box. The program creates additional variables in the data set to record the drug names and number of drugs.”¹⁰¹

Summary statistics from these variables can be used to better understand the frequency of specific drug types and drug combinations in overdose mortality. It can also be used to scan for newly emerging drug trends.

Resources for using mortality data include:

- [Recommendations and Lessons Learned for Improved Reporting of Drug Overdose Deaths on Death Certificates](#) (Council of State and Territorial Epidemiologists [CSTE])
- [Opioid Overdose Prevention: Using Data to Drive Action](#) (CDC)
- [Improving the Timeliness and Quality of State Electronic Death Registration Systems](#) (CDC)
- [Monitoring and Surveillance, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (National Association of County and City Health Officials [NACCHO])
- [RxStat: Technical Assistance Manual](#) (New York City Department of Health and Mental Hygiene)

Morbidity Data

Additionally, several morbidity indicators can help point health departments to populations and areas at increased risk of opioid overdose. Non-fatal overdoses can be tracked via emergency medical service (EMS) runs, ED visits and hospital admissions, hospital billing data, poison control data and naloxone administration reports. However, non-fatal overdose reporting often misses the portion of overdoses that occur when medical care is not summoned.^{102,103}

Among each data source, if the data allow, stratify by demographics (e.g., gender, age group, race and ethnicity) and geography (e.g., neighborhood, ZIP code, census tract) to tailor interventions to their primary populations.

A detailed guide with information on how to use each type of data to assess for trends in morbidity, including ICD-10 codes, can be found in the [RxStat Technical Assistance Manual](#).¹⁰⁴



Overdose Detection Mapping Application Program

For mapping suspected overdose events, the [Overdose Detection Mapping Application Program](#) (ODMAP) was developed by the Washington/Baltimore High Intensity Drug Trafficking Areas (HIDTA). It is a free, mobile-friendly, web-based platform and is in use by more than 2,200 public health agencies. This is one example of a commonly used digital tool that can help facilitate data-sharing across agencies.¹⁰⁵ Some local jurisdictions, however, have reported that ODMAP is not as accurate or timely, compared to other local sources of data.

Service Utilization Data

If information on people receiving SUD treatment is available, these data can be a primary indicator of risk for opioid overdose. Service utilization data can be sourced from traditional SUD treatment providers, including acute medical withdrawal, inpatient care, outpatient care and MOUD programs, as well as harm reduction providers, such as SSPs. Data that is already collected by providers, such as performance data and quality improvement, can be repurposed with an eye toward better understanding where linkages can occur. These data can illustrate where services are being provided and to whom, as well as gaps and missed opportunities in service provision.

Other types of utilization data, such as re-entry services, can be helpful tools. For example, because re-entry to the community after periods of incarceration increases risk for opioid overdose, data on the neighborhoods or areas where people who were formerly incarcerated live may also direct interventions by place.^{106,107}

ESTABLISH DATA SHARING PROCESSES WITH COMMUNITY PARTNERS AND OTHER GOVERNMENT HEALTH AND SOCIAL SERVICE AGENCIES.

Health departments can also play a key role in facilitating data sharing between partners to better identify those at risk of opioid overdose and understand points of entry and possible places to intervene and offer linkages to care. Additionally, providers and stakeholders in the community rely on data provided by local and state health departments to inform their strategies and practices.



“The [local] health department had a great system where they are doing overdose mapping. In the beginning we were looking to coordinate with them to give us hot spots and locations where we could outreach to, to provide care for individuals. . . . we ended up hitting ground zero on our own and combing the street to find out from the community where those hot spots were. It would have been very beneficial as an agency to have access to that system ourselves. . . . direct access to that system would have helped provide us a more readily available sense of the areas that need to be outreached to, or community providers that we can partner with.”

— Tylica Pope, BestSelf Behavioral Health, New York

Syndromic Surveillance

A formalized, rigorous, real-time example of data sharing across sectors is syndromic surveillance of nonfatal overdose.^{108,109,110} Syndromic surveillance is used to detect new and emerging public health issues and monitor trends in near real-time. While a cornerstone of public health, it has only more recently been applied to drug overdose. Syndromic surveillance of non-fatal overdose typically uses ED data, though EMS, poison control and public safety data may be used as well.

In 2016, CDC launched the Enhanced State Opioid Overdose Surveillance program funding 32 states and the District of Columbia.¹¹¹ One of the objectives of this program is to support states in implementing syndromic surveillance of nonfatal overdose drawing on ED and EMS data. These “early warning systems” can be used to detect increases and decreases in nonfatal overdose, changes in drugs used that led to nonfatal overdose and demographic descriptors of patients.

Another opportunity sometimes available to health departments is capitalizing on existing data shares and other spaces where information from multiple sectors come together. These may be regularly collected, maintained and shared data, such as prescription drug monitoring programs (PDMP) or research projects, that analyze one moment or period in time.



Webinar Series on Overdose Surveillance

CSTE hosted a free [four-part webinar](#) on overdose surveillance, focusing on how health departments and partners can “reduce barriers to combine various data sources to build a more complete picture of the overdose burden in their jurisdiction.”

Example from the Field: Hennepin County, Minn.

Hennepin County, Minn., combined data from four public sectors with the objective of understanding cross-sector utilization patterns among Medicaid expansion enrollees, hoping to inform future cost containment measures.¹¹² Important information was gained about PWSUD in the process, which could be used to link individuals to care.

Researchers identified that people enrolled in Medicaid expansion coverage not only visited the ED or were hospitalized at higher rates than the national average, but also had frequent interactions with housing (e.g., shelters, supportive housing), criminal justice and social services (e.g., food support, case management).¹¹³ To understand cross-sector utilization of services, data from four sectors were merged:

1. Health care, including rates of ED, primary care and inpatient visits.
2. Social services, including enrollment in the Supplemental Nutrition Assistance Program, Minnesota Family Investment Program, General Assistance, Social Security, Medicare or Hennepin County case management.
3. Criminal justice, including pretrial detention, post-trial consequences and convictions.
4. Housing, including supportive housing and emergency shelters.¹¹⁴

Among the sample of 98,282 people enrolled in Medicaid expansion, those with both a mental illness and SUD diagnosis, compared to those with only a mental illness diagnosis or a SUD diagnosis, had higher rates of social services utilization, higher rates of criminal justice system involvement and greater cross-sector services utilization. Similarly, compared to other races, Black people reported higher rates across those four categories. By contrast, primary care was most utilized by White people (40.7%) and people with only a mental illness diagnosis (31.3%).

These data suggest opportunities to link people to SUD care outside of traditional clinical care pathways. The data further highlight racial disparities in service utilization and the need to create equitable interventions to best support Black communities and other communities of color. Understanding how these various sectors are connected is critical to Hennepin County's ability to not only link people to care through health care systems, but also through social services agencies, criminal justice and housing supports, as well as identify cost-effective strategies to co-locate or more efficiently refer patients to other services.

Cross-Sector Data Sharing

Within health departments, data sharing across divisions, such as infectious disease, substance use and mental health, can help identify people who are encountering the public health system multiple times. The program collaboration and service integration model is one useful framework for working across interrelated health issues, activities and prevention strategies to facilitate a more comprehensive delivery of services.^{115,116} Findings from cross-divisional data sharing within health departments can inform the co-location of services, facilitate partnerships to leverage resources and enhance coordination of care across divisions.

Health departments can also facilitate voluntary data sharing across SUD treatment providers, SSPs, housing services, EMS, public safety and corrections. Other data sharing mechanisms include legislation and executive action.¹¹⁷ Regular data sharing across sectors can improve the tracking and response to drug overdose. Health department epidemiologists, health information technologists and legal and privacy officers can each play a role in these activities.

Some jurisdictions share only aggregated patient information, while others share patient-specific identified data and each can play an important role in improving care. Sharing aggregated data can assist jurisdictions in assessing larger service utilization patterns, trends across time and by population or service area. Sharing identified patient-level data related to overdose across health and social service providers can enhance coordination of care and ensure caregivers are aligned on individualized risk reduction plans for patients. Any sharing of identifiable patient-level data needs to be clearly communicated to the patient, including the benefits and potential risks to the patient and only with their consent.

Legal and Ethical Considerations Related to Data Sharing

When sharing data across agencies and organizations, it is important to understand how regulations impact what types of data can be shared and with whom. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and section 42 CFR Part 2 of the Public Health Service Act, commonly known as “Part 2,” are two federal laws that govern how patient data can be shared. Part 2 pertains specifically to SUD-related patient information.¹¹⁸ Further, state laws may have more stringent privacy protections than HIPAA or Part 2, so stakeholders involved in data sharing should be aware of any additional limitations in place and identify appropriate strategies to share data.

Additionally, not all providers are covered by Part 2 regulations and may not be subject to these data sharing limitations. To be considered a Part 2 program, providers must meet certain criteria to qualify as a program as defined by 42 CFR § 2.11.¹¹⁹ For more on who is covered under Part 2, see SAMHSA’s [Substance Abuse Confidentiality Regulations](#).

Public Health and Safety Team (PHAST) Toolkit

The CDC Foundation’s [PHAST Toolkit](#) provides guidance for data-driven overdose response coordination among public health, criminal justice, law enforcement and other professional first responders.

Example from the Field: HIDTA, State of Ohio

The HIDTA public health analysts for Ohio have integrated data from a variety of state and federal sources to create county-specific profiles of overdose trends. Local health departments and providers can then use these data to inform resource allocation, policies and programs. Data sources include:

- Overdose fatality data from CDC WONDER and the Ohio Department of Health, Bureau of Vital Statistics.
- Prescription and commercial sale of controlled substances data from the Ohio Board of Pharmacy's Ohio Automated Rx Reporting System and the Automation of Reports and Consolidated Orders System.
- Substance use treatment availability data from The National Survey of Substance Abuse Treatment Services.¹²⁰

Example from the Field: Philadelphia Department of Public Health, Pennsylvania

In 2020, the Philadelphia City Council enacted legislation requiring health care systems to report opioid overdose data to the Philadelphia Department of Health to improve the city's ability to track and respond to overdoses.¹²¹ Under this law, hospitals report the aggregate number of people seen in EDs for substance use-related conditions. In addition to tracking the number of people who present to EDs with an overdose or withdrawal symptoms, these metrics assess the frequency of various overdose response strategies implemented, including:

- Referrals to any SUD treatment, MOUD and buprenorphine.
- Referrals to inpatient rehabilitation, intensive outpatient, outpatient treatment and medically monitored withdrawal.
- Referrals to abstinence-oriented programs (e.g., 12-step programs).
- Placing patients on observation status for treatment.
- Providing naloxone upon discharge from the ED.

Monthly data is submitted to the Philadelphia Department of Public Health on a quarterly basis using REDCap, a secure online data collection and reporting platform. Using these data, the health department can better understand the landscape of substance use in Philadelphia to inform implementation of effective prevention and intervention strategies and identify partners and stakeholders who can meet the needs of the community outside hospital settings.

Overdose Fatality Review Teams

Numerous jurisdictions have established overdose fatality review teams (OFRTs) that bring together experts from various sectors to analyze individual cases of opioid overdose fatality, assess risk factors and opportunities for intervention and inform local policy and programs to prevent future overdoses. Committees use qualitative data gathered from detailed analyses of individual cases with quantitative population data to gain a richer understanding of population trends.¹²² While the aim of most OFRTs is to better understand the causes that contributed to individual overdose deaths, identified patterns, trends and gaps in service can inform improvements to care to prevent future overdose deaths. To better understand the needs of specific communities, the Minnesota Department of Health established culturally specific overdose fatality review teams, including for East African Americans, American-born African Americans and Native Americans.¹²³



Example from the Field: Local Overdose Fatality Review Teams, Maryland¹²⁴

In 2014, the Maryland Department of Health and Mental Hygiene (DHMH) developed three Local Overdose Fatality Review Teams (LOFRT) and provided them individual case data from the Office of the Chief Medical Examiner to review during meetings. Committee members also provided additional information from their respective agency databases, when available. Formal recommendations for policy and practice change are stored in a database housed by DHMH and reviewed to inform recommendations for state partners and to support local overdose prevention initiatives.

Since its inception, the three pilot LOFRTs have met 21 times and discussed more than 70 cases. Committee members reported improvements in their agencies' referral systems to community resources and improved identification of risk factors unique to their own communities that would have otherwise been missed. Following the original pilot programs in Baltimore City, Cecil County and Wicomico County, legislation was passed to establish a framework for this LOFRT approach and, to date, 15 jurisdictions have met or created plans to form their own LOFRT.¹²⁵



Overdose Fatality Review Teams Tools and Resources

- [Overdose Fatality Review resource catalog](#) (Bureau of Justice Assistance Comprehensive Opioid, Stimulant and Substance Abuse Program [BJA COSSAP])
- [Overdose Fatality Review: A Practitioner's Guide to Implementation](#) (BJA COSSAP)
- [Overdose Fatality Review Data Sharing Protocol](#) (BJA COSSAP)

IMPLEMENT DATA MANAGEMENT PROTOCOLS AND DATA USE AGREEMENTS TO ENSURE PATIENT CONFIDENTIALITY.

Protecting patient-specific information and protected health information is critical when sharing data across agencies. Health departments can facilitate these data linkages by providing data use agreement templates and guidance on protecting patient confidentiality and privacy, particularly regarding information around substance use and mental health. Health department legal staff, epidemiologists and statisticians can also provide analytic and technical support around data management and use protocols. The [Center of Excellence for Protected Health Information Resource Center](#) provides guidance, fact sheets and sample templates and forms to assist organizations with sharing data.



Leveraging Data Sharing for Overdose Prevention

ChangeLab Solutions, with support from CDC, developed this [guide](#) providing an overview of health data sharing legislation and strategies for sharing data with stakeholders.



Data Sharing Toolkit

The State Data Sharing Initiative is a grant-funded project that facilitates the sharing of administrative data within state agencies for use in program evaluation and policy analysis. They created a [Data Sharing Toolkit](#) that provides guidance to states on practices to share data safely, confidentially and legally.

Ethical Considerations Related to Data Use

When using and presenting data that is stratified by group, particular care should be taken to ensure that data is not used to further stigmatize groups that have experienced disproportionate impact. For example, when Black, Latinx, Indigenous and other communities of color are over-represented in prevalence, mortality or morbidity data, attention should be paid to the systemic ways racism – specifically, in health care and in SUD treatment – contributes to these outcomes. For more information about ethical considerations for data collection and about applying an equity lens to data collection, see ChangeLab Solution’s [Leveraging Data Sharing for Overdose Prevention](#) and the American Institutes of Research and Robert Wood Johnson Foundation’s [Aligning Systems with Communities to Advance Equity through Shared Measurement](#).



STRATEGY 1 IMPLEMENTATION TOOLS AND RESOURCES

- [Overdose Detection Mapping Application Program \(ODMAP\)](#) (Washington/Baltimore HIDTA)
- [Creating an Action Plan for Opioid Surveillance Data Linkage Webinar Series](#) (CSTE)
- [Epi Tool to Analyze Overdose Death Data](#) (CSTE)
- [Recommendations and Lessons Learned for Improved Reporting of Drug Overdose Deaths on Death Certificates](#) (CSTE)
- [RxStat: Technical Assistance Manual](#) (New York City Department of Health and Mental Hygiene)
- [Opioid Overdose Prevention: Using Data to Drive Action](#) (CDC)
- [Monitoring and Surveillance, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (National Association of County and City Health Officials [NACCHO])
- [Overdose Fatality Review resource catalog](#) (BJA COSSAP)
- [Public Health and Safety \(PHAST\) Toolkit: Guidance for Data-driven Overdose Response Coordination Among Public Health, Criminal Justice, Law Enforcement and First Responders](#) (CDC Foundation)
- [Leveraging Data Sharing for Overdose Prevention: Legal, Health and Equity Considerations](#) (ChangeLab Solutions)
- [Aligning Systems with Communities to Advance Equity through Shared Measurement](#) (American Institutes for Research and Robert Wood Johnson Foundation)

STRATEGY 2:

Develop a public health workforce that supports linkage to care.



The public health workforce must be adequately equipped with knowledge and tools to ensure people at risk of overdose are linked to care. Health departments can employ several strategies to improve workforce preparedness, including training, adopting non-stigmatizing language policies, developing resources and tools, hiring people with lived experience and supporting staff wellness.



Action Steps

- Provide staff training to increase knowledge on substance use, SUD, MOUD, overdose prevention education and use of naloxone and stigma.
- Support academic detailing for providers on substance use-related topics.
- Adopt policies that support non-stigmatizing language use within the organization.
- Develop and disseminate resources and tools to support implementation efforts.
- Hire people with lived experience and provide training on the importance of incorporating the voice of lived experience at every level.
- Hire people who are representative of the community they serve.
- Promote staff wellness through training and support.



PROVIDE STAFF TRAINING TO INCREASE KNOWLEDGE ON SUBSTANCE USE, OVERDOSE AND LINKAGE TO CARE.

Opportunities to link people at risk of overdose to care can happen across numerous settings and programs; therefore, it is important that your community's public health workforce has a basic understanding of SUDs, overdose risk and the availability of treatment and services, including MOUD. All health department staff, even those who do not work directly on substance use-related issues, should receive foundational training and education on substance use. Staff who work directly on substance use-related issues should receive more advanced training. A checklist of recommended staff trainings is below. Training can be provided internally by health department staff, or externally by engaging with an expert trainer. Training resources are also available in [Appendix B](#).

All Staff Training Topics Checklist

- Overview of SUDs, including OUD.
- Overview of evidence-based treatment and services for PWUD, including MOUD and harm reduction.
- Overview of naloxone and how to access it in the community.
- Avoiding stigmatizing language.
- Overview of the resources available for PWUD and PWSUD in the community.

Additional Training for Staff Directly Involved with Substance Use-related Activities

- Science of SUD, including OUD.
- Science of opioid withdrawal.
- Recovery-oriented principles and approaches.
- Trauma-informed principles and approaches.
- Science of MOUD, including all three FDA-approved medications.
- Co-occurring SUD and mental health challenges.

Training Resource

The Providers Clinical Support System (PCSS) offers an extensive catalog of 22 self-guided training modules on a range of introductory topics related to SUDs in its [Substance Use Disorder 101 Core Curriculum](#). All trainings are free-of-charge.

In addition to foundational training on SUD, opportunities exist for health departments to promote and support training for providers seeking their x-waiver to prescribe buprenorphine for OUD. These training activities are discussed in [Strategy 5](#).

SUPPORT ACADEMIC DETAILING FOR PROVIDERS ON SUBSTANCE USE-RELATED TOPICS.

Academic detailing is an educational outreach strategy that provides clinicians with education, data, tools and resources on a range of health topics and clinical challenges with the goal of improving health care quality. Providing tailored education helps ensure that clinicians have the most up-to-date information and tools to enhance service delivery and best support their patients. Some health departments may provide academic detailing directly, but more often, health departments fund the work through contracts with clinicians from external organizations, such as community-based health providers. The National Resource Center for Academic Detailing (NaRCAD) was founded in 2010 to provide technical assistance and capacity-building resources for academic detailers and expand the reach and impact of clinical outreach education. Academic detailing can be used to improve community clinicians' knowledge, attitudes and treatment of patients with SUDs, and has been used to educate physicians on MOUD, safe prescribing and opioid overdose prevention.



Academic Detailing Tools and Resources

- [Introductory Guide to Academic Detailing](#) (NaRCAD)
- [Example Academic Detailer/Clinical Educator Job Description](#) (NaRCAD)
- [Example Opioid Safety Support Academic Detailing Flyer](#) (NaRCAD)
- [Academic Detailing Program Building Resources](#) (NaRCAD)
- [Local Opioid Overdose Prevention Using Academic Detailing: Implementation Guide 2019](#) (NaRCAD)

ADOPT POLICIES THAT SUPPORT NON-STIGMATIZING LANGUAGE USE WITHIN THE ORGANIZATION.

Because pervasive discrimination, stigma and shame are barriers to care for many PWUD and PWSUD, it is important that the public health workforce adopts policies and practices that reinforce evidence-based truths related to substance use and reject myths and misperceptions.^{126,127} Adopting policies related to using person-first, non-stigmatizing language standardizes language across an organization and offers an opportunity to educate staff on why stigmatizing language is harmful to PWUD and PWSUD. All staff should receive training on using non-stigmatizing language that is person-first. Several training resources and guides exist, including the Shatterproof [Addiction Language Guide](#), which provides recommended language and the rationale for preferred terms and implementation tools. Additional training resources can be found in [Appendix B. Resources and Tools to Support Strategies for Linkage to Care](#).



Example from the Field: Person First Guidelines, Philadelphia, Pa.

To promote the use of non-stigmatizing, strengths-based language, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services developed [Person First Guidelines](#). The guidelines identify person-first and strengths-based terms for staff to use that replace phrases that are stigmatizing or deficit-based. To inform the development of the guidelines, a Person First Taskforce was convened, which included people with lived experience of substance use and mental health challenges. The Person First Guidelines are regularly updated as language related to substance use is continually evolving.

DEVELOP AND DISSEMINATE RESOURCES AND TOOLS TO SUPPORT IMPLEMENTATION EFFORTS.

Local and state health departments are uniquely positioned to develop and disseminate resources and tools to support public health efforts to link individuals at risk of overdose to care. Drawing from local data, resources and partners, substance use staff within health departments can craft resources that are specifically tailored to local needs. Examples of resources and tools could include toolkits, checklists, training curricula and fact sheets, among others. Several state health departments and public health associations have developed toolkits to address opioid use and prevent overdose using the [10 Essential Public Health Services](#) framework. Because these toolkits are informed by local data, legal and regulatory considerations and resources, they offer local public health agencies and community-based organizations specific actionable recommendations that are relevant for their communities. Recommendations for the types of information that could be included in a toolkit are below.



Recommended Toolkit Components

- Sources of local data related to opioid use, SUD and overdose.
 - » Syndromic surveillance data (near-real-time monitoring of a disease or condition using automated data collection and analysis. For more information, see CDC’s [“What is Syndromic Surveillance?”](#) and [“New to Syndromic Surveillance?”](#)).
 - » Interactive dashboards.
 - » Medical examiner statistics.
 - » Emergency medical services data.
 - » ODMAP data.
 - » PDMP data.
- Information on local laws and regulations related to opioid overdose prevention (e.g., Good Samaritan laws and standing naloxone orders).
- Health education and promotion resources.
- Care coordination resources, including provider directories and harm and risk reduction planning tools.
- Training resources and opportunities for public health and community-based workers.
- Local OEND information.
- SSPs and other harm reduction services.
- Local SUD treatment resources.
- Local recovery support and mutual aid groups.
- Local housing resources.
- Social and economic support services.
- Local coalitions and opportunities for collaboration.
- Funding opportunities to support overdose response and linkage to care initiatives.
- Resources for conducting program evaluation.

Examples from the Field: Essential Services Toolkits Connecticut, Massachusetts and North Carolina

- [Opioid and Substance Use Disorder Toolkit for Connecticut](#) (Connecticut Association of Directors of Health)
- [North Carolina Essential Actions to Address the Opioid Epidemic: A Local Health Department's Guide](#) (North Carolina Department of Health and Human Services and North Carolina Association of Local Health Directors)
- [Essential Measures: A Local Public Health Toolkit for Addressing the Opioid Epidemic](#) (Massachusetts Health Officers Association and Education Development Center)

HIRE PEOPLE WITH LIVED EXPERIENCE AND PROVIDE TRAINING ON THE IMPORTANCE OF INCORPORATING THE VOICE OF LIVED EXPERIENCE AT EVERY LEVEL.

People with lived experience of substance use, including friends and family of PWUD or PWSUD, bring incredibly valuable knowledge, skills and expertise not only to substance use-related services, but also to other public health programs and the workforce in general. Peer support services are increasingly recognized as a critical component to overdose response and linkage to care efforts. Peer support workers are people with lived experience of substance use who have completed specialized training to provide support to PWUD and PWSUD.¹²⁸ Given their lived experience and training, peer support workers are not only skilled at helping others navigate the recovery process and facilitate connections to SUD treatment and recovery supports, but are also viewed as credible, trusted messengers who can connect more easily with PWUD and PWSUD.¹²⁹ A growing number of studies show that PSS improve substance use-related outcomes.¹³⁰ There are four general types of PSS: emotional, informational, instrumental and affiliational (Table 3).¹³¹



Peer Support Worker

There are different terms for and types of peer-based positions, including peer navigator, peer specialist, recovery specialist, recovery coach, peer practitioner and certified peer specialist, among others. Throughout this document, we will use “peer support worker” except when referring to specific types of peer positions.

Table 3. Types of Support and Examples of Peer Support Services^{132,133}

Type of Support	Description	Examples of Peer Support Services
Emotional	Demonstrate empathy, caring or concern to bolster a person’s self-esteem and confidence.	<ul style="list-style-type: none"> • Peer mentoring and coaching • Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	<ul style="list-style-type: none"> • Provide OEND • Offer training, education and information, including related to: <ul style="list-style-type: none"> » Job readiness » Parenting » Wellness » Self-advocacy
Instrumental	<p>Provide concrete assistance to help others accomplish tasks.</p> <p>Increase access and opportunities; reduce barriers.</p>	<ul style="list-style-type: none"> • Assist in navigating the SUD treatment system • Link to community health and social services • Link to harm reduction services and supports • Assist in obtaining transportation passes • Assist in securing safe housing
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.	<p>Arrange outings or activities, including:</p> <ul style="list-style-type: none"> • Recovery center events and meetings • Sports league participation • Lunches • Socialization opportunities • Celebrations, such as reaching personal goals or milestones

Because peer support worker roles can vary depending on the program or setting, and because peer support workers provide a wide range of services, it is important to delineate their roles and responsibilities. Generally, peer support workers provide services and supports to help people develop personal goals and support them across a continuum of recovery. Not all peer support workers are necessarily treatment-focused, as some work primarily in harm reduction and overdose prevention. However, typically, peer support workers do not diagnose, assess or treat individuals. Table 4 offers guidance on what peer support workers generally do and don’t do. An example of a peer support worker role within an overdose response program is in [Appendix F](#).

Table 4. What Peer Support Workers Do and Don't Do

Peer Support Workers Do:	Peer Support Workers Don't:
Share lived experience.	Give directives.
Motivate through hope and inspiration.	Motivate through fear or shame.
Support many pathways to recovery.	Support only one pathway to recovery.
Guide or accompany others in accomplishing daily tasks.	Do tasks for others.
Provide informational, instrumental, emotional and affiliational support.	Provide counseling.
Use language based on common experiences.	Use clinical language or language specific to only one recovery pathway.
Teach others how to acquire needed resources, including money.	Give resources and money to others.
Help others find professional services from lawyers, doctors, psychologists and financial advisors, among others.	Provide professional services.
Encourage, support and praise.	Diagnose, assess and treat.
Help others set personal goals.	Mandate tasks and behaviors.
Role model positive recovery behaviors.	Tell others how to lead their lives in recovery.

Peer support workers focused on overdose prevention and linkage to care efforts are employed by a range of different organizations, including health departments, hospitals, EDs, SUD treatment agencies, recovery community centers, recovery residences, SSPs, first responder agencies (e.g., EMS and police departments), correctional settings and primary care settings, among others.



Example from the Field: Waterbury Department of Public Health, Connecticut

The Waterbury Department of Public Health in Connecticut recently implemented a comprehensive plan to address substance use and prevent overdose. Peer support workers are integrated into several overdose prevention, response and linkage to care efforts, including the Waterbury Warm Hand-off program.¹³⁴ The program employs Overdose Response Technicians, people with lived experience of substance use with training from the [Connecticut Community for Addiction Recovery \(CCAR\)](#), to connect with people who have experienced an overdose. (An example of the Overdose Response Technician job description is in [Appendix E](#).) In addition, overdose response technicians help address misperceptions of PWUD and PWSUD among police, health department staff and hospital staff by sharing personal stories, providing trainings and connecting with staff individually. Supervisors of the Warm Hand-off program from the health department and police department also participated in CCAR training to better understand the role of recovery coaching and to better support the Overdose Response Technicians. Funding for the Warm Hand-Off program is provided by the Office of National Drug Control Policy's [Combating Opioid Overdose through Community-level Intervention](#) program.¹³⁵

PROMOTE STAFF WELLNESS THROUGH TRAINING AND SUPPORT.

Because public health staff, particularly peer support workers, employed within overdose prevention and response programs face high rates of stress and trauma, they should have access to resources and information to support their own wellness.¹³⁶ The Massachusetts Department of Public Health identified 10 actions organizations can take to help prevent compassion fatigue, secondary traumatic stress and vicarious trauma among staff who are exposed to overdose in their work.¹³⁷ Additional strategies to support staff wellness include providing adequate pay and benefits and creating safe spaces to debrief, whether one-on-one or as a team.

10 Actions to Support Staff Wellness (Massachusetts Department of Public Health)

1. Assess your organization's preparedness. Numerous assessment tools are available for trauma-informed care, but agencies should consider using a tool, such as the [Vicarious Trauma Organizational Readiness Guide](#).
2. Clearly establish helping staff cope with the aftermath of overdose fatalities as an organizational objective.
3. Recognize that staff reactions to trauma and distress is normal; establish staff's exposure to trauma and stress as a normal topic of discussion; and encourage colleague-to-colleague support for issues related to trauma and stress.
4. Ensure that staff are assigned reasonable caseloads and workloads and that concerns about adequate client resources are addressed.
5. Include instruction and practice focused on traumatic stress and self-care in all professional development activities.
6. Provide relationally based, trauma-informed clinical supervision with sufficient regularity to meet staff needs.
7. Engage staff meaningfully in organizational planning, development and quality assurance for all services.
8. Acclimate frontline service providers to the nature of the overdose crisis and the reality that they may be exposed to deaths during their work—beginning during hiring practices and continuing through ongoing training and support.
9. Recognize that public concern about the opioid crisis is marginal because overdose deaths are stigmatized and validate for staff the magnitude of the epidemic and the effects of stigma on them (in other words, buffer how stigma marginalizes and isolates them).
10. Implement a protocol based on current best practices for rescuing someone who has overdosed, including a quality assurance process that involves staff in determining that they are doing all that reasonably can be done to respond effectively to life-or-death situations to which they are exposed.



STRATEGY 2 IMPLEMENTATION TOOLS AND RESOURCES

- [SUD 101 Core Curriculum](#) (PCSS)
- [Introductory Guide to Academic Detailing](#) (NaRCAD)
- [Academic Detailing Program Building Resources](#) (NaRCAD)
- [Peer Support Toolkit](#) (Philadelphia Department of Behavioral Health and Intellectual disAbility Services)
- [Coping with Overdose: Tools for Public Health Workers](#) (Massachusetts Department of Health)

STRATEGY 3:

Increase overdose awareness among providers and community members.



In addition to ensuring that health department staff are knowledgeable about SUD, overdose risk and available treatment and services, it is equally important that community-based providers, organizations and community members are aware of overdose risk and how to help people who may be at risk of unintentional overdose.



Action Steps

- ❑ Develop public education and awareness campaigns.
- ❑ Conduct community training and education on substance use-related topics.
- ❑ Ensure community outreach and engagement efforts are culturally responsive and tailored to specific groups.



DEVELOP PUBLIC EDUCATION AND AWARENESS CAMPAIGNS.

Many jurisdictions have developed public education and awareness campaigns to prevent opioid overdose. Health departments should use a range of different media and communication tools to disseminate messages to the public, including billboards, public press, social media, flyers, handouts and recorded videos, among others. Additionally, messages should be tailored for specific audiences and available in all of the languages spoken in the community. Outreach and education materials should be developed through collaboration with health department substance use staff and health communications staff and include information about how to respond to someone experiencing an overdose, information about how to access SUD treatment services, specific overdose risks, such as fentanyl and information about how to access naloxone in the community. People with lived experience should be involved in the development of public education and awareness materials. Stakeholders from the intended audience should pilot test materials prior to wide dissemination.



Decisions in Recovery: Treatment for Opioid Use Disorder

A useful tool to educate community members about MOUD is [Decisions in Recovery](#), a SAMHSA-funded initiative that provides fact sheets, testimonials and videos about MOUD and other recovery services and supports.



Example from the Field: San Francisco Department of Public Health

The San Francisco Department of Public Health provided funding and resources to the National Harm Reduction Coalition to gather recommendations from PWUD in San Francisco to inform a public messaging campaign to raise awareness of fentanyl.¹³⁸

The project activities included:

1. Reviewing existing data and patterns of fentanyl-related overdose in San Francisco, with a focus on understanding fentanyl overdose among non-opioid users.
2. Identifying organizations and stakeholders to participate in a series of focus groups and key informant interviews.
3. Developing a focus group facilitator guide and key informant interview guides.
4. Conducting focus groups and key informant interviews with 20 people and conducting follow-up interviews for message testing and refinement.
5. Compiling the findings into a report, including recommended messaging strategies.¹³⁹

Findings in several considerations related to the types of messages that were needed, the images of substances and people that should be used in the campaign, the type of foundational information that should be included (e.g., a brief description of what fentanyl is), the tone of language that should be used for messaging and which areas campaign messages should be posted (e.g., public transportation stations and libraries in specific neighborhoods).¹⁴⁰



Examples of Overdose Response Public Education Materials

- [KNOW Overdose public campaign posters](#) (National Harm Reduction Coalition and San Francisco Department of Public Health)
- [Iknowmine.org](#) (Alaska Native Tribal Health Consortium)
- [Navigating the Substance Use Disorder System of Care video series](#) (New York State SUD Treatment Insurance Workgroup)
- [Washington Tribal Opioid Solutions public campaign](#) (Washington State Health Care Authority)
- [Rx Awareness](#) (CDC)

CONDUCT COMMUNITY TRAINING AND EDUCATION ON SUBSTANCE USE-RELATED TOPICS.

In addition to developing public education campaigns, trainings conducted with community members and groups offer opportunities to not only educate others, but also better understand the needs of community members. Substance use staff from the health department are ideally situated to deliver these trainings, and trainings can also be externally contracted with a training provider. Potential audiences for community trainings could include housing providers, correctional staff, group living residences, public library staff, faith-based organizations, professional associations and schools, among many others.



Recommended Training Topics for Community Members

- Overview of SUDs, including OUD, including the impact on the local community.
- Overview of evidence-based treatment and services for PWUD, including MOUD and harm reduction.
- Overview of naloxone and how to access it in the community.
- Information on Good Samaritan laws and other related policies.
- Resources available for PWUD and PWSUD and their friends and family in the community.



Example from the Field: Philadelphia Department of Public Health

The Philadelphia Department of Public Health hosts an online [Opioid Speaker Request Form](#) in which community members and organizations can request a presentation from a public health expert in the health department. Presentation topics include: an overview of opioids, how Philadelphia has been impacted by opioids and other drugs, what the City and its partners are doing to address the opioid crisis and what community members can do to help.¹⁴¹ In addition to the speaker request form, the city offers information on how community members can access OEND at its [website](#).

ENSURE COMMUNITY OUTREACH AND ENGAGEMENT EFFORTS ARE CULTURALLY RESPONSIVE AND TAILORED TO SPECIFIC GROUPS.

When conducting outreach to community members, it is important that messages and materials are culturally responsive and relevant to intended audiences. A checklist of considerations when developing outreach and education materials follows.



Considerations for Developing Culturally Responsive Outreach Materials¹⁴²

- Do the messages in the materials reflect the beliefs and practices of the intended community?
- Are the materials available in the languages spoken by the intended community?
- Have the social, environmental and political contexts of the community been taken into consideration when developing materials?
- What types of images or pictures will resonate with the intended community?
- Have people from the community contributed to the development of materials?
- Who will be the best messenger of the information for the community?
- Which partners are credible messengers and trusted by community members?
- What forms of communication are most effective for reaching the intended community members (e.g., social media, flyers, word-of-mouth)?



Example from the Field: Hennepin County Public Health, Minnesota

The Hennepin County Public Health Department has developed culturally responsive outreach efforts to engage communities disproportionately impacted by overdose and those that are underserved in the county. In 2018, the opioid-related overdose death rate among American Indians and Alaska Natives was nearly seven times higher than African Americans and 16 times higher than White people.¹⁴³ To better engage American Indian and Alaska Native and other communities impacted by overdose, a task force created culturally tailored education and training materials. The training material development was led by an expert on developing culturally responsive trainings related to substance use. When training materials are developed, they are used in a “train the trainer” model to equip credible messengers within communities to deliver the trainings, rather than having a health department staff person or someone external to the group conduct the training.



STRATEGY 3 IMPLEMENTATION TOOLS AND RESOURCES

- [Decisions in Recovery](#) (SAMHSA)
- [Prevention, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (NACCHO)

STRATEGY 4:

Support cross-sector collaboration and partnerships.



Local and state health departments can play a pivotal role in identifying partners across their jurisdictions and convening stakeholders who share a common goal of linking people at risk of unintentional overdose to care. Through establishing formal and informal partnerships and facilitating collaboration, health departments can raise awareness of available resources in the community and foster relationships between service providers that can benefit patients seeking care.



Action Steps

- ❑ Identify key partners within and across sectors and develop meaningful relationships with partners to gain buy-in and support.
- ❑ Identify and participate in existing collaboratives and coalitions.
- ❑ Develop and maintain a directory of relevant services for PWUD and PWSUD for your jurisdiction, if one does not already exist, and disseminate to partner organizations and stakeholders.
- ❑ Leverage the health department as a convening organization to incentivize linkage to care activities.





“In order to get stakeholders to buy in and build those personal relationships, sometimes you have to give on things that aren’t part of your job or related to the end goal, but it’s something they want. For example, we go to a range of trainings, even though they’re not directly related to our work. It’s all about building relationships, remembering people’s names, remembering to ask about their kids.”

— Zach Kosinski, Harm Reduction Program Coordinator, Harford County Health Department, Maryland

IDENTIFY KEY PARTNERS WITHIN AND ACROSS SECTORS AND DEVELOP MEANINGFUL RELATIONSHIPS WITH PARTNERS TO GAIN BUY-IN AND SUPPORT.

Awareness of the existing health care providers, treatment providers, community-based organizations and other stakeholders that interact with PWUD and PWSUD in your jurisdiction is the first, most basic element of supporting partnerships. Within the health care sector, does the health department have a working relationship with clinical providers across the continuum of care – outpatient, inpatient and residential treatment – and harm reduction providers? Emergency departments and primary care providers who may see PWUD and PWSUD in their practices? Mental health, infectious disease and other specialty care providers? It may be that the bureau responsible for substance use is not connected to some external partners, but other health department bureaus are and can serve as a liaison.

Outside of health services, the health department can benefit from having a familiarity and working relationship with sectors that come in contact with and impact the lives of people who are at risk of overdose and whose services and policies may impact linkage to care. Corrections, probation and parole, police, public defenders and the courts; affordable housing and services for people experiencing housing instability; cash assistance and other social services; and education and vocational services are all potentially meaningful partners in linking people to care.

Partnerships and collaborations are more fruitful when you understand in detail the ways in which programs operate and how workflows are managed. Take time to understand how people move through each of these systems, with an eye towards key opportunities for linkages to care.



Partnering for Health Equity

The Prevention Institute’s report, [Partnering for Health Equity: Grassroots Organizations on Collaborating with Public Health Agencies](#), details interviews with grassroots organizations across the U.S. to better understand community perspectives on partnering with public health departments. With a focus on health equity, the report identifies structural factors, organizational practices and ways of navigating partnerships that have proven effective.



Example from the Field: Harford County Health Department, Maryland

In Harford County, Md., the health department receives weekly overdose data and real-time alerts to overdoses through ODMAP and shares these data with community organizations that may otherwise not be able to easily access this information. These data enable trusted community organizations to better serve their participants through targeted outreach, education and supply distribution.

Harford County also works closely with recovery community organizations and harm reduction organizations to provide supplies for their SSP, as well as offer support in developing capacity to provide harm reduction services. As a trusted agency in the community, the health department has been instrumental in helping build relationships with partners and stakeholders, such as law enforcement, and creating buy-in in the community. It often serves as a convener to bring various stakeholders together at community meetings, where multi-disciplinary groups may present together on an issue to achieve buy-in among their respective field. For example, a person in recovery presenting alongside a law enforcement officer helped build trust in law enforcement among the recovery community, and also validated SUD as a health concern, not a criminal justice issue, from the perspective of law enforcement.

In rural Harford County, it has not always been easy to achieve buy-in with stakeholders. In some cases, the health department has provided trainings that stakeholder groups expressed an interest in, such as suicide prevention trainings, or staff have built personal relationships with individual stakeholders. Demonstrating an interest in stakeholders outside their role in linkage to care has been critical to their success in building meaningful relationships.

While Harford County has developed strong relationships with community partners, the health department continues to identify strategies to improve linkage to care, including learning from other health departments. In the neighboring Cecil County, the health department receives overdose data from the sheriff's office and EMS and shares these data with a peer-run community organization that then conducts outreach to PWUD in the community. Harford County is currently working to implement a similar model to collect and share more detailed overdose data with community partners.



Quick Tip: Shadow Partner Programs and Agencies

A great way to learn how a program works from the inside is to shadow the program for a short period of time if staff consent and patient confidentiality is not breached. Having peer support workers participate in ride-alongs with police officers can help peers understand how police respond to calls and identify training opportunities for police officers. Health department staff can shadow mobile homeless outreach teams to learn how they interact with people experiencing homelessness on the street, address barriers to engagement and make novel linkages. Outpatient treatment staff may benefit from touring a harm reduction program, and criminal justice staff may benefit from shadowing an OTP.

Health departments can also greatly improve their impact and effectiveness by partnering with community-based organizations led by and for people impacted by substance use. Organizations and alliances such as these can help inform health departments of new and ongoing trends, as well as help champion health department policies and programs.



“Increasingly, [health] departments approach the communities they work in as equal partners, seeing residents and community-groups as bearers of solutions, ingenuity and power, rather than as “consumers” of safety-net care, recipients of services or clients in health education. In this work, public health rarely sees itself ‘at the center’ of health efforts, but increasingly views itself as lending its resources, skills and capacity to advance community-defined priorities. . .”

— Prevention Institute¹⁴⁴

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHCs) are a new Medicaid provider type that offer comprehensive community-based mental health and SUD treatment and services. Originally authorized by the Protecting Access to Medicare Act of 2014 as a demonstration program in eight states, CCBHCs now operate in 40 states through more than 340 sites.^{145,146} Similar to federally qualified health centers (FQHCs), CCBHCs are non-profit organizations whose services must be available to everyone, regardless of ability to pay.¹⁴⁷ Additionally, evaluation results also show that CCBHCs have been effective at decreasing patient wait times for services.¹⁴⁸ A survey of CCBHCs conducted in November 2018 showed that 46% of CCBHCs indicated that their average wait time was less than a day for services.¹⁴⁹ To find CCBHCs, the National Council maintains a [CCBHC Locator Map](#) that identifies individual CCBHCs at the county level.

While the specific types of services provided by each CCBHC differ based on local needs, every CCBHC offers a comprehensive range of services provided directly or through a referral agreement that includes:

- 24-hour crisis management services.
- Screening, assessment and diagnosis, including risk assessment.
- Patient-centered treatment planning.
- Outpatient mental health and SUD services.
- Primary care services or partnerships with primary care providers, including FQHCs and rural health clinics.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer recovery support services.
- Intensive, community-based mental health care for members of the armed forces and veterans.¹⁵⁰

Because CCBHCs are equipped to address a range of needs related to mental health and substance use, partnerships between health departments and CCBHCs are incredibly valuable to ensure people are linked to appropriate care and services. Additionally, CCBHCs are well connected with other existing community-based organizations that serve PWUD and PWSUD. Services for PWUD and PWSUD are a core component of CCBHCs and nearly all CCBHCs offer MOUD.¹⁵¹ In rural areas and areas with a lack of MOUD providers, CCBHCs have been critical to increase access to evidence-based treatment.



“Prior to becoming a CCBHC, one of our clients who received psychiatric care at Swope Health Services would drive a 250-mile round trip for Suboxone treatment for his opioid addiction. During this time, he was struggling to maintain a job and attend other treatment services. Now that we are a CCBHC, he can get his MAT service at Swope, much closer to home.”

— Swope Health Services, Missouri¹⁵²

Numerous CCBHCs have partnered with local and state health departments, public safety, EMS, hospitals and EDs and other organizations and agencies to develop coordinated overdose response and linkage to care programs and services.



Example from the Field: New Britain Recovers, Connecticut

New Britain Recovers is a collaboration between the New Britain Health Department, the Connecticut Department of Public Health, Community Mental Health Affiliates (a CCBHC), the Hospital of Central Connecticut, New Britain EMS, New Britain Fire Department, New Britain Police Department, Greater Hartford Harm Reduction Coalition and other community-based organizations created in January 2019 to address the opioid crisis in the community.¹⁵³ New Britain Recovers has adopted a trauma-informed, recovery-oriented system approach that includes training staff and partners on trauma-informed principles and having paramedics and other responders receive certification as recovery coaches.

The collaboration is focused on several initiatives to better respond to overdose and link people to care, including:

- 1.** Providing education and training to community members and partners.
- 2.** Establishing an overdose response team that follows up with people who have experienced an overdose within 48 hours to link them to care and services.
- 3.** Establishing the Heroin, Opioid, Prevention and Education (HOPE) initiative, a collaboration between first responders, the local CCBHC, hospitals and other community providers that trains police officers on how to link people at risk of overdose to care rather than arresting for substance use-related crimes.
- 4.** Establishing a safe station model within an EMS station where people can go without fear of arrest to receive assistance by an EMS recovery health navigator.
- 5.** Launching a mobile MOUD initiative.

The New Britain Recovers [website](#) offers community members resources including where to find naloxone, treatment providers, recovery and mutual aid support meeting locations, support for family members, harm reduction services, legal services and other community-based services and supports. Between 2018 and 2020, there was a significant reduction in opioid-involved overdose deaths in New Britain from 43 in 2018 to 20 in 2020.¹⁵⁴

The CCBHC, Community Mental Health Affiliates, offers the collaboration a range of treatment services and supports to address the needs of people at risk of overdose, including a “living room”-style drop-in center where people can rest, access food and initiate MOUD. Community Mental Health Affiliates also engages in extensive street outreach based on the principle of “meeting people where they’re at” and has established partnerships with diverse community organizations, including faith-based centers and a faith-based recovery house that provides housing to people re-entering the community from incarceration. Community Mental Health Affiliates also conducts in-reach services to correctional facilities to link people to services and care, including MOUD, prior to release.

IDENTIFY AND PARTICIPATE IN EXISTING COLLABORATIVES AND COALITIONS.

Coalitions and alliances, both public and private, can be excellent resources to health department bureaus of substance use services. Organizations funded by federal, state and private donors may already be convening to discuss issues pertinent to opioid use, overdose risk and linkage to care. Additionally, health department leadership on community coalitions has been correlated to lower rates of opioid-related ED visits per opioid analgesic script dispensed.¹⁵⁵ A study conducted in North Carolina found that counties with funded coalitions led by the local health department had a 27% lower rate of opioid-related ED visits.¹⁵⁶ The Connecticut Association of Directors of Health, for example, hosts a [list](#) of existing local, regional and statewide partnerships and alliances that address substance use.¹⁵⁷

Even if there are not groups specifically centered on opioid use, groups devoted to other topics that can be adjacent to opioid use can be valuable places to insert a discussion around opioid use and overdose risk. For example, task forces on housing and homelessness or mental health can provide valuable in-roads, as can trade groups within the treatment system, faith-based groups and local business sectors.

DEVELOP AND MAINTAIN A DIRECTORY OF RELEVANT SERVICES FOR PWUD FOR YOUR JURISDICTION AND DISSEMINATE TO PARTNER ORGANIZATIONS AND STAKEHOLDERS.

Resource inventories that are frequently updated are valuable resources to individuals working with PWUD and PWSUD. These inventories can be used to help link an individual to the type of care they need or request, at the time that they need it.



Example from the Field: Help is Here, Delaware Division of Public Health

The Delaware Division of Public Health created [Help is Here](#), an online directory of resources and providers in Delaware, to provide people with mental health conditions or SUD or their friends and family easy access to information and care options in their community.¹⁵⁸ In addition to listing clinics and providers, Help is Here offers video testimonials from people in recovery, education on addiction and opioid prescribing practices and overdose prevention information, including where naloxone is dispensed.

LEVERAGE THE HEALTH DEPARTMENT AS A CONVENING ORGANIZATION TO INCENTIVIZE LINKAGE TO CARE ACTIVITIES.

Within sectors, there may be providers who are unfamiliar with each other. For example, within the SUD treatment system, residential treatment providers may be unfamiliar with outpatient programs or harm reduction programs. Across sectors, it is very likely that individuals who work in one sector that may impact patients' overdose risk and linkage to care are unaware or unfamiliar with programs in other sectors. When stakeholders have a common goal, linking a patient to care, the health department's substance use staff can play a key role in convening them to raise awareness and foster collaboration.

Health departments can formally do this in a variety of ways. Convening a task force or learning collaborative, holding a monthly breakfast meeting for stakeholders across the jurisdiction, or posting a periodic electronic bulletin that spotlights a new provider each month, each can help educate stakeholders of the other organizations in their jurisdiction and help facilitate relationship building.

Health departments can informally forge partnerships as well, particularly when focused on a specific geographic region, topic or population (e.g., youth, LGBTQ+ communities, people engaged in sex work, etc.). While organizations that may be doing similar activities in similar areas may not know of each other, the health department may be able to connect the organizations so they can more strategically serve their populations.



Tools and Resources

- [Stakeholders and Partnerships, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (NACCHO)
- [Mobilizing Community Partnerships in Rural Communities: Strategies and Techniques](#) (NACCHO)
- [Aligning City, County and State Resources to Address the Opioid Epidemic: Lessons Learned and Future Opportunities](#) (National League of Cities)



Example from the Field: Philadelphia Department of Public Health, Pennsylvania

To facilitate greater collaboration with the local hospital EDs, the Philadelphia Department of Public Health's health commissioner forged relationships with each ED's chief medical officer by personally reaching out to each chief medical officer to offer support. The health commissioner meets with each ED leadership team on a semiannual basis to understand the current trends and experiences of ED providers, offer support and resources and collaboratively identify strategies to address challenges. Meeting with hospital leadership on an individual basis, rather than in a group setting, fosters an environment where hospital leaders may feel more open to sharing challenges in addition to successes. Developing a one-on-one relationship between the health department and local hospitals has helped break down silos and led to joint initiatives related to increasing buprenorphine access within EDs and increased data sharing. In addition to the semiannual meetings with the health commissioner, health department staff communicate and work with ED staff regularly.



STRATEGY 4 IMPLEMENTATION TOOLS AND RESOURCES

- [Partnering for Health Equity: Grassroots Organizations on Collaborating with Public Health Agencies](#) (Prevention Institute)
- [Stakeholders and partnerships, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (NACCHO)
- [Mobilizing Community Partnerships in Rural Communities: Strategies and Techniques](#) (NACCHO)
- [Aligning City, County and State Resources to Address the Opioid Epidemic: Lessons Learned and Future Opportunities](#) (National League of Cities)

STRATEGY 5:



Provide linkage to care services directly or by funding community partnerships.

There are a growing number of health departments that provide linkage to care services for people at risk of overdose directly or by funding community partners to provide linkage to care services. Common types of overdose prevention and linkage to care models include public safety and public health overdose response teams, ED-based MOUD initiation, peer support programs and mobile response teams. Additionally, health departments can support linkage to care efforts by expanding MOUD treatment availability and addressing social and structural barriers to care. This section provides an overview of existing types of linkage to care models and key planning and implementation considerations.



Action Steps

- Expand MOUD treatment availability.
- Expand access to harm reduction services.
- Address additional social and structural barriers to care.
- Implement linkage to care interventions.



EXPAND MOUD TREATMENT AVAILABILITY.

Despite being the gold standard treatment for OUD, MOUD remain largely unavailable in many communities across the U.S. In 2018, 40% of counties in the U.S. did not have a waived provider to prescribe buprenorphine for OUD.¹⁵⁹ Significant disparities in MOUD treatment access exist.^{160,161,162,163} People living in rural areas also face significant challenges to accessing MOUD.^{164,165} In 2018, 72% of counties with low-to-no patient capacity for prescribing buprenorphine for OUD were located in rural areas.¹⁶⁶ In 2011, more than 95% of medium and small nonmetropolitan counties had a shortage of OTPs, limiting access to methadone treatment for OUD.¹⁶⁷ Because of accessibility challenges in so many communities, MOUD are widely underutilized, with only approximately 18% of people with OUD receiving MOUD in 2019.¹⁶⁸ Health departments can improve access to MOUD by developing and promoting training and mentorship programs to increase the number of buprenorphine-waivered prescribers; working with health care provider organizations to establish incentive programs and supporting telehealth models of OUD care. Most importantly, the success of linkage to care activities relies on MOUD and harm reduction services being readily available.



X-waivered Prescribers County Data

The U.S. Department of Health and Human Services hosts a [searchable database and map](#) to identify county OUD treatment needs by patient capacity and number of buprenorphine-waivered prescribers.

Buprenorphine Waiver Training and Mentorship

Health departments can increase the number of providers who offer buprenorphine treatment for OUD by offering information, training and mentorship to providers in their communities. In 2021, HHS issued [Practice Guidelines](#) that changed the prescriber requirements for buprenorphine treatment for OUD. As of April 28, 2021, eligible providers (physicians, nurse practitioners and physician assistants) can treat up to 30 patients at a given time without completing additional training. Providers are still required to submit a “Notice of Intent” to prescribe buprenorphine for OUD. This regulatory change offers an important opportunity to expand access to MOUD within communities; however, navigating these regulations can be challenging for providers. Health departments can help reduce confusion by offering information and education related to prescribing regulations and requirements.

Furthermore, the prescriber training exemption applies only to providers treating up to 30 patients at a time. Providers seeking to treat more than 30 patients must complete the necessary training requirements to obtain an x-waiver. [PCSS](#) offers comprehensive information, training resources and mentorship support for providers seeking their x-waivers. Physicians, advanced practice registered nurses, physician assistants and medical students can complete all their training requirements free through training modules to obtain their x-waiver to prescribe buprenorphine for OUD. Additionally, a mentoring program offers a discussion forum, clinical roundtables and one-on-one mentorship opportunities.¹⁶⁹



Example from the Field: Philadelphia Department of Public Health, Pennsylvania

The Philadelphia Department of Public Health, in collaboration with the Health Federation of Philadelphia, developed an advanced clinical training program and mentorship program to increase the availability of buprenorphine among primary care providers in Philadelphia. The MAT Mentoring Preceptorship program offers participants: 1) one full day of training led by experienced buprenorphine-waivered primary care providers and 2) a clinical observation session with expert providers. The training and mentorship program is offered at no cost to participants and offers continuing medical education credits. The preceptorship program also offers advanced training on OUD-related topics, such as caring for families impacted by perinatal OUD.^{170,171,172} In addition to offering training and mentorship opportunities, the health department established a 24/7 clinical consultation phone line to support buprenorphine prescribers. In 2019, there were 691 x-waivered prescribers in Philadelphia; the health department's goal is to have 1,300 prescribers by 2022.¹⁷³

Incentive Programs to Increase MOUD Availability

In addition to increasing the availability of MOUD treatment through training and mentorship programs, health departments, in partnership with health care organizations, can support programs to incentivize providers to obtain their buprenorphine waiver. Hospitals and other health care settings have implemented incentive programs and mandates, including monetary incentives and paid time off for training, to increase the number of x-waivered staff. The University of Pennsylvania's hospital system in Philadelphia offered ED physicians a six-week financial incentive of \$750 for obtaining an x-waiver to prescribe buprenorphine. Participants also received a \$199 reimbursement for the cost of an x-waiver training course. The financial incentive program increased the number of waived physicians in the participating hospitals from six percent to 90% and a total of 89% of eligible physicians completed the x-waiver training. Buprenorphine prescribing rates increased 15% during the first four months of the program.¹⁷⁴

EXPAND ACCESS TO HARM REDUCTION SERVICES.

Harm reduction organizations, such as SSPs, not only provide life-saving supplies, services and supports to PWUD, but offer critical linkage to treatment, housing, employment, health care and other services. Community-based harm reduction organizations are trusted sources of care for many PWUD and are often their primary source of care. Research shows that people who access SSPs are up to five times more likely to engage in SUD treatment and remain in SUD treatment longer compared to PWUD who do not receive SSP services.^{175,176} Health departments can increase access to harm reduction by providing services directly or by supporting community-based harm reduction organizations. Furthermore, as credible messengers, health departments have an important role in educating community members, organizations, policymakers, public safety and other stakeholders to overcome stigma and misperceptions about harm reduction.

A survey of 388 local health departments conducted by NACCHO in 2019 demonstrated an opportunity for local health departments to increase their provision of harm reduction services. Among local health department respondents, 53% provided naloxone education and training directly, 21% provided SSP services and 11% provided fentanyl and drug testing.¹⁷⁷ While not all local or state health departments may be able to implement a full range of harm reduction services, health departments should seek opportunities to increase their capacity and capability to offer some harm reduction services or supports. For example, a recent policy change enables the use of federal funds to purchase fentanyl test strips. Health departments can leverage to expand access to supplies. Additionally, a growing number of technical assistance tools to support health departments' harm reduction efforts are available to support planning and implementation efforts.



Quick Tip: Fentanyl Test Strips

An increased prevalence of illicitly manufactured fentanyl in the drug supply has been a primary driver of the alarming increase in drug overdose deaths in recent years. Rapid fentanyl test strips offer PWUD an easy way to check their drug supply for fentanyl prior to using. While some state and local health departments have provided fentanyl test strips for several years, purchasing these supplies with federal grant funds was prohibited until recently. In April 2021, CDC and SAMHSA announced that fentanyl test strips could now be purchased using federal funding, including through the Overdose Data to Action cooperative agreement and the State Opioid Response grants. For more information on fentanyl test strips, see the CDC's [press release](#).



Example from the Field: New Jersey Harm Reduction Centers

To increase access to harm reduction services, the New Jersey Department of Health established seven Harm Reduction Centers across the state. While funded and supported by the state department of health, the centers are operated by community-based organizations and each center is tailored to meet the needs of the community it serves. For example, some centers are fixed sites, while others are mobile units.¹⁷⁸ All of the centers are SSPs and provide a range of services, including naloxone, pre-exposure prophylaxis, health education, wound care and linkage to other treatment and services, among others.¹⁷⁹ The Harm Reduction Centers are supported in part by CDC Overdose Data to Action grant funding.¹⁸⁰

In addition to providing services directly, health departments can support community-based harm reduction organizations through funding, technical assistance, data sharing, policy advocacy and helping establish collaborations and partnerships between harm reduction and other organizations. Because the purchasing of some harm reduction supplies, such as syringes, may be prohibited through federal funding mechanisms, state and local health departments can help to identify or provide supplemental funding or resources to community-based organizations.



Example from the Field: Portsmouth City Health Department, Scioto County, Ohio

Scioto County, Ohio, has one of the highest rates of opioid overdose in the state, with 2018 data indicating a fatal overdose rate of 67.3 per 100,000 in the county.¹⁸¹ The Portsmouth City Health Department (PCHD) has led the county in several initiatives to reduce opioid-related morbidity and mortality and link individuals to care and services. In 2017, PCHD received a three-year grant to establish Recovery Gateway, a health navigation program that connects people to SUD treatment, harm reduction services and other health care and social services.^{182,183} Participants are assigned to a navigator who assists them in accessing services, such as SUD consultations, linkage to care for treatment and services, including syringe services, in-house primary care and applying for medical insurance.¹⁸⁴

The health department has collaborated with several community stakeholders to increase access to services and improve linkage to care, including partnering with the prosecutor's office to develop the Early Intervention Program within the county drug court to provide an alternative to incarceration.^{185,186} Recovery Gateway patient navigators meet with drug court participants to screen, assess and identify an appropriate treatment plan for each individual, which may include access to naloxone, PCHD's SSP and other harm reduction services. Patient navigators work with participants throughout their treatment plan and communicate with the court system on participants' progress. Upon completion of the program, the participant's drug-related charge is dropped. Since the inception of the Early Intervention Program, justice-involved clients have been able to receive treatment and services that appropriately meet their needs.

Outside of the legal system, PCHD partnered with the local hospital to provide education and reduce stigma related to their SSP. In the first four years of operation, the number of syringes exchanged quadrupled from 22,000 needles in 2012 to 85,891 needles in 2015.¹⁸⁷ While hepatitis C rates continued to rise in neighboring counties, cases in Scioto County decreased by 40%. Additionally, PCHD staff provided basic medical care at the syringe exchange, relieving some of the burden from emergency departments.¹⁸⁸ The success of the PCHD SSP has led neighboring counties and states to reach out for support in establishing their own programs.



Harm Reduction Planning and Implementation Tools

- [Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design and Implementation](#) (CDC)
- [Harm Reduction Community of Practice](#) (NACCHO)
- [Harm Reduction Listserv for Funding, Technical Assistance and Other Opportunities](#) (NACCHO)
- [COVID-19: Suggested Health Department Actions to Support Syringe Services Programs](#) (National Alliance of State and Territorial AIDS Directors [NASTAD])
- [Harm Reduction Technical Assistance Center](#) (CDC)

ADDRESS ADDITIONAL SOCIAL AND STRUCTURAL BARRIERS TO CARE.

Linkage to care efforts should address how people’s social, economic and housing needs may pose barriers to linkage. Studies have shown that meeting individuals’ basic and social needs, such as housing, employment and Medicaid assistance, is important for supporting recovery and engagement in treatment.^{189,190} By reducing barriers, including transportation, housing, food insecurity and income instability, people are able to access and engage in treatment and services more easily.^{191,192} Because of their lived experience and training, peer support workers are often excellent resources to help people address unmet social needs, including navigating complex application processes and bureaucracies. However, there is only so much they can do when services are inaccessible or unavailable, thereby necessitating structural change to provide linkage to care.



Opportunities to Address Harmful Social Determinants to Improve Linkage to Care

- ❑ Incorporate social needs screening within services and programs for PWUD and PWSUD.
- ❑ Explore opportunities to provide transportation or support transportation programs.
- ❑ Ensure services and treatment hours are in alignment with public transportation schedules.
- ❑ Explore partnerships with rideshare organizations in areas where public transportation is limited.
- ❑ Develop warm hand-off referral systems with public housing, shelters and homelessness providers.
- ❑ Provide training to housing agency staff on working with PWUD, SUD, MOUD and overdose response.
- ❑ Connect with local Continuums of Care and other housing coalitions.
- ❑ Partner with businesses and employers to support [recovery friendly workplaces](#).
- ❑ Partner with local educational institutions and universities to increase access to degree programs and training.
- ❑ Develop partnerships with local legal aid organizations that provide free or low-cost civil legal services.
- ❑ Assist with applying for Medicaid and public benefits, including cash and food assistance, or linking people to these services.



“We also have a peer navigator that will connect with people to, to provide peer support and navigation. ... She also does a lot of referrals to other service providers because we definitely recognize our limitations and she’s really great at connecting people. So, for instance, when the federal government gave out the stimulus checks, it was really challenging for people without a stable address or people who didn’t file taxes to receive those. And so, she taught herself essentially how to help people apply to get their stimulus checks.”

— Betsy Chanthapaseuth, Denver Department of Public Health and Environment, Colorado



Example from the Field: Mobile Care Collaborative, Caroline County, Md.

To overcome transportation and other access barriers in rural communities, the Caroline County Health Department, in partnership with the University of Maryland School of Medicine and with funding from the Health Resources and Services Administration (HRSA), established the Eastern Shore Mobile Care Collaborative (ESMCC) in 2019. The ESMCC is a 40-foot mobile MOUD treatment unit that is staffed by a nurse and peer support worker who provide onsite assessments and services. The mobile unit is also equipped with an encrypted, HIPAA-compliant videoconferencing platform to provide patients access to tele-psychiatry consultation and services.^{193,194} Addiction medicine specialists from the University of Maryland School of Medicine provide clinical assessments and diagnoses, prescribe buprenorphine and refer to long-term treatment.¹⁹⁵ The peer support worker can support participants during the mobile sessions and provides follow-up after they have left the ESMCC. The ESMCC operates Monday through Friday and can be accessed by anyone in Caroline County, as well as the neighboring Talbot and Queen Anne's counties. Self-referrals and referrals for others can be made by calling the unit's phone number or Maryland's resource hotline. For more information about ESMCC, including a video describing its services, see [The Eastern Shore Mobile Care Collaborative at the Caroline County Health Department](#).

IMPLEMENT LINKAGE TO CARE INTERVENTIONS.

Common types of overdose response and linkage to care models include public health and safety overdose response teams, ED-based MOUD initiation and peer support programs and mobile response teams. These models assess the unique needs of PWUD and PWSUD in various settings and address challenges related to linkage to care. This section provides an overview of existing types of models and key planning and implementation considerations for each model type.

Public Health and Safety Overdose Response Teams

Public safety and public health overdose response teams pair first responders, such as police, EMS or fire, with peer support workers or outreach staff to provide follow-up services in the community to people who have experienced an overdose, as well as their friends and family in the event of a fatal overdose. Examples of follow-up services include naloxone distribution, overdose education and linkage to treatment and harm reduction services. Overdose outreach teams can vary in composition. For example, some teams include a police officer and peer support worker, while others include only peer support workers, as they are often seen as credible messengers and may build trust more easily with PWUD and PWSUD.

Criminal Justice System Involvement and Overdose Risk

The criminal justice system is an important setting to engage people at risk of overdose in linkage to care efforts. Opioid use disorder is highly prevalent among people who are justice-involved, leading to increased risk of early all-cause and overdose death, hepatitis C and HIV, among other harms.¹⁹⁶ The availability of OUD treatment for people who are currently incarcerated is limited; only approximately 20% of people who are incarcerated and have a history of opioid use receive treatment.^{197,198} Risk of overdose and overdose death among PWUD and PWSUD recently released from incarceration is great due to decreased drug tolerance as a result of abstinence while incarcerated.^{199,200,201,202,203} A study of the Washington State Department of Prisons showed that prisoners' risk of overdose death was more than 120 times more likely than the general public within the first two weeks after release.²⁰⁴ There are a growing number of overdose response and linkage to care programs tailored to people who have criminal justice involvement. Existing resources and tools for criminal justice-related programs are below and in [Appendix B](#).



Resources and Tools for Criminal Justice-related Overdose Prevention Programs

- [Public Health and Safety Team \(PHAST\) Toolkit](#) (CDC Foundation)
- [Overdose Prevention Services in Jails: The 2019 Overdose Response Strategy Cornerstone Report](#) (High Intensity Drug Trafficking Area, Overdose Response Strategy)
- [Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project](#) (High Intensity Drug Trafficking Area, Opioid Response Strategy)
- [Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders](#) (SAMHSA)
- [Law Enforcement Diversion Programs](#) (Curated Library about Opioid Use for Decision-makers [CLOUD])
- [Medication-assisted Treatment \(MAT\) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit](#) (National Council for Mental Wellbeing and Vital Strategies)
- [A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons](#) (RTI International)
- [Bureau of Justice Assistance's Comprehensive Opioid, Stimulant and Substance Abuse Program Resource Center](#) (BJA COSSAP)



Example from the Field: Outreach to Survivors of Overdose, Cecil County, Md.

The Cecil County, Md., Outreach to Survivors of Overdose Program is a collaboration between the Cecil County Health Department, Cecil County Sheriff's Department and Voices of Hope, a recovery community organization. To engage people who recently experienced an overdose, the Outreach to Survivors team works together to quickly share information when an overdose occurs in the community. When an overdose occurs, a heroin coordinator situated within the Sheriff's Office submits data to the Health Department, which has established a database to share data in real time with Voices of Hope outreach staff. Members of a peer outreach team are notified of the overdose through the shared data system with the health department. When an overdose occurs in the community, a two-person peer outreach team visits the home of the person who recently experienced an overdose. The peer team provides information, supplies and linkage to care, including MOUD. Peer teams are equipped to "meet people where they're at" and offer naloxone and safer use supplies. Voices of Hope has partnered with several local SUD treatment centers to coordinate easier access to treatment for individuals engaged through overdose response outreach. Through these partnerships, Voices of Hope can generally connect people at risk of opioid overdose to MOUD quickly, including during nights and weekends.

Emergency Department Overdose Response Programs

There are a growing number of ED-based overdose response and linkage to care programs in the U.S, focused on increasing access to MOUD.²⁰⁵ Because nonfatal opioid overdose is a strong predictor of future overdose,²⁰⁶ EDs are incredibly important settings to engage people at risk of overdose and link them to care. Emergency department-initiated buprenorphine programs have been shown to increase engagement in OUD treatment and decrease illicit opioid use.^{207,208} A study of three EDs in rural South Carolina that implemented an ED-initiated buprenorphine program with funding support from the South Carolina Department of Health and Human Services found that 59% of patients initiated on buprenorphine in the ED remained

in treatment for at least 30 days.²⁰⁹ While few of these programs are directly led by health departments, many health departments have partnered with hospitals or provided funding to support overdose response initiatives. For example, several ED-initiated buprenorphine programs provide naloxone to patients at risk of OUD; health departments can be instrumental in assuring that EDs have access to naloxone for patients. Additionally, many ED-based overdose response programs integrate PSS through partnerships with health departments or recovery community organizations.

In 2020, the National Council for Mental Wellbeing hosted a [technical experts' panel](#) to identify best and promising practices to assist people presenting to the ED having experienced an overdose or at risk of overdose. The technical experts' panel focused on buprenorphine prescribing and the integration of PSS as two main strategies to prevent overdose and link people to care. The panel identified 10 key recommendations for establishing successful ED-based overdose response programs, described in Appendix G. Recommendations for ED-based Overdose Response Programs.



Example from the Field: Treatment on Demand, Denver Department of Public Health and Environment, Colorado

The Denver Department of Public Health and Environment developed a Treatment on Demand pilot project, in collaboration with the Denver Health and Hospital Authority and Denver Comprehensive Addictions Rehabilitation and Evaluation Services, to establish several pathways for people to be linked to MOUD 24/7. While several Denver hospitals were already initiating people on MOUD, the availability of those services was limited. Recognizing the importance of linking people to care when they are ready, the Treatment on Demand program embedded social workers and other clinicians within hospitals 24/7 to assist individuals with completing assessments for MOUD initiation. Several pathways link individuals to care in addition to hospitals, including through self-referrals, public safety and human services agencies. Similarly, several settings offer MOUD, including OTPs, FQHCs and hospital outpatient clinics. The pilot project is funded by the Denver Department of Public Health and Environment's Public Health and Wellness Special Revenue Fund. Program evaluation metrics for the pilot include the number of individuals presenting for evaluation, the number of MOUD inductions, the number of successful referrals, defined as full enrollment within 48 hours and percent of individuals retained in treatment at 90 days.²¹⁰



Example from the Field: RWJBarnabas Health, New Jersey

Supported by funding from the New Jersey Department of Health, Division of Mental Health and Addiction Services, the RWJBarnabas Peer Recovery Program provides recovery support to individuals with SUD presenting in EDs and other hospital departments within the RWJBarnabas Health hospital network across New Jersey.²¹¹ Peer recovery specialists are employed full-time and available to patients in hospitals 24/7.

In 2019, the program's recovery specialists were deployed to patient bedsides 18,586 times and staff conducted 116,698 instances of follow-ups with individuals. Nearly 75% of visits occurred in the ED. A total of 3,179 individuals accepted referrals to levels of care either at the bedside or during follow-up. Follow-up interactions between patients and recovery specialists were made primarily through telephone calls (n=102,304), but also occurred through face-to-face contact (n=14,002).²¹² The program staff tracked outcomes by assessing the number of individuals in recovery at three, six, nine and 12 months. In 2019, 6.4% of individuals contacted

at three months were in recovery and 3% reported being in recovery at 12 months. The average percent of individuals who were in recovery across the 12 month follow-up period was 5.2.²¹³

The program experienced a 38% increase in encounters in the second half of 2019 due to the implementation of an automatic referral system for recovery support services within eight participating hospitals. Referrals can be placed through a non-physician order or automatically based on certain criteria in the electronic health record (EHR).

Example from the Field: Relay, New York City

Housed in the New York City Department of Health, the Relay program provides 24/7 peer-based overdose response services to individuals presenting to hospital EDs and their friends and family. Relay's wellness advocates offer a range of peer-based services and supports, such as overdose risk counseling and naloxone education and distribution, as well as linkages to critical services, such as food and shelter. Following hospital discharge, wellness advocates continue to provide follow-up and support for 90 days. The City of New York funds the Relay program as part of the Mayor's initiative, HealingNYC.²¹⁴

Between June 2017 and December 2018, 649 people were enrolled into the Relay program from seven participating EDs in New York City. Wellness advocates successfully contacted participants within 48 hours after discharge (47%), at 30 days (36%) and at 90 days (33%). Wellness Advocates distributed 1,007 naloxone kits to 827 unique participants and their family/social supports. Participants were also referred to various care and services: 165 accepted referrals to harm reduction services, 104 accepted referrals to MOUD, 72 accepted referrals for outpatient SUD treatment and 62 accepted referrals for inpatient SUD treatment.²¹⁵

Mobile Overdose Prevention and Response Programs

In addition to public health and safety teams and ED-based overdose response programs, there are a growing number of mobile overdose prevention and response initiatives led by or supported by health departments. Mobile overdose programs provide education, supplies and linkage to care information in neighborhoods or areas where an overdose has occurred or areas in which substance use commonly takes place. A range of different types of mobile response efforts exist, including mobile teams that use vans or other vehicles to deliver services and conduct assessments in scheduled locations and teams that visit locations in communities where people have recently experienced an overdose to offer services, supports and linkage to care. Many mobile teams integrate PSS to provide support to people at risk of overdose, which has been cited by mobile outreach team participants as a benefit of the service.²¹⁶



Example from the Field: Wellness Winnie, Denver Department of Public Health and Environment, Colorado

The Denver Department of Public Health and Environment's Wellness Winnie is a recreational vehicle (RV) that provides a wide range of mobile services and supports to PWUD and PWSUD in neighborhoods throughout the city. The Wellness Winnie is staffed by mental health counselors and peer navigators who provide free comprehensive services, including linkage to primary care, mental health, SUD treatment, specialty care and dental services; OEND and rescue breathing masks; sharps containers; wound care supplies; survival basics, such as socks and sunscreen; safer sex supplies; and access to food, laundry, showers and help getting identification cards from partner organizations.²¹⁷ The Wellness Winnie is staffed by people with lived experience and services are built on a model of "friendly, nonjudgmental care to create an environment of trust."²¹⁸ More than half the people served through the Wellness Winnie experience homelessness or housing instability and face significant challenges accessing services. The location of the RV is posted online daily; common community locations are public libraries. The Wellness Winnie's locations were determined using several data points, including syringe disposal complaints received through the 311 system, mapping areas that had few treatment services and resources and through discussions with service providers and community members to inform where the mobile services would have the highest impact.²¹⁹



When is the best time to offer linkage to care to a person who has experienced an overdose?

Overdose response programs' protocols vary in terms of when they connect with people who have experienced an overdose to offer support and linkage to care. Evidence comparing the effectiveness of interventions delivered at different times is lacking.²²⁰ The timing for when an overdose response team initiates contact with a person may also depend on where the overdose response program is housed as opposed to when people are most amenable to services; for example, if it is based within an ED, the first contact might be made while the person is still receiving care in the hospital. If the overdose response team is a partnership with public safety, the first contact may happen the next day or within 48 hours after the overdose occurred. Many people who have recently experienced an overdose may not immediately be ready to engage in treatment or accept support. Overdose is a traumatic event and the overdose reversal process can be very unpleasant for people due to the effects of precipitated withdrawal.²²¹ Findings of focus groups of PWUD support this idea, suggesting that intervention may be more effective in the days after the overdose event, not immediately after.²²² Because people may not be ready to accept support or engage in treatment after the first outreach or contact, it is important that outreach teams make contact with people multiple times and assure people that they can reach out to the outreach team whenever they want assistance.



Example from the Field: Waterbury Department of Public Health, Connecticut

The Waterbury Department of Public Health's Warm Hand-Off program employs overdose response technicians to connect in EDs with people who experienced an overdose with the person's consent.²²³ Recognizing that many people who experienced an overdose in the ED may not be ready to engage immediately, the overdose response technicians continue to follow up for 30 days. Waterbury Warm Hand-Off uses a minimum of "five touches" to reach out to people who have experienced an overdose, including at 24 hours, 48 hours, 72 hours, two weeks and up to 30 days post-overdose.²²⁴ At each encounter, the overdose response technician gets permission from the individual to stay in touch. The goal of the overdose response technicians is to "leave a message of hope" and to let the person know that they will support them and connect them to treatment and services when they are ready.



"I think the main focus is meeting people where they're at. When somebody overdoses and is revived, that window of opportunity one would think is very large, but it's actually very small. So, you have to be there, be available in that moment and connect them to care."

— Grace Cavallo, Community Mental Health Affiliates, Connecticut



Strategy 5 Implementation Tools and Resources

- [X-waiver training modules](#) (PCSS)
- [Addressing Opioid Use Disorder in Emergency Departments: Expert Panel Findings](#) (National Council for Mental Wellbeing)
- [Linkage to Care, Opioid Overdose Epidemic Toolkit for Local Health Departments](#) (NACCHO)
- [Trauma-informed, Recovery-oriented Systems of Care Toolkit](#) (National Council for Mental Wellbeing)

STRATEGY 6:

Promote policy that enhances linkage to care.



In addition to providing direct services, health departments also play an important role in adopting, enforcing and advocating for policies and regulations that support linkage to care efforts. Many states and jurisdictions have passed legislation related to naloxone, SSPs and housing. Additionally, during the COVID-19 pandemic, local, state and federal laws and regulations were changed to support increased access to telehealth services, including for MOUD treatment. These policies not only increase access to SUD treatment and harm reduction services, but they also support people through the continuum of care by addressing social determinants of health that can impact an individual's recovery efforts and quality of life. Further, enacting and enhancing policies that promote linkage to care can help sustain programs in the long term to ensure PWUD continue having access to necessary services.

Action Steps

- Assess the policy and regulatory landscape.
- Develop and enhance policies to support linkage to care.
- Advocate for policies across partner systems to sustain linkage to care activities.



ASSESS THE POLICY AND REGULATORY LANDSCAPE.

One core responsibility of health departments is advancing policies and practices that promote individual and community health and support linkage to care. Health departments have an opportunity to both implement and enforce policies and regulations under their authority as well as educate lawmakers on policies that would support improved outcomes for PWUD at the local, state and federal levels. Assessing the policy landscape enables health departments to identify gaps in policies and opportunities for advocacy.

There are a number of substance use-related policies that have already been enacted in various states across the country to increase access to services for people who have experienced an overdose. Some common examples include:

- **Good Samaritan laws** provide immunity from prosecution for both the person seeking medical assistance “in good faith” when they believe an overdose is occurring and the person who overdosed.²²⁵ Find your state’s [Good Samaritan laws](#).
- **Naloxone standing orders** written by prescribers allowing a prescription medication to be dispensed to a patient they have not examined who meets a certain set of criteria.²²⁶ Additional provisions, such as the following examples, may vary by state or jurisdiction. Find your state’s [naloxone standing orders](#).
 - » **Third party prescription** allows a naloxone prescription to be written for a friend or family member of an individual considered to be at risk for overdose.
 - » **Liability protections** for physicians prescribing naloxone, first responders who administer naloxone, or laypersons who administer it “in good faith.”
 - » **Naloxone distribution programs** are organizations providing naloxone and education to PWUD and their friends or family members.
- **Syringe services laws**, including paraphernalia laws, provision and disposal of syringes and SSP governance. Legislation varies by state.²²⁷ Find your state’s [syringe services laws](#).

Additionally, it is important to identify and educate stakeholders on your state’s laws and regulations related to patient confidentiality, particularly medical emergency exemptions to Part 2 and HIPAA. Under Part 2, a health care program or provider may disclose patient information to medical personnel if there is an immediate threat to the health of the individual and immediate medical intervention is required, or to law enforcement if there is an immediate threat to the health or safety of the individual or due to a crime against program personnel or on the program’s premises.²²⁸ If the medical emergency exemption is invoked, the health care program must document the recipient of the information, the provider who disclosed the information, the date and time the information was disclosed and the nature of the medical emergency. While no state laws “may authorize or compel any disclosure prohibited by [Part 2] regulations,” states may implement more stringent confidentiality protections, which programs must adhere to, regardless of whether they are allowed under Part 2.²²⁹

Because state legislation impacts local governance, it is critical that local health departments are aware of what types of local policies and practices are feasible to implement within the scope of their state’s laws and regulations. Substance use staff and legal staff at the health department can collaborate on these activities.

DEVELOP AND ENHANCE POLICIES THAT SUPPORT LINKAGE TO CARE.

An understanding of the local policy landscape enables health departments to identify strategies to enhance widespread adoption of policies. Community members may be unaware that certain legislation exists. Health departments should educate community members on laws that support overdose response and linkage to care efforts, such as Good Samaritan laws.

Because local laws vary by jurisdiction, it is important that health departments understand unintended consequences or impacts of laws and the perception of laws and policies among PWUD. For example, while most states have implemented Good Samaritan laws, the condition of immunity varies, with some protecting individuals from arrest, others protecting individuals from prosecution only and even others that limit individuals to receive immunity no more than twice under the Good Samaritan law.²³⁰ This ambiguity and variability, in conjunction with individuals' fear of criminal justice involvement, often leads Good Samaritan laws to be underutilized.²³¹ Health departments can provide community education about local legislation or partner with trusted community organizations to deliver this information to their participants and minimize distrust related to calling 911 and potential criminal consequences.

In addition to analyzing local legislation, health departments can work with community partners to develop interagency policies and protocols related to linkage to care to put local legislation into practice. While health departments may not always provide services directly, they often serve as a convener to bring various partners and stakeholders together and, in this role, they can develop protocols to ensure efficient processes are in place to link individuals to care. Clear roles and responsibilities for each agency participating in linkage to care should be presented, in addition to definitions of the various services provided, such as harm reduction or recovery support services. Ensuring the linkage to care team has a clear understanding of the protocols will help facilitate increased access to services and supports for participants. The National Alliance for Model State Drug Laws created the [Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment](#) as an example of how legislative text and protocols can be framed and developed as a resource for the program team.

Ensure Policies Promote Health Equity

As health-promoting policies are developed and enhanced, it is critical to ensure that they are equitable and effectively serve the needs of the community. Racial disparities remain prevalent in treatment access and health outcomes, as well as in housing, employment, criminal legal system involvement and other related social services. The Network for Public Health Law developed the [Equity Assessment Framework for Public Health Laws and Policies](#) to guide agencies to create equitable policies by engaging diverse stakeholders throughout development, implementation and evaluation.

ADVOCATE FOR POLICIES ACROSS PARTNER SYSTEMS TO SUSTAIN LINKAGE TO CARE ACTIVITIES.

Sustainability is cited as a common concern among health departments and community partners when implementing substance use-related programming. Advocating for policy changes that promote linkage to care can help ensure that services remain available and accessible. Policy change should also support linkages across other partner agencies, such as social services or the criminal legal system, recognizing that the overdose crisis should be addressed from a variety of perspectives within a social determinants of health framework.

Engaging with Policymakers

Health department staff and policymakers often operate within their own silos; however, collaboration and coordination between the two groups is necessary to help implement policies that support and sustain linkages to care, whether through allocation of resources or reliable funding mechanisms. Because policymakers and their staff do not engage in day-to-day operations providing health services, it is important to provide them a baseline understanding of SUD as a chronic disease, overdose prevention and response strategies and recovery support services outside of the health care sector.

As the opioid crisis has impacted communities across the U.S., many legislators have expressed an interest in learning how to support programs on the ground providing overdose prevention and OUD care through policy initiatives. While health department or community organization staff can present theoretical information on various strategies, another opportunity to engage the policy sector is to bring them onsite to observe how programs are implemented. Seeing programs in operation can be a strong motivator to create buy-in and push legislators to be greater advocates for opioid-related policies to sustain linkage to care activities.

Housing

Two primary housing models exist to support PWUD and individuals with OUD in their recovery efforts: recovery housing and Housing First. Recovery housing is peer-centered, providing direct connections to peers in recovery and recovery support services.²³² As a recovery-oriented environment, people living in recovery housing have access to the social supports and services needed to achieve and sustain long-term recovery, which enable them to build recovery capital. Positive outcomes associated with recovery housing include decreased substance use, lower rates of incarceration, increased employment and improved family functioning.

The Housing First model primarily supports people experiencing homelessness; however, mental health and substance use challenges concerns are highly prevalent among people experiencing housing instability and, therefore, Housing First often provides services to support people with mental health and substance use challenges.²³³ Through this approach, housing is viewed as the foundation for people to improve their health and wellbeing and enables them to access short-term or long-term permanent housing without prerequisites like employment status or treatment engagement. People living in these housing programs often report reductions in substance use, as well as greater housing stability, attendance in job training programs and decreased hospitalizations.

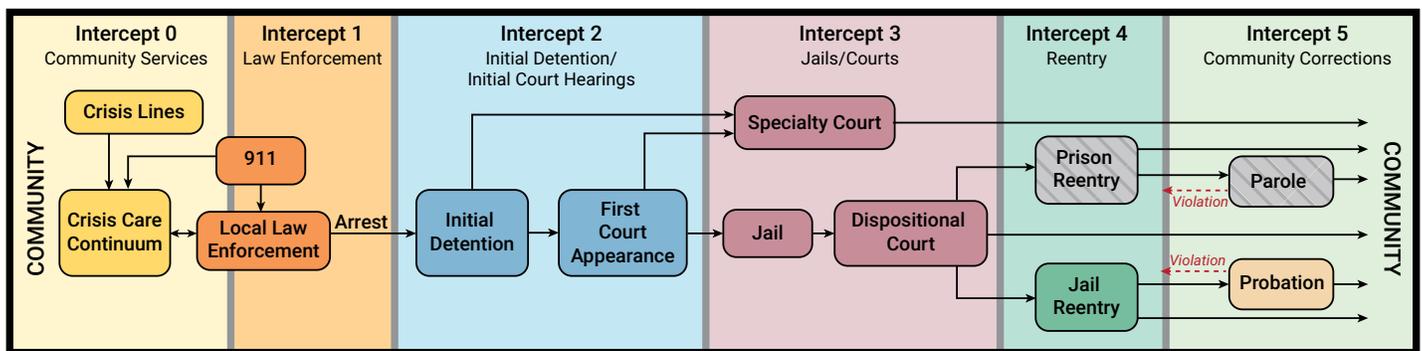
Employment

Employment status and financial stability are frequently cited factors contributing to a person’s likelihood to sustain long-term recovery. Fair chance hiring laws are an important strategy for linking individuals to employment opportunities. Also referred to as “ban the box” policies, these laws prohibit employers and private employers that contract with government agencies from requesting conviction history during the job application process.²³⁴ Currently, 36 states and more than 150 cities and counties have adopted “ban the box” policies and laws, though specific provisions vary by state; find your state’s [fair chance hiring policies](#).

Criminal Justice System

Substance use and SUDs have long been criminalized in the U.S., rather than addressed as a health concern. Over recent decades, various strategies have emerged to better support PWUD who come in contact with the criminal legal system and link them to necessary care across the Sequential Intercept Model developed by Policy Research Associates (Figure 3).

Figure 3. Sequential Intercept Model²³⁵



Deflection and pre-arrest diversion programs have been implemented in many jurisdictions across the country, offering individuals access to community-based treatment and resources for SUDs, including MOUD.²³⁶ There are several national deflection and pre-arrest diversion models that have been adopted by local jurisdictions, including:

- **Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD):** The first LEAD program was established in Seattle, Washington in 2011 as a post-arrest/pre-booking diversion program where officers exercise discretion to divert individuals engaged in low-level offenses, such as drug possession or sex work, to community-based services instead of jail.²³⁷ As of 2020, 39 LEAD programs are currently in operation in at least 21 states.
- **Police Assisted Addiction and Recovery Initiative (PAARI):** This national network and technical assistance organization support more than 400 police departments in 32 states implementing non-arrest or early diversion program models. At the outset of the program, PAARI was founded in partnership with the Gloucester, Mass., Police Department’s ANGEL Program, which connects people with substance use-related challenges who present to the police department to services and care.²³⁸
- **Project SHIELD (Safety and Health Integration in the Enforcement of Laws on Drugs):** This multi-level intervention supports police/public health partnerships in response to overdose through delivering culturally and geographically tailored education, training the trainers and building sustainable collaborations between law enforcement and service providers.²³⁹



Example from the Field: North Carolina Association of Local Health Directors

To address the worsening opioid crisis in North Carolina, the North Carolina Association of Local Health Directors developed [North Carolina Essential Action to Address the Opioid Epidemic: A Local Health Department's Guide](#).²⁴⁰ This resource, developed in partnership with the North Carolina Department of Health and Human Services and the North Carolina Harm Reduction Coalition, provides information and tools for local health departments to address the opioid crisis through the 10 essential public health services framework. Policy development and enforcement are discussed in essential services five and six.

North Carolina has implemented a variety of strategies in local jurisdictions throughout the state, including naloxone standing orders, syringe services, fair chance hiring policies and Housing First models. This resource explains the rationale behind implementing such policies and additional resources for jurisdictions exploring similar strategies. Links to opioid-related legislative text are included, as well as easy-to-understand explanations for laypeople reading about the policies. Finally, ongoing efforts to promote policies are described, demonstrating buy-in from the various sectors involved in these efforts and local jurisdictions' commitment to increasing access to overdose prevention and response resources for PWUD. Contact information is listed for some ongoing initiatives as an additional resource for anyone with follow-up questions.



Strategy 6 Implementation Tools and Resources

- [Good Samaritan Overdose Prevention Laws](#) (Prescription Drug Abuse Policy System [PDAPS])
- [State Naloxone Access Rules and Resources](#) (SAFE [Stop the Addiction Fatality Epidemic] Project)
- [Naloxone Overdose Prevention Laws](#) (PDAPS)
- [Syringe Service Program Laws](#) (The Policy Surveillance Program)
- [Equity Assessment Framework for Public Health Laws and Policies](#) (The Network for Public Health Law)
- [Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment \(Second Edition\)](#) (National Alliance for Model State Drug Laws)

STRATEGY 7: Evaluate linkage to care initiatives.

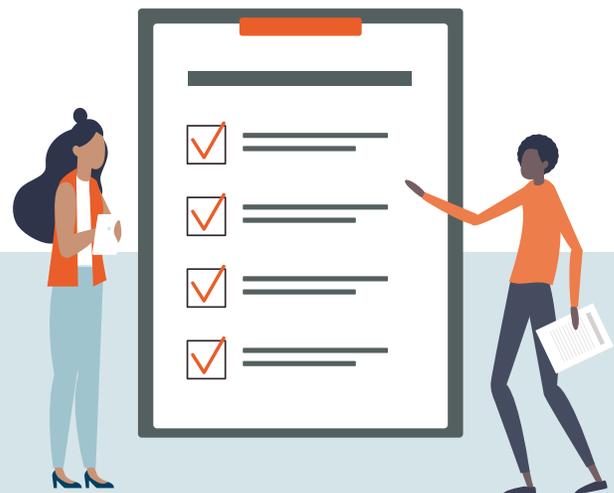


Public health departments have a responsibility to “improve and innovate through evaluation, research and quality improvement.”²⁴¹ Activities undertaken to support linkage to care for people at risk of opioid overdose should be monitored, evaluated and improved based on evaluation findings. While this strategy is presented last in this Roadmap, monitoring and evaluation of any program should be carefully thought through at the beginning of the program planning process to ensure that program operations include realistic and timely methods for understanding program performance.



Action Steps

- Define measures of linkage to care that key partners agree on.
- Identify methods to evaluate linkage to care activities, including quality improvement activities.
- Identify strategies to improve and sustain service delivery based on evaluation findings.



DEFINE MEASURES OF LINKAGE TO CARE THAT KEY PARTNERS AGREE ON.

Linkage to care: *Connecting people at risk of overdose to evidence-based treatment, services and supports using a non-coercive warm hand-off that helps people navigate care systems and ensures people have an opportunity to participate in care when they are ready.*

Because the definition of “linkage to care” can vary by setting and stakeholder, there are a variety of evaluation measures that have been proposed to assess various aspects of linkage to care. These measures often need further refinement. Consider what markers are being used, such as intake, completed visit or completed course of treatment, as well as duration, keeping in mind that people can receive multiple and repeat linkages to care. Some measures classify a linkage as successful when a person attends the first appointment; others define success as continued engagement for a pre-determined amount of time or completion of a program.

HIDTA, in its [2018 Overdose Response Strategy Cornerstone Project](#) report, suggests several measures for various linkage activities, includingⁱⁱ:

- Number/percent of individuals linked to MOUD.
- Number/percent of individuals re-arrested.
- Number/percent of patients referred to treatment.
- Number/percent of patients admitted to treatment.
- Number/percent of patients who complete treatment.
- Number of ED visits.
- Number of linkages to stable housing services.
- Number of linkages to harm reduction services.
- Size of prison population.
- Number of fatal and non-fatal overdoses.²⁴²

Several measures from the Healthcare Effectiveness Data and Information Set (HEDIS) may also be considered, including measures of follow-up after ED visits for alcohol or other drug use or dependence,²⁴³ transitions of care,²⁴⁴ initiation and engagement in alcohol and other drug use or dependence treatment,²⁴⁵ identification of alcohol and other drug services²⁴⁶ and ED utilization.²⁴⁷ One benefit of using HEDIS measures is that they are standardized and widely used, allowing for comparison across systems and jurisdictions.

A detailed table of linkage to care evaluation measures, including measures used by programs in the field, is in [Appendix D](#).

ⁱⁱ **Note:** While HIDTA data specifically concerns people involved with the criminal justice system, this resource was chosen because the measures are applicable across populations.



Tips for Evaluating Linkage to Care Efforts

- Begin planning your evaluation at the same time you begin planning the initiative itself.
- Involve stakeholders, including program leadership, staff and participants, in each stage of the evaluation, wherever possible.
- Only collect data directly relevant to informing your evaluation. Extra information, particularly participant-specific data, that is not necessary to answer the evaluation questions should not be collected.
- Make sure your evaluation metrics align with program goals. What is the linkage activity ultimately trying to achieve and through what pathways?
- Disseminate results transparently and in easy-to-understand language to stakeholders inside and outside the health department and health care settings.
- Use evaluation findings to adjust and inform linkage to care initiatives.

IDENTIFY METHODS TO EVALUATE LINKAGE TO CARE ACTIVITIES, INCLUDING QUALITY IMPROVEMENT ACTIVITIES.

Evaluators of linkage to care activities can use several different methodologies. EHR record reviews and matching records across sectors (e.g., health care and criminal justice, public safety, EMS, etc.) are common methods used. Program participant experiences can be accessed via survey or focus group. Some of these methods, such as participant surveys and focus groups, evaluate the linkage to care program at one point in time, while other methods, such as EHR review, can assess broader time periods and changes over time.

Quantitative data, such as trends in admissions or overdoses over time, can be used to quantify numbers or proportions of patients linking to care. Qualitative data, such as interviews and focus groups with staff, stakeholders and participants, can help identify how programs are working or where barriers or bottlenecks may be present. Health departments conduct these evaluations internally or via contract with an outside evaluator, depending on the capacity of health department staff.

Many approaches to measuring linkage to care necessitate data sharing across organizations or sectors. Health departments can play an important role in initiating, managing and maintaining data sharing agreements (see more on data sharing in [Strategy 1](#)). Substance use staff, with support from health department epidemiology and surveillance staff, can collaborate on these activities.



Tools and Resources for Evaluation

The Centers for Disease Control and Prevention (CDC) has a [compilation of resources](#) publicly available to support effective evaluations of public health programs. This site includes tools, sample indicators and performance metrics, health impact assessments, economic evaluation resources, examples of model evaluations, podcasts and webinars. These resources are pulled from a variety of health areas and many have applicability to opioid overdose.

Quality Improvement

The quality of treatment for SUD varies greatly.²⁴⁸ The National Academy of Medicine has recommended a “learning health care system” to encourage the system to improve adoption and delivery of evidence-based services. Quality improvement is one way of implementing a learning health care system. Similarly, the Institute of Medicine identified quality measurement as an essential first step to improving patient care for PWSUD.²⁴⁹

There are multiple approaches to implementing quality improvement in health care, including Plan-Do-Check-Act or Plan-Do-Study-Act, Lean, Balance Scorecard and Six Sigma, and many have been implemented in SUD treatment settings. All methods have in common the general process of assessment, implementing measures and then improving program operations based on what has been learned from the results.



What is the difference between evaluation and quality improvement?

Both evaluation and quality improvement use scientific processes to produce evidence that can be used in decision-making. Evaluation, usually conducted by independent evaluators or designated program staff, aim to study the impact of public health programs, while quality improvement, often conducted by all staff on a team, aims to provide quick feedback on programmatic operations such as workflow. While evaluation is usually time-limited, quality improvement is continuous and ongoing.

Despite the broad consensus that more quality improvement processes are needed to improve SUD treatment, there are still significant gaps in the availability of validated quality measures for SUD treatment. Only 5% of measures in the [Measures Inventory](#), compiled by the Centers for Medicare and Medicaid Services, focus on mental health or substance use and only five of the over 650 measures endorsed by the National Quality Forum are related to substance use.²⁵⁰

Some mental health and SUD treatment experts have called for the creation of specific measures that could address linkage to care, recognizing the risks and costs of siloed care.²⁵¹ These measures could analyze the organizational level by, for example, requiring formal mechanisms of integrating care across systems, and the individual level by measuring the ease at which people are able to access care across systems.



Example from the Field: The Network for the Improvement of Addiction Treatment

SAMHSA’s Center for Substance Abuse Treatment (CSAT), in partnership with the Robert Wood Johnson Foundation, supported a demonstration project among SUD treatment providers called The Network for the Improvement of Addiction Treatment (NIATx).²⁵² NIATx partner programs conduct the rapid-cycle quality improvement process, Plan-Do-Study-Act, to reduce wait times before program admission and improve retention in care. An evaluation across NIATx sites found significant improvements in both wait times to treatment admission and retention in care following the implementation of the quality improvement process²⁵³ and a second cohort of NIATx member programs replicated this finding.²⁵⁴

Ethical Considerations when Identifying Evaluation Methods

When considering various methods of evaluating of linkage to care, it is important to weigh not only factors such as scientific rigor, accuracy, timeliness and cost, but also the ramifications of the data collection methods on the populations being served. If people are asked to give their time and/or information via survey, interview or focus group, for example, they should be compensated. Particular care should be taken if any information collected may have the potential to cause trauma or re-traumatization to the person, with the benefits of collecting this information clearly outweighing the costs. Additionally, ensure, wherever possible, that the collection of data cannot put the person's care at risk or discourage individuals from accessing care.



Tip for Accessing Additional Evaluation Capacity

For larger evaluation projects, local health department staff may lack the personnel, resources or expertise to design and conduct the evaluation. Consider partnering with universities and other academic institutions or research firms that can contribute design services and students or other staff who may be able to conduct parts of the evaluation. Public health programs, social work programs, medical schools and others may have relevant expertise and available capacity but lack the primary data of health departments. A partnership between a local health department and a university can benefit both parties.

IDENTIFY STRATEGIES TO IMPROVE AND SUSTAIN SERVICE DELIVERY BASED ON EVALUATION AND QUALITY IMPROVEMENT FINDINGS.

Findings from evaluations and quality improvement initiatives should be shared transparently and rapidly with the end users, including the organizations that contributed data. Use the lessons learned from program evaluation to implement sustained and meaningful change in public health practice. The Institute of Medicine proposed a strategy to move from measurement to improvement in the mental health and substance use sector. The strategy included building capacity for clinicians to deliver evidence-based care, cultivating leadership in the field to advocate for the development and implementation of quality measurement and incorporating quality improvement in the day-to-day activities of SUD treatment providers, among others.²⁵⁵

A study of SUD treatment systems implementing evidence-based practices found a large variety in effective strategies, including top-down and bottom-up strategies. Some commonalities emerged, which can serve as suggestions for implementing program changes to improve linkage to care. Trusted partnerships between providers and policymakers resulted in wider adoption of evidence-based practices. Incremental testing and piecemeal adaptation, rather than wholesale system change, resulted in sustained change. Trial-and-error processes, in which organizations learned how to tailor their approach to meet the unique contexts of their environments, were common.²⁵⁶



Tools and Resources for Evaluation

- [CDC Evaluation Resources](#)
- [Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project](#) (HIDTA)
- [HEDIS Measures](#) (National Committee for Quality Assurance)

Appendix A. Organizational Checklist

The following checklist offers key questions health departments should consider when identifying opportunities to better support linkage to care efforts for people at risk of overdose. Aligned with the strategies in this Roadmap, the checklist is organized into seven categories of public health activities that can support successful linkage to care.

STRATEGY 1. COLLECT DATA AND CONDUCT SURVEILLANCE.

Question	No	In progress	Yes
1. Does the health department regularly collect data to identify neighborhoods and/or populations at high risk for opioid overdose?			
2. Are any of the following sources of data being collected?	--	--	--
Opioid-involved overdose death certificates and/or medical examiner records			
EMS activations related to opioids			
Syndromic surveillance data specific to overdose			
Emergency department admissions related to opioids			
SUD treatment utilization (e.g., outpatient, inpatient, MOUD)			
Harm reduction services utilization (e.g., syringe services, naloxone distribution)			
3. Are data stratified by the following?	--	--	--
Race/ethnicity			
Age group			
Gender			
Zip code, neighborhood, census tract or another geographic identifier			
4. Is this data shared regularly with provider organizations who can prioritize services accordingly?			
Aggregate de-identified data			
Individual identified data			

Question	No	In progress	Yes
5. Does the health department facilitate the sharing of data to promote linkage to care with the following partners and organizations?	--	--	--
Relevant divisions within the health department (HIV, STI, tuberculosis, etc.)			
Aggregate de-identified data			
Individual identified data			
Other local government agencies (e.g., housing and homelessness services, benefits/cash assistance, emergency response, public safety, corrections)			
Aggregate de-identified data			
Individual identified data			
Health care providers (e.g., hospitals, emergency departments, community health centers, FQHCs, CCBHCs)			
Aggregate de-identified data			
Individual identified data			
Community-based organizations			
Aggregate de-identified data			
Individual identified data			
6. Are data sharing agreement templates readily available and accessible?			
7. Are data shared in a secure manner?			
8. Are data shared in real time or near-real time (within 24 hours or less)?			
9. Which of the following sources of data are used to inform linkage to care for individuals at risk of overdose?	--	--	--
Overdose fatality review committee information			
PDMP			
Syndromic surveillance			
Health information exchange (HIE)			
Large cross-system data matches (e.g., health care, housing/homelessness, SUD treatment, corrections)			
Frequent user analyses			

STRATEGY 2. DEVELOP A PUBLIC HEALTH WORKFORCE THAT SUPPORTS LINKAGE TO CARE.

Question	No	In progress	Yes
1. Does the health department provide training for staff on any of the following topics?	--	--	--
Substance use and SUDs			
SUD treatment, including MOUD			
Harm reduction services			
Overdose prevention education and the use of naloxone			
Addressing stigma, including the use of person-first language			
2. Does the health department provide training to staff in any of the following organizations?	--	--	--
Other government agencies			
SUD treatment providers			
Health care providers			
Community-based organizations			
Faith-based organizations			
General public			
Home health care			
3. Has the health department adopted policies to ensure non-stigmatizing language is used?			
4. Does the health department proactively seek to hire people with lived experience?			
5. Does the health department proactively seek to hire people who are representative of the community they serve?			
6. Do hiring practices and prerequisite qualifications value lived experience as much as professional experience and education?			
7. Are jobs flexible enough to accommodate the specific needs of people with lived experience, when necessary?			
8. Does the health department promote a culture of valuing and not stigmatizing the lived experiences of its staff?			

STRATEGY 3. INCREASE OVERDOSE AWARENESS AMONG PROVIDERS AND COMMUNITY MEMBERS.

Question	No	In progress	Yes
1. Does the health department use its role as credible messenger to raise awareness of substance use and overdose risk?			
2. Are any of the following activities being conducted to raise awareness of overdose?	--	--	--
Provide public education and training on substance use, SUDs, stigma, addiction treatment including MOUD or overdose prevention education and use of naloxone			
Offer training to other government agencies (e.g., housing and homelessness providers, correctional staff, group living residences, public library staff, transit drivers/staff)			
Public communications/media campaigns			
Press releases and public-facing news pieces on local substance use trends			
3. Is the education and training culturally specific and relevant to the population(s) of focus?			

STRATEGY 4. SUPPORT CROSS-SECTOR COLLABORATION AND PARTNERSHIPS.

Question	No	In progress	Yes
1. Has the health department identified key partners within and across sectors?			
2. Does the health department have meaningful relationships with partner organizations?			
3. Does the health department convene organizations across sectors or within sectors to help establish partnerships and foster collaboration?			
4. Does the health department support any existing linkage to care activities in health care and community-based organizations?			
5. Does the health department maintain a publicly available directory of relevant services for PWUD for the jurisdiction?			
6. Has the health department partnered with the state Medicaid agency, managed care organizations or department of insurance to identify opportunities to share data?			

STRATEGY 5. PROVIDE LINKAGE TO CARE SERVICES DIRECTLY OR BY FUNDING COMMUNITY PARTNERSHIPS.

Question	No	In progress	Yes
1. Does the health department directly provide any of the following linkage to care services or programs?	--	--	--
Partnerships with public safety			
ED-initiated MOUD			
Peer support services			
Care coordinators, patient navigators or bridge counselors			
Transportation			
Harm reduction			
2. Does the health department fund linkage to care activities in other organizations?	--	--	--
Partnerships with public safety			
ED-initiated MOUD			
Peer support services			
Care coordinators, patient navigators or bridge counselors			
Transportation			
Harm reduction			
3. Do sufficient services exist for individuals to be linked to?			

STRATEGY 6. PROMOTE POLICY THAT ENHANCES LINKAGE TO CARE.

Question	No	In progress	Yes
1. Does the health department actively advocate for policies, such as access to naloxone and syringe service programs, that can reduce overdose risk and support linkages across other sectors?			
2. Does the health department provide consultation to other governmental sectors, such as housing, corrections and education, on programs and policies that may impact overdose risk?			
3. Does the health department work to overcome policies within and outside of the health care sector that may make linkage to care challenging when they arise?			

STRATEGY 7. EVALUATE LINKAGE TO CARE INITIATIVES.

Question	No	In progress	Yes
1. Does the health department evaluate any efforts to provide and promote linkage to care?			
If yes, are evaluation activities conducted in collaboration with community partners?			
2. Does the health department encourage and facilitate the evaluation of linkage to care activities in other organizations?			
3. Does the health department share findings from any relevant evaluations with communities and partner organizations who may be able to use the information to improve linkage to care activities?			
4. Does the health department adjust its own programs, policies and activities as a result of evaluation findings, when applicable?			

Appendix B. Resources and Tools to Support Strategies for Linkage to Care

Type of Resource	Title	Source	Date	Description
Overview and background information and tools				
Report	Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States	Centers for Disease Control and Prevention (CDC)	2018	Provides information and guidance on evidence-based strategies to prevent opioid overdose.
Toolkit	Opioid Epidemic Toolkit 2021	National Association of County and City Health Officials (NACCHO)	2021	Toolkit for local health departments to address the overdose crisis through five overarching strategies, including local, state and national resources.
Primer	Local Opioid Overdose Prevention and Response: A Primer for Local Health Departments	NACCHO	2019	Toolkit for local health departments to address the overdose crisis.
Resource guide	Local Responses to the Opioid Epidemic: An Environmental Scan, Local Health Department Resources	NACCHO	2019	Resource guide listing tools, resources and case examples across a continuum of overdose response for local health departments.
Resource guide	Now What? The Role of Prevention Following a Nonfatal Opioid Overdose	Substance Abuse and Mental Health Services Administration (SAMHSA)	2018	Presents importance of prevention interventions following nonfatal overdose to reduce risk of subsequent overdose, highlighting case examples of post-overdose interventions.
Checklist	Community Response Checklist	Brandeis Opioid Resource Connector	2020	Checklist tool for communities to implement interventions, policies and practices related to preventing and addressing opioid-related harms across the continuum of care.
Convening summary	Strengthening Community-Clinical Linkages to Improve Health Outcomes: Convening Summary	Association of State and Territorial Health Officials (ASTHO)	2019	Findings from a convening related to improving linkages between community and clinical partners to address social determinants and health-related social needs. Not specific to substance use or overdose.

Type of Resource	Title	Source	Date	Description
Issue brief	The Opioid Crisis and the Black/African American Population: An Urgent Issue	SAMHSA	2020	Presents data on prevalence of opioid misuse and death rates in the Black/African American population, contextual factors and challenges to prevention and treatment and innovative outreach and engagement strategies to connect people to evidence-based treatment and the importance of community voice.
Guideline	The ASAM National Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update	American Society of Addiction Medicine (ASAM)	2020	Provides expert recommendations and guidance related to the treatment of OUD.
Toolkit	Public Health and Safety (PHAST) Toolkit: Guidance for Data-driven Overdose Response Coordination Among Public Health, Criminal Justice, Law Enforcement and First Responders	CDC Foundation	2020	Tools and resources for implementing a data-driven collaboration between public health and public safety sectors. Toolkit is organized into two modules, one for PHAST leadership, one for multi-sector partners.
Report	Overdose Prevention Services in Jails: The 2019 Overdose Response Strategy Cornerstone Report	High Intensity Drug Trafficking Areas (HIDTA)	2019	Report describing overdose prevention services offered in jails and barriers and facilitators to implementing overdose prevention services.
Report	Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project	HIDTA	2018	Report describing five types of public safety-led post-overdose linkage to care programs.
Toolkit	Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders	SAMHSA	2018	Toolkit describing processes for first responders to respond to opioid overdose.
Resources	Law Enforcement Diversion Programs	Curated Library about Opioid Use for Decision-makers (CLOUD)	2020	Collection of resources for law enforcement diversion programs, including case examples of existing models.

Type of Resource	Title	Source	Date	Description
Toolkit	Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit	National Council for Mental Wellbeing and Vital Strategies	2020	Toolkit for implementing MOUD in jails and prisons, including tools and resources from existing programs.
Primer	A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons	RTI International	2019	Primer describing strategies and resources for developing, coordinating, monitoring and evaluating jail- and prison-based OEND programs.
Resources	Bureau of Justice Assistance's (BJA) Comprehensive Opioid, Stimulant and Substance Abuse Program (COSSAP) Resource Center	Bureau of Justice Assistance Comprehensive Opioid, Stimulant and Substance Abuse Program (BJA COSSAP)	2021	Provides information on site-based grants, demonstration projects and training and technical assistance opportunities for local, state and tribal agencies responding to the opioid crisis in the criminal justice system.
Strategy 1: Collect data and conduct surveillance.				
Toolkit	Monitoring and Surveillance, Opioid Overdose Epidemic Toolkit for Local Health Departments	NACCHO	2019	Provides local, state and national resources related to data monitoring and surveillance to address the opioid crisis.
Resources	Overdose Fatality Review resource catalog	BJA COSSAP	2020	Provides a toolkit, recorded webinars, templates and other guidance and tools for implementing overdose fatality reviews.
Toolkit	Overdose Fatality Review: A Practitioner's Guide to Implementation	BJA COSSAP	2020	Toolkit that provides step-by-step guidance, tools, templates and other resources for implementing overdose fatality reviews.
Template	Overdose Fatality Review Data Sharing Protocol	BJA COSSAP	2020	Template with key fields data sharing agreements should include.
Resource center	Center for Excellence for Protected Health Information (COE PHI)	COE PHI	2021	Provides training, individualized technical assistance and other resources on topics related to sharing protected health information.

Type of Resource	Title	Source	Date	Description
Toolkit	Public Health and Safety (PHAST) Toolkit: Guidance for Data-driven Overdose Response Coordination Among Public Health, Criminal Justice, Law Enforcement and First Responders	CDC Foundation	2020	Tools and resources for implementing a data-driven collaboration between public health and public safety sectors. Toolkit is organized by two modules, one for PHAST leadership, one for multi-sector partners.
Resource guide	Leveraging Data Sharing for Overdose Prevention: Legal, Health and Equity Considerations	ChangeLab Solutions	2020	Provides an overview of data sharing for overdose prevention, federal laws governing data sharing and strategies for data sharing across agencies.
Strategy 2: Develop a public health workforce that supports linkage to care.				
Toolkit	Coping with Overdose Fatalities: Tools for Public Health Workers	Massachusetts Department of Public Health	2019	Presents core actions and strategies for supporting service providers following overdose fatalities among the population served.
Resource guide	Introductory Guide to Academic Detailing	National Resource Center for Academic Detailing (NaRCAD)	2017	Provides guidance on seven key steps to conducting an academic detailing outreach visit.
Resource center	Academic Detailing Program Building Resources	NaRCAD	2021	Provides guidance and tools for building an academic detailing program, as well as example resources on various health topics.
Virtual training	SUD 101 Core Curriculum	Providers Clinical Support System (PCSS)	2019	A catalog of 22 training modules that provide an overview of evidence-based practices in the prevention, identification and treatment of SUDs and co-occurring mental health challenges.
Implementation guide	Addiction Language Guide	Shatterproof	2021	Identifies recommended non-stigmatizing terms to use when discussing substance use and the rationale for using those terms. Also offers implementation tools and resources, including training materials.

Type of Resource	Title	Source	Date	Description
Webinar	Culturally Competent Public Health Practice for Deaf and Hard of Hearing Populations	Region V Public Health Training Center	2019	Recorded webinar training that presents tools and information for working with the deaf and hard of hearing community, as well as common misconceptions about deaf culture and sub-cultures within the community.
Webinar	Rural LGBTQ+ Populations: Creating Welcoming and Inclusive Health Care Experiences	Region V Public Health Training Center	2020	Recorded webinar that provides information on best practices for inclusive, affirming and culturally competent care for rural LGBTQ+ populations.
Toolkit	Trauma-informed, Recovery-oriented Systems of Care Toolkit	National Council for Mental Wellbeing	2020	Toolkit for county change teams to implement trauma-informed and recovery-oriented practices. Offers several training resources and tools.
Training module	HealtheKnowledge: Understanding Substance Use Disorders	HealtheKnowledge	2020	A two-hour self-guided course on SUD and SUD treatment. Continuing education credits for health care and social work professionals are available.
Strategy 3: Increase overdose awareness among providers and community members.				
Toolkit	Prevention, Opioid Overdose Epidemic Toolkit for Local Health Departments	NACCHO	2019	Provides local, state and national prevention resources related to the opioid crisis, including tools to increase awareness.
Fact sheet	Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)	CDC	2019	Provides information and evidence related to the efficacy of SSPs.
Handbook	Decisions in Recovery: Treatment for Opioid Use Disorder	SAMHSA	2016	Provides guidance on using decision support tools and offers information about medication-assisted treatment. This handbook helps people with opioid use disorder compare treatment options and discuss their preferences with a provider.

Type of Resource	Title	Source	Date	Description
Fact sheet	Opioid Crisis Resources for Tribal Communities	SAMHSA	2017	Provides information on technical assistance and funding opportunities to address the opioid crisis for tribal populations.
Strategy 4: Support cross-sector collaboration and partnerships.				
Toolkit	Stakeholders and Partnerships, Opioid Overdose Epidemic Toolkit for Local Health Departments	NACCHO	2019	Provides local, state and national resources related to engaging stakeholders and building partnerships to better address the opioid crisis.
Guide	Mobilizing Community Partnerships in Rural Communities: Strategies and Techniques	NACCHO	2013	Provides guidance for initiating partnerships in rural communities and highlights three case examples.
Report	Partnering for Health Equity: Grassroots Organizations on Collaborating with Public Health Agencies	Prevention Institute	2018	Report discussing strategies for advancing equity in public health practice through partnerships with community organizations, including case examples.
Report	Aligning City, County and State Resources to Address the Opioid Epidemic: Lessons Learned and Future Opportunities	National League of Cities	2017	Provides recommendations for coordinating services in communities to address the opioid crisis.
Resource	CCBHC Success Center	National Council for Mental Wellbeing	2021	Resource page about the CCBHC model and supports for implementation.
Resource	CCBHC Locator Map	National Council for Mental Wellbeing	2021	Interactive map identifying CCBHC locations across the U.S.

Type of Resource	Title	Source	Date	Description
Strategy 5: Provide linkage to care services directly or by funding community partnerships.				
Report	Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project	HIDTA	2018	Report describing five types of public safety-led post-overdose linkage to care programs.
Resource guide	Overdose Prevention and Response in Behavioral Health Settings	New York State Office of Alcoholism and Substance Abuse Services	2018	Guide for providers to develop trauma-informed strategies related to preventing and reducing risk of opioid overdose.
Implementation guidance	Emergency Department Naloxone Distribution: Key Considerations and Implementation Strategies	American College of Emergency Physicians	2015	Guidance and resources for implementing OEND programs in emergency departments.
Checklist	Medication-assisted Treatment (MAT) Readiness and Implementation Checklist	National Council for Mental Wellbeing	2020	Implementation checklist that guides organizations through a set of readiness considerations for implementing MOUD.
Toolkit	Public Health and Safety Team (PHAST) Toolkit	CDC Foundation	2020	Toolkit for developing overdose response teams involving public health, public safety and other partners.
Resource catalog	PCSS Implementation Project Resources	PCSS	2020	Catalog of resources and tools related to providing MOUD, including training modules, clinical workflows, business plans, peer recovery resources and others.
Expert panel findings	Addressing Opioid Use Disorder in Emergency Departments: Expert Panel Findings	National Council for Mental Wellbeing and Opioid Response Network	2021	Describes recommendations related to addressing OUD in emergency departments identified through a 1.5-day expert panel convening.

Type of Resource	Title	Source	Date	Description
Strategy 6: Promote policy that enhances linkage to care.				
Toolkit	MAT Advocacy Toolkit	Legal Action Center	2020	Provides information, sample advocacy letters, policy guidance and other resources for supporting people's access to MOUD.
Roadmap	National Roadmap on State-Level Efforts to End the Opioid Epidemic	American Medical Association and Manatt Health	2019	Provides state-level guidance on policy and financing levers that could be used to increase access to services and supports for people at risk of opioid overdose.
Report	Cross-Sector Approach to Removing Legal and Policy Barriers to Opioid Agonist Treatment	Network for Public Health Law	2020	Identifies barriers to buprenorphine and methadone treatment access and potential solutions to improve uptake across eight sectors.
50-state survey	Harm Reduction Laws in the United States	Network for Public Health Law	2020	Provides information on harm reduction-related laws in 50 states.
Fact sheet	Naloxone Prescription Mandates	Network for Public Health Law	2020	Provides information on state laws that have required that naloxone be recommended or prescribed to some patients.
50-state survey	Characteristics of Statewide Naloxone Distribution Mechanisms	Network for Public Health Law	2020	Provides information on statewide naloxone distribution legal directives, practice agreements or protocols in 50 states.
Webinar	Linking and De-identifying State-level Data Sets to Tackle the Opioid Epidemic	Network for Public Health Law	2019	90-minute webinar featuring case studies and strategies on de-identifying and linking datasets to address the opioid epidemic. Also provides information on navigating the legal framework to collect, use and share data across sectors to improve community health.
Policy guidance	Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)	Centers for Medicare and Medicaid Services (CMS)	2021	Letter to state health officials outlining ways in which Medicaid reimbursement can support activities to improve social determinants of health.
Model legislation	Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment	National Alliance for Model State Drug Laws	2018	Provides model state legislation for the establishment of a warm hand-off program for people who experienced an overdose.

Type of Resource	Title	Source	Date	Description
Strategy 7: Evaluate linkage to care initiatives.				
Resource catalog	Public Health Evaluation	CDC	2021	Catalog of resources for developing public health evaluations.
Report	Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project	HIDTA	2018	Report describing five types of public safety-led post-overdose linkage to care programs.
Guidance document	Aligning Systems with Communities to Advance Equity through Shared Measurement: Guiding Principles	American Institutes for Research and Robert Wood Johnson Foundation	2021	Describes five guiding principles for using shared measurement to align systems with communities to advance equity.
Guidance document	Framework for Program Evaluation	CDC	2017	Provides an overview of the steps to conduct public health program evaluation.

Appendix C. COVID-19 Pandemic-related Resources and Tools

Type of Resource	Title	Source	Date	Description
Resources and information	Coronavirus (COVID-19) SAMHSA Resources and Information	SAMHSA	2020	Provides a list of COVID-19-related resources for people with behavioral health conditions, including PWSUD and PWUD.
Resources and information	COVID-19 and People At Increased Risk	CDC	2020	Provides answers to a series of questions related to COVID-19 risks among PWUD and PWSUD.
Environmental scan	COVID-19 Pandemic Impact on Harm Reduction Services: An Environmental Scan	National Council for Mental Wellbeing	2021	Describes findings from a literature review and 21 key informant interviews about the impacts of the COVID-19 pandemic on harm reduction services and PWUD.
Guidelines	Interim Guidance for Syringe Services Programs	CDC	2020	Provides guidance to SSPs on education, prevention and screening for COVID-19.
Resources and information	COVID-19 Updates and Resources	NASTAD	2020	Provides a list of resources and information relevant to people at risk for HIV and hepatitis, including PWUD.
Respite facility procedure manual	COVID19 Respite Facility for People Experiencing Homelessness: Procedure Manual	City of New Haven, Connecticut	2020	Procedure manual for City of New Haven respite facilities, which includes guidance related to substance use, based on harm reduction principles and practices.
Policy brief	Policy Brief: Disasters and Substance Use, Implications for the Response to COVID-19	National Association of State Alcohol and Drug Abuse Directors (NASADAD)	2020	Provides policy recommendations related to protecting the health of PWSUD and PWUD during disasters.
Assessment and resource manual for organizations serving PWUD and PWSUD	Oregon Substance Use Disorder Resource Document	Oregon Substance Use Disorder Resources Collaborative (ORSUD)	2020	A real-time capacity needs assessment for local safety net programs and organizations or PWSUD in Oregon during COVID-19.

Type of Resource	Title	Source	Date	Description
Brief	Syringe Services Programs & Harm Reduction Programs as Essential Services	AIDS United	2020	Describes the impact of COVID-19 on PWUD's health, the main services of SSPs and importance of SSPs during the COVID-19 pandemic.
Resource compilation	Harm Reduction Amidst the COVID-19 Pandemic	National Harm Reduction Coalition	2020	Compilation of resources related to protecting the health of PWUD during the COVID-19 pandemic.
Provider fact sheet	COVID-19, Surface and Disinfection for Syringe Service Providers and Other Harm Reduction Providers	Vital Strategies and National Harm Reduction Coalition	2020	Provides guidance to SSPs and other harm reduction providers on effective cleaning and disinfection practices during the COVID-19 pandemic.
Resource compilation	COVID-19 Resources For people who use drugs, people who engage in sex work and people vulnerable to structural violence	National Harm Reduction Coalition	2020	Compilation of resources related to protecting the health of PWUD during the COVID-19 pandemic.
Fact sheet	Administering Naloxone During the COVID-19 Pandemic	Vital Strategies and National Harm Reduction Coalition	2020	Guidance and frequently asked questions related to administering naloxone during the COVID-19 pandemic.
Webinar	Increased Access to Medications for Opioid Use Disorder during the COVID-19 Epidemic and Beyond	Network for Public Health Law	2020	90-minute webinar describing COVID-19-related legal and regulatory modifications and how they are being used to increase access to OUD treatment and opportunities to permanently increase access to MOUD.
Video	Harm Reduction Services During COVID-19	Maryland Department of Health	2020	11-minute video showing how various organizations provided harm reduction services in Maryland during the COVID-19 pandemic.
Policy guidance	How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency	Drug Enforcement Administration	2020	Decision tree that guides providers through the steps to prescribing buprenorphine and other controlled substances during the COVID-19 pandemic.
Policy guidance	Supporting Access to Telehealth for Addiction Services: Regulatory Overview and General Practice Considerations	ASAM	2020	Guidance on regulatory and practice issues related to the use of telehealth during the COVID-19 pandemic.

Type of Resource	Title	Source	Date	Description
Checklist	<u>Ongoing Management of the Continuum of Addiction Care During COVID-19</u>	ASAM	2020	A checklist of considerations for substance use treatment clinicians and programs during the COVID-19 pandemic.
Guidance	<u>Adjusting Drug Testing Protocols</u>	ASAM	2020	Guidance and recommendations related to adjusting drug testing protocols during the COVID-19 pandemic.
Guidance	<u>Promoting Support Group Attendance</u>	ASAM	2020	Recommendations for conducting virtual support groups during the COVID-19 pandemic.
Guidance	<u>Treating Unhoused People with Addiction During COVID-19</u>	ASAM	2020	Guidance and recommendations for providing services to people experiencing housing instability with SUD during the COVID-19 pandemic.
Guidance	<u>Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder</u>	Rhode Island Department of Health and Department of Behavioral Healthcare	2017	Provides guidance to Rhode Island hospitals on the Levels of Care certification criteria for responding to an overdose.

Appendix D. Linkage to Care Evaluation Measures

Source	Measure	Description	Notes
Healthcare Effectiveness Data and Information Set (HEDIS): Follow-up after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence ²⁵⁷	ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).	N/A	N/A
HEDIS: Follow-up after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence ²⁵⁸	ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	N/A	N/A
HEDIS: Transitions of Care ²⁵⁹	Notification of inpatient admission.	Documentation in the medical record of receipt of notification of inpatient admission on the day of admission or the following day.	N/A
HEDIS: Transitions of Care ²⁶⁰	Receipt of discharge information.	Documentation in the medical record of receipt of discharge information on the day of discharge or the following day.	N/A
HEDIS: Transitions of Care ²⁶¹	Patient engagement after inpatient discharge.	Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	N/A
HEDIS: Transitions of Care ²⁶²	Medication reconciliation post-discharge.	Medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	N/A
HEDIS: Initiation and Engagement of Alcohol and Other Drug Abuse (AOD) or Dependence Treatment ²⁶³	Initiation of AOD treatment.	Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis.	N/A

Source	Measure	Description	Notes
HEDIS: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment ²⁶⁴	Engagement of AOD treatment.	Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.	N/A
HEDIS: Identification of Alcohol and Other Drug Services ²⁶⁵	Number and percentage of individuals who had a service for AOD abuse or dependence.	Inpatient, intensive outpatient or partial hospitalization, outpatient or an ambulatory MAT dispensing event, ED, telehealth, any service.	N/A
Eskenazi Emergency Department's Project POINT (Project POINT) ²⁶⁶	Number of individuals given referral to treatment.	Unclear if engagement in referral, depending on type, is also measured.	Project POINT is a collaboration between Eskenazi ED, Indiana University, emergency medical services and Midtown Mental Health that provides peer-based overdose response and a range of services to individuals in Indianapolis hospitals.
Project POINT ²⁶⁷	Number of individuals referred for HIV testing.	Unclear if receipt of HIV test is also measured.	
Project POINT ²⁶⁸	Number of individuals referred for HCV testing.	Unclear if receipt of HCV test is also measured.	
Project POINT ²⁶⁹	Number of participants who attended the first follow-up appointment.	N/A	
Project POINT ²⁷⁰	Number of participants engaged in services at 30 days post-discharge.	Unclear how “engaged in services” is defined.	
Project POINT ²⁷¹	Number of participants on MAT at 30 days post-discharge.	N/A	

Source	Measure	Description	Notes
NYC Department of Health and Mental Hygiene Relay ²⁷²	Number of naloxone kits distributed by peer wellness advocates.	Number of naloxone kits distributed within the evaluation timeframe.	The NYC Relay project provides 24/7 peer-based services to individuals in hospitals who have experienced an overdose.
NYC Department of Health and Mental Hygiene Relay ²⁷³	Number of individuals who agreed to participate in the program.	Number of individuals who agreed to participate in the program.	
NYC Department of Health and Mental Hygiene Relay ²⁷⁴	Number of participants reached for follow-up within 48 hours after hospital discharge.	Number of participants reached for follow-up within 48 hours after hospital discharge.	
NYC Department of Health and Mental Hygiene Relay ²⁷⁵	Contact rates at 30, 60 and 90-day check-ins.	Rates of contact between participant and peer wellness advocates at 30, 60 and 90 days.	
NYC Department of Health and Mental Hygiene Relay ²⁷⁶	Number of participants who accepted referrals to harm reduction services.	Time period for this measure was not defined.	
NYC Department of Health and Mental Hygiene Relay ²⁷⁷	Number of participants who accepted referrals to MAT/MOUD, outpatient SUD and inpatient SUD treatment.	Time period for this measure was not defined. This is most likely limited to the first referral appointment.	
NYC Department of Health and Mental Hygiene Relay ²⁷⁸	Number of participants who kept treatment appointments.	Time period for this measure was not defined. This is most likely limited to the first referral appointment.	

Source	Measure	Description	Notes
Anchor Recovery Center AnchorED and AnchorMORE (Anchor) ²⁷⁹	Number of contacts between peer recovery specialists and individuals.	N/A	AnchorED and AnchorMORE are two peer-based overdose response models implemented in Rhode Island. AnchorED peer recovery specialists provide 24/7 support to individuals in EDs who have experienced an overdose. AnchorMORE provides long-term recovery support and services through Anchor Recovery Community Center as well as providing community-based overdose response.
Anchor ²⁸⁰	Number of ED participants that agreed to peer specialist engagement post-discharge.	N/A	
Anchor ²⁸¹	Number of clients enrolled.	Tracked during evaluation timeframe.	
Anchor ²⁸²	Number of naloxone training sessions offered.	N/A	
Anchor ²⁸³	Number and type of referrals to recovery support and treatment services.	Completion of referral/engagement in referral service not identified as a measure.	
Anchor ²⁸⁴	Number of ED participants who received naloxone training.	N/A	
Anchor ²⁸⁵	Number of naloxone kits distributed within communities.	Mapped in comparison to where overdoses occur in the communities.	
Houston Emergency Response Opioid Engagement System (HEROES) ²⁸⁶	Percentage of eligible individuals who elected to participate in outpatient-based medical and behavioral treatment program divided by the total number of people approached.	Willingness to engage in medication and behavioral treatment program. Engagement was defined as the patient's willingness to participate and attend a treatment program.	Evaluation of HEROES at the University of Texas Health Science Center, a mobile outreach overdose response model.
HEROES ²⁸⁷	Retention in treatment at 30 and 90-day endpoints.	Treatment retention defined as ongoing confirmed participation in a medication-based and behavioral treatment program through the 30 and 90-day endpoints.	

Source	Measure	Description	Notes
Missouri Medication First ²⁸⁸	Rate of receipt of MOUD.	Frequency of specific types of MOUD across episodes of care.	Evaluation of Missouri's Medication First program is supported by State Targeted Response (STR) funds. Provides low-barrier access to MOUD facilitated through state-level structural changes and 14 state-contracted treatment agencies.
Missouri Medication First ²⁸⁹	Time between first billable service and the first MOUD prescription.	How quickly medications were prescribed defined as the number of days between the first billable service and the first billable medication prescription.	
Missouri Medication First ²⁹⁰	Hours per day of psychosocial services in the first month of treatment.	Psychosocial services were defined using billable service codes.	
Missouri Medication First ²⁹¹	Rates of retention treatment at 1, 3 and 6 months.	Defined as whether there were continued billable services 1, 3 and 6 months after the first billable service.	
Missouri Medication First ²⁹²	Cost per month of treatment.	Calculated by creating an adjusted cost of services, dividing the total price per episode of care by length of treatment episode in months.	
Oregon Health & Science University (OHSU) IMPACT program ²⁹³	SUD treatment engagement after hospital discharge.	Defined as 2 or more claims on 2 separate days for SUD care within 34 days of discharge.	OHSU IMPACT provides patient-centered care offering MAT, linkage to care after discharge and harm reduction support to individuals with SUDs who present with medical and surgical complications of addiction in a hospital setting.

Source	Measure	Description	Notes
OPTUMLabs ²⁹⁴	Evidence of MAT among patients with OUD or overdose.	Evidence of MAT therapy at any time during the measurement period among patients with OUD or overdose. Patients with MAT therapy appear in both the numerator and the denominator. A single MAT claim may serve as both evidence of MAT and evidence of OUD. No criteria around timing of MAT in relation to the overdose or overdose claim is required.	Commercial insurance metrics.
OPTUMLabs ²⁹⁵	Evidence of MAT among patients who experienced an overdose.	Defined as evidence of MAT therapy on or following first diagnosis of overdose.	
OPTUMLabs ²⁹⁶	Evidence of naloxone among patients with OUD or overdose.	Defined as evidence of naloxone on or after the earliest detected OUD claim.	

Appendix E. Principles Central to Harm Reduction²⁹⁷

1	Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2	Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.
3	Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
4	Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
5	Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
6	Affirms PWUD themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use.
7	Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.
8	Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

Appendix F. Sample Job Description

City of Waterbury, Connecticut

Overdose Response Technician

Salary Range: \$40,000 - \$45,000 per year plus benefits

Purpose of Position:

The purpose of this position is to provide support to individuals who may experience an overdose related to the use of opioids. Working with the Waterbury Department of Public Health, this position shall be responsible for responding to the scene of an overdose, secondary to the City of Waterbury Police and/or Fire Departments being called to the scene of an overdose. This position shall engage and support persons by providing vital linkages to care for patients who wish to navigate a path toward recovery from a substance use disorder and/or to provide harm reduction resources to prevent a subsequent overdose and/or death. This position shall also provide support resources for family or loved ones of someone who has experienced an overdose or died as a result of a suspected or confirmed overdose.

Short-term outcomes:

- Position shall seek to meet persons at various stages of readiness with solutions for harm reduction.
- Position shall provide persons who experienced an overdose with a path to resources that will help the individual to avoid an additional overdose.
- Position shall provide persons who experienced an overdose with multiple options to seek treatment for a substance use disorder.
- Position shall seek to support caregivers and/or families with resources to help a person who has experienced an overdose.

Intermediate outcomes:

- The position shall provide persons who have experienced overdose with options for treatment of a substance use disorder.
- The position shall provide persons who have experienced overdose with a clear path to reduce harm to prevent a subsequent overdose or death if the individual is not treatment-ready.
- The position shall provide families with strategies and options to engage in self-care and to encourage support of those persons who have experienced overdose to seek and complete treatment.



Long-term outcomes anticipated for realization within 4-6 years or earlier:

- Decreased rate of emergency department (ED) visits due to opioid misuse or overdose.
- Decreased drug overdose death rate, including prescription opioid and illicit opioid overdose death rates.
- Decreased rate of opioid misuse and opioid use disorder.
- Increased provision of evidence-based treatment for opioid use disorder.

Activities:

Reporting to the Chief of Police or his/her designee, this position shall respond to the scene (or transport destination) of a person who has experienced an overdose. Upon contact, the Overdose Response Technician (ORT) shall provide the person with treatment options and other support resources for substance use disorders and/or harm reduction tools appropriate to the person's stage of readiness for change. Examples of such resources include but are not limited to:

- Information regarding face-to-face counseling and/or telephone support services.
- Schedules and locations of peer support and recovery meetings.
- Contact information to reach the ORT, should the individual choose to engage in services at a later time or date.
- Specific information about where and how to obtain harm reduction tools such as naloxone or fentanyl test strips.

Working with police department personnel, the ORT shall provide support resources to families of persons experiencing overdose and/or death as a result of an overdose.

The ORT shall receive clinical field supervision from the Health Department Prevention Coordinator and operational supervision from the Chief of Police or his / her designee.

The Overdose Response Technician will be required to:

- Respond to scenes of overdose and/or overdose related deaths as requested by the Police and/or Fire Departments.
- Complete training(s) related to the position as assigned by the Chief of Police or his/her designee.
- Complete established reports as directed.
- Provide data entry regarding contacts and recommendations as established by rules, regulations or procedures.
- Attend meetings as assigned to relay field information to responders and administration.
- Use communications equipment such as cellular telephones, mobile data terminals and/or two-way radio communications.
- Other ancillary duties as assigned.



Education & Experience:

This position requires the following qualifications:

- Completion of a recognized training program in recovery coaching/navigation/treatment (or equivalent) to be determined by the Chief of Police and Prevention Coordinator.

Employment Requirements:

This position requires the following:

- Must possess and maintain a valid CT driver's license.
- Must have previous experience (lived and/or clinical) with provision of services to persons with substance use disorders.
- Must have familiarity with routine office equipment and computer programs including Microsoft Outlook, Word, Excel, etc.

Note: This is a grant-funded position.

Application Procedure:

If you are interested in applying for this position, please complete and submit the following documents:

1. A "Temporary Application" located on the HR home page at www.waterburyct.org.
2. An updated resume.
3. Any pertinent diplomas, transcripts, certifications, etc.
4. 3 reference letters.

Appendix G. Recommendations for ED-based Overdose Response Programs²⁹⁸

- 1. Identify overarching values.** Members of the team should commit to shared values, such as providing person-centered, choice-driven, comprehensive and compassionate care; promoting and advocating for cultural intelligence and sensitivity; and building a culture of wellness.
- 2. Implement a recovery-oriented workforce.** Recovery-oriented values should be practiced by shifting the service emphasis from an acute to a chronic care model, using evidence-based practices and offering PSS.
- 3. Create buy-in and establish an implementation team.** To be successful, all members of the team must see the value in the program. An implementation team led by a project champion can help gain support from other stakeholders, including organizational leadership.
- 4. Identify team members.** Many ED-based overdose response programs include a team of at least one x-waivered prescriber and a peer support worker. Sometimes all team members are employed directly by the hospital, while other times, some staff are employed by health departments or recovery community organizations.
- 5. Establish working relationship between EDs and the recovery community.** Recognizing that not all people will be ready to engage in long-term treatment for OUD while they are in the ED, it is essential that they receive ongoing support and follow-up from peer support workers and other recovery support services.
- 6. Develop a shared language.** Because ED-based health care providers may speak a “different language” than peer support workers and recovery community organizations, it is important that project teams develop mutually agreed upon language, which should be grounded in person-first, non-stigmatizing words and phrases.
- 7. Provide orientation, training and supervision.** Multidisciplinary teams, such as ED physicians and peer support workers, can pose unique challenges related to training and supervision. It is important that all team members understand each other’s roles on the project. It is also important that each team member gets the specific type of supervision necessary for professional growth. For example, peer support workers benefit from receiving supervision from others that have experience in a peer role or are experienced at supervising peers.
- 8. Establish protocols and workflows.** Implementation teams should develop protocols and workflows in compliance with prescribing regulations designed to meet the unique needs of the community and project team. Examples of key considerations for teams include how notifications or referrals will be communicated to peer support workers and how follow-up will be conducted with patients.
- 9. Provide linkage to community-based services.** Emergency department-based overdose response teams must identify how individuals will continue to engage in treatment and services when they are released from the hospital. Establishing follow-up appointments in the community prior to a person’s release and having peer support workers help individuals overcome barriers to treatment will increase the likelihood of treatment engagement.
- 10. Collect data and measure outcomes to sustain the program.** Because many overdose prevention and response programs are largely funded through grant dollars, it is important that programs track their impacts and outcomes to better communicate the value of services to funding partners and other stakeholders and to inform quality improvement efforts.

Appendix H. Key Informants

Name	Title	Organization	State
Ramona Anderson	Prevention Program Coordinator	Connecticut Department of Public Health	CT
Julie Bauch	Opioid Response Coordinator	Hennepin County	MN
Bruce Baxter	Chief Executive Officer and Chief of Service	New Britain Emergency Medical Services, Inc.	CT
Grace Cavallo	Chief Program Officer	Community Mental Health Affiliates	CT
Betsy Chanthapaseuth	Substance Use Program Supervisor	Denver Department of Public Health and Environment	CO
Patrick Ciardullo	Captain of Professional Standards and Training	New Britain Emergency Services	CT
Liz Connors	Outreach Coordinator	Missouri Institute of Mental Health	MO
Jennifer DeWitt	Prevention Coordinator	Waterbury Department of Public Health	CT
Kabaye Diriba	Lead Analyst	National Association of County and City Health Officials	DC
Dana Farley	Principal State Planner	Office of Statewide Health Improvement Initiatives, Minnesota Department of Health	MN
Jeffrey Hom	Medical Director	Division of Substance Use Prevention and Harm Reduction, Philadelphia Department of Public Health	PA
Angela Jeffers	Director	Relay NYC	NY
Holly Johnson	Overdose Surveillance and Planning Specialist	North Central Health District	GA
Jerry Joseph	Vice President of Addiction Medicine	Care Plus New Jersey	NJ
Zach Kosinski	Harm Reduction Program Coordinator and Regional PrEP Navigator	Harford County Health Department	MD
Jack Latchford	Outreach Worker	Harford County Health Department	MD
Marie Mormile-Mehler	Planning and Performance Improvement Officer	Community Mental Health Affiliates	CT

Name	Title	Organization	State
Bill Kinch	Project Manager	New Britain EMS	CT
Nicole O'Donnell	Certified Recovery Specialist	University of Pennsylvania Hospital	PA
Tamanna Patel	Director	National Council for Mental Wellbeing	DC
Tylica Pope	Vice President of Specialty SUD Services and Housing	BestSelf Behavioral Health	NY
Paige Prentice	Senior Vice President of Operations	Health Management Group, Horizon Health	NY
Sam Robertson	Community Overdose Prevention Coordinator	Injury and Violence Prevention Section, Minnesota Department of Health	MN
Marion Rorke	Substance Use Resource Coordinator	Denver Department of Public Health & Environment	CO
Elizabeth Salisbury-Afshar	Visiting Associate Professor	University of Wisconsin, Department of Family Medicine and Community Health	WI
Stacy Stanford	Director, Public Health Transformation	National Association of County and City Health Officials	DC
Jennifer Tuerke	Executive Director	Voices of Hope	MD
Erin Woodie	Chief Operations Officer	Voices of Hope	MD
Ann Marie Zihal	Senior Vice President, Clinical Services	Care Plus New Jersey	NJ

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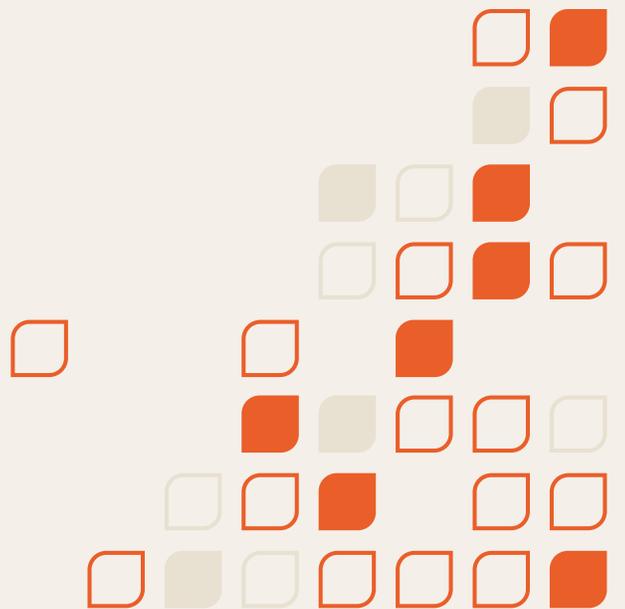
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