OD2A-S Performance Measures Technical Guidance

Division of Overdose Prevention
State Program and Implementation Branch
Version 2.2

October 2024

Acknowledgments

We want to acknowledge everyone who played a crucial role in the development of performance measures for Overdose Data to Action in States (OD2A-S). This would not have been possible without the dedication, expertise, and collaboration of a diverse group of public health partners. Special thanks to the subject matter experts at the Centers for Disease Control and Prevention (CDC), whose invaluable insights and domain knowledge shaped the selection and prioritization of indicators. Thank you also for the active engagement of our recipients during the initial performance measures webinar, whose feedback provided essential perspectives and ensured the relevance of our measures. Finally, thank you to the evaluators from the Program Evaluation Team, who each played a critical role in the development of this guide. This collective effort underscores the spirit of collaboration and commitment that defines our work in OD2A-S.

Contents

Introduction

This technical guidance is specifically developed to support recipients of Overdose Data to Action in States (OD2A-S) in their reporting of performance measures, also referred to as indicators. Performance measures will be reported by recipients during the period of funding to track progress on key interventions and outcomes as outlined in the Notice of Funding Opportunity (NOFO).

This Technical Guidance will support recipients to collect and report on the outlined performance measures. This document includes:

- Introduction
- Snapshot of performance measures
- Detailed descriptions of each performance measure
- Reporting timeline and guidance
- Appendices (acronyms and glossary)

Purpose and Objectives

The primary goal of performance measures in OD2A-S is to provide a common set of indicators that will be used by recipients and their partners to monitor progress and identify areas for improvement. Performance measures data can be used to help:

1) Recipients show progress and communicate progress to their health department leadership.
2) CDC and recipients inform future CDC programmatic investments.
3) CDC and recipients understand the contributions of OD2A-S across overdose prevention strategies and use data for programmatic improvement.
4) CDC communicates with Health and Human Services (HHS) and other federal policymakers about the progress made under OD2A-S.

At CDC, these performance measures are not meant to compare jurisdictions to each other, but rather to monitor progress for a recipient over time and to examine OD2A-S as a program, overall. By establishing and regularly monitoring performance measures, recipients can identify areas of strength, pinpoint challenges, and align their efforts with intended objectives, ultimately fostering accountability and continuous enhancement within their programs.

Assumptions and Considerations

The data reported should be based on work and support conducted using OD2A-S funding.

Activities do not have to be directly funded with OD2A-S funds but must be supported by OD2A-S funding in some way to be counted in the performance measures. This may be direct funding (e.g., paying for an activity, paying for resources or supplies) or indirect support (e.g., in-kind staff support, surveillance and evaluation support, coordination of activities across multiple partners). Please work with your project and evaluation officer to determine what data should be collected for your jurisdiction.

Overdose prevention programs will vary in their capacity to collect and analyze these data. As programs build their relationship, data, and technology capacities, their ability to collect these data will improve. There are no CDC-specified benchmarks or targets; however, individual recipients can examine their current capacities and set their own benchmarks or targets. We also encourage recipients to develop specific, measurable, achievable, relevant, and time-bound (SMART) objectives across the performance measures. We hope programs will see improvements over time across performance measures, recognizing the focus for OD2A-S will be primarily on program use, goal setting, and progress on an individual recipient level as well as examining OD2A-S as a program, overall.

In addition, OD2A-S as a program may change over time, influenced by external factors, changes in the drug overdose epidemic, and the effectiveness of prevention interventions. Consequently, a commitment to flexibility is inherent in our approach. Although we aim to have consistency in performance measurement reporting across the cooperative agreement (CoAg) period of performance, the performance measures selected in Year 1 will be subject to periodic reassessment and refinement to ensure they remain aligned with recipients' work and continue to provide meaningful insights. Additional performance measures—required and/or optional—might be provided by the CDC to recipients for reporting during the latter years of the OD2A-S CoAg.

It is important to remember that these performance measures do not account for everything we expect to learn from the implementation of OD2A-S strategies; rather, they serve as a key complement to what recipients will share in Annual Performance Reports (APRs), ongoing evaluation of their prevention activities, surveillance data shared by recipients, ongoing communication and evaluation community of practice conversations, completed targeted evaluation projects, and shared translational products and other recipient-developed reports and resources.

Performance Measure Development Process

CDC's Division of Overdose Prevention (DOP) staff, with input from public health partners, conducted an iterative process to identify the set of performance measures. Specifically, we:

1. We conducted a comprehensive literature review and environmental scan which included a review of LOCAL and State overdose dashboards as well as a review of OD2A 1.0 evaluation plans.
2. We convened a group of DOP subject matter experts to review the initial list and recommend a short list of potential indicators connected with OD2A-S logic model outcomes and strategies described in the NOFO. We also reviewed performance measures recipients recommended in NOFO applications.
3. Considered all available information and guidance from SMEs, partners, and DOP leadership and developed a draft list of performance measures for OD2A-S recipient reporting.
4. Incorporated the feedback, questions, and concerns shared during the fall 2023 recipient performance measure webinars into the set of 8 performance measures presented within this guidance.

The performance measures included account for measures we anticipate will be useful to assess OD2A-S performance and that we believe are feasible for most recipients to report.

Addressing Health Equity

Foundational to the OD2A-S CoAg and these performance measures is a commitment to addressing equitable delivery of and improved access to care and services for people who use drugs (PWUD) and other populations of focus that could include:

- Groups disproportionately affected by overdose as well as those previously underserved by overdose prevention programs and the healthcare system.
- Persons with lived and living experience (PWLE) with drug use, misuse, Substance Use Disorder (SUD), Opioid Use Disorder (OUD), and Stimulant Use Disorder (StUD), or who experienced an overdose, including but not limited to people who are seeking care and services for OUD and StUD.
- Persons involved in the criminal justice setting, who might be incarcerated, detained, or recently released from incarceration.
- People experiencing a mental health condition.
- People experiencing homelessness or unstable housing.
- Pregnant woman.
- People who lack access to any or adequate health insurance.
- Specific demographic groups defined by race, ethnicity, gender identity, sexual orientation, and/or age.

Performance measures also can endeavor to address the needs of populations of focus, noting the intersectionality and interconnectedness across sociodemographic characteristics (e.g., people experiencing homelessness, people who are incarcerated, race, ethnicity, LGBTQIA+) and the communities in which populations of focus live. Performance measures can reveal health disparities in overdose prevention, treatment, and recovery efforts among disproportionately affected communities that may be defined geographically and/or socio-demographically, including but not limited to communities affected by high rates of opioid prescribing, overdose morbidity, overdose mortality, or naloxone administration.

Ethics of Data Collection

In developing performance measures, we considered the ethics of data collection among people who are seeking care or services for OUD or StUD. Therefore, we believe the performance measures included for OD2A-S avoid requiring any data that would need to be gathered from an individual seeking care or services for OUD or StUD. Rather, we anticipate that performance measures data can be gathered from organizations and partners delivering care and services, likely utilizing existing procedures for accounting for care and services provided. We anticipate that performance measure data collection should not impede service provision, existing workflows, or interfere with the relationship between clinicians and participants/clients and patients.

Data Quality

We strive for high-quality data reported across performance measures. High-quality data ensures that the information collected is accurate, consistent, and reflective of the true impact of program activities. Addressing data quality requires a proactive approach to include staff training, standardized data collection protocols, regular data quality assurance checks, and continuous monitoring and improvement processes. Investing in data quality enhances the credibility of performance measures, supporting evidence-based decision-making and ensuring the program's overall success. Consider the following:

- Accuracy – The information collected should clearly and adequately measure the indicator within a plausible range.
- Consistency – Written documentation of data collection and analysis methods can ensure the same procedures are followed each time.
- Timeliness – The information collected should be available to inform program management decisions and it should represent the most current data available. Reporting the data soon after it is collected is a good practice and can help to reflect the true impact of program activities.
- Integrity – Safeguards should be established to minimize the risk of bias or errors in data transcription. This may be achieved by having more than one person conduct the data transcription. In addition, there should be independence in key data collection, management, and assessment procedures and mechanisms to prevent unauthorized changes to the data.

We are asking OD2A-S recipients to keep us informed if you identify any data quality concerns and challenges in data collection or reporting processes that could affect data quality. Each of the performance measures includes data quality and contextual questions in which any data quality concerns should be shared with CDC. Ultimately, we want to ensure that performance measure data we review and share account for any needed caveats regarding data quality.

OD2A-S Performance Measures

There are 8 performance measures. There are 7 quantitative measures and 1 qualitative measure. The labels and brief descriptions are listed here for a quick reference. All quantitative data should be answered in the Excel reporting tool. All qualitative questions including HE_Impact, contextual questions, and data quality questions should, be reported directly in Partners Portal.

Quick View

Icon	Label Name	Performance Measure
	HE_Impact	Impactful practices for improving access to care and treatment for PWUD who are historically underserved by overdose prevention programs
	HE_Activities	Number of health equity focused overdose prevention activities implemented with OD2A funding
	HR_Encounters	Number of harm reduction service encounters at OD2A funded or supported organizations
	HR_Naloxone	Number of naloxone doses distributed by OD2A funded or supported organizations
	LTC_Navigators	Number of navigators who link PWUD to care and harm reduction services via warm handoffs
	LTC_Referrals	Number of referrals to care and harm reduction services
	HS_Training	Number of clinicians who received training on implementing the “2022 CDC Clinical Practice Guidelines for Prescribing Opioids for Pain”
	HS_SUD_Protocols	Number of health/clinical settings implementing or improving protocols and/or policies for evidence-based substance use disorder (SUD) treatment or referrals

This guide uses a standard format to describe each performance measure. Each indicator reference sheet is organized by an overview of the measure and its key reporting fields. Each indicator reference sheet includes a section on reporting specifications to explain exactly what needs to be reported for each performance measure. Each quantitative measure includes required and optional disaggregates, contextual questions, and data quality questions. Contextual questions are required and help recipients explain any nuances in the data and provide a fuller picture of the quantitative measures. Data quality questions are included for you to provide information about the data reported to help explain representativeness, completeness, and other data quality considerations.

Each indicator reference sheet also provides additional indicator details, which include definitions, health equity considerations, potential data sources and data collection partners, suggested uses, resources that may be helpful, and its relevance and rationale for inclusion for OD2A-S. The example below describes the fields in each of the indicator reference sheets.

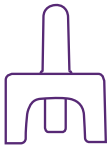
Key Reporting Fields

Label	Used to give a shorthand to each measure
Name	Descriptive name of performance measure
Unit of Measure	Quantitative value (e.g., count or percentage)
Numerator	Suggested numerator
Denominator	Suggested denominator (if applicable).
Disaggregates	The separation of indicators into smaller units to identify underlying trends and patterns. Allows for understanding of how subgroups are impacted differently. All disaggregates are required unless otherwise noted as optional.
Reporting Specifications	Descriptions that operationalize how to report each measure to CDC
Contextual Questions	Questions to improve CDC's understanding of numeric data. As a complement to the reported performance measures data, recipients are asked to provide qualitative contextual explanatory information.
Data Quality	Specific questions for which recipients should describe data quality and representativeness of the data, for example, issues or concerns with respect to data quality and completeness.

Indicator Details

Description	
Definitions	Relevant indicator definitions
Health Equity	
Considerations	Health equity considerations for analysis and reporting
Data Collection	
Data Source	Suggested data source(s) for this indicator
Data Collection Methods	Suggested data collection approach and frequency
Data Collection Partners	Individuals or organizations from which data about this indicator are most commonly collected
Data Use	
Suggested Use	Suggestions for how this indicator can be used by the recipient in reporting and/or programming.
Limitations	Potential limitations to consider
Examples and Resources	Examples of public reports/dashboards; relevant training materials, implementation guides related to this topic; relevant survey guides related to this topic.
Rationale & Relevance	
Rationale	Provides justification for inclusion of this performance measure grounded in the literature and the OD2A-S NOFO.
Relevant Outcome and Strategy	OD2A-S strategies and logic model outcomes related to this indicator
Required Intervention	Any required OD2A-S interventions associated with this indicator
Setting	Setting in which the indicator is relevant (community, public safety, and health systems)
Priority	Core required indicator or optional (at this time all are required)
References	Relevant references, particularly for the rationale section.



Indicator Reference Sheets for Each Performance Measure




HE_Impact

Impactful practices for improving access to care and treatment for PWUD who are historically underserved by overdose prevention programs

Key Reporting Fields

Primary Measure	**This is a qualitative measure.** It is a narrative description of the impactful practices you observe in your jurisdiction that improve access to care and treatment for PWUD. **There is no quantitative reporting required for this performance measure**. This may be reported in Partner's Portal.
Disaggregates	N/A
Reporting Specifications	The following format is recommended for reporting this qualitative indicator: 1. Brief description of the implemented and/or tailored (*adapted to specific cultural, linguistic, environmental, or social needs of populations*) evidence-based intervention or innovative practice (*including setting and whether navigators were included if applicable*) and how these compare to previous efforts. 2. How access to care or treatment has been improved, and what new/existing community assets were leveraged. 3. Specific populations disproportionately affected by overdose and underserved with care and treatment programs are impacted by efforts (*if tracked*). 4. *This is optional. Any other outcomes that were improved (provides recipients the option to expand beyond access to care and include any other outcomes, for example, retention in care, decreased opioid use).* The length of the narrative should be succinct, but each impactful practice* should have a descriptive paragraph if more than one is outlined. **Note: If your jurisdiction or partners have not implemented any impactful practices at the time of reporting, please note in the relevant data submission field "no practices have been implemented to improve access to care and treatment to date."*

Contextual Questions	1. What barriers prevent achieving equitable access to care and treatment for SUD? 2. What facilitators support achieving equitable access to care and treatment for SUD?
Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	**Impactful practices** are OD2A-funded activities and interventions designed to reduce barriers to or facilitate access to SUD care and treatment, especially for those who have been underserved by care and treatment programs. This indicator accounts both for what you have done intentionally to deliver OD2A-funded interventions to persons from disproportionately affected populations **AND** that you have observed meaningful change (e.g., implemented a pre-post survey to assess knowledge, attitudes, and self-efficacy; measured pre-post differences in access to harm reduction services) following the implementation of the OD2A-funded interventions. **Please note**: We are aware that observing meaningful change takes time. Therefore, we understand there might be limitations in what you can report for this performance measure earlier in the cooperative agreement. If you have an effective intervention that broadly serves your jurisdiction but was not intentionally designed for or tailored to a population of focus or that you did not intentionally partner with organizations that serve your population of focus to conduct, it would **not** be counted here. Examples of impactful practices addressing health equity could include: - Distribution of naloxone and overdose prevention education in jails specifically among Black/African American and Hispanic/Latino populations who are disproportionately held on minor drug offenses, resulting in access to naloxone and increased knowledge regarding naloxone use and overdose prevention among

	Black/African American and Hispanic/Latino persons who are incarcerated. - Utilization of navigators to conduct outreach through homeless service organizations to link non-Hispanic, Black/African American men experiencing homelessness to harm reduction services, resulting in harm reduction service utilization for Black/African American men experiencing homelessness. - Utilization of Spanish-speaking navigators to share information about community-based treatment services, resulting in increased access to treatment services for Hispanic/Latino PWUD. **See *glossary* for additional definitions.**
Exclusion	The following should **NOT** be counted as an impactful practice: • OD2A-funded interventions for which you have **NOT** observed meaningful change. • If your jurisdiction is composed of majority-minority populations but an OD2A-funded activity or intervention is **NOT** designed or tailored to specific populations of focus • OD2A-funded interventions conducted for all PWUD in your jurisdiction
Health Equity	
Considerations	Analyzing and reporting this indicator should be done from a health equity lens. In addition to race and ethnicity, more attention to health inequities and disparities within and across populations is also warranted. When thinking about what practices are most impactful for improving access to care and treatment, consider the impact on populations underserved by care and treatment. These considerations may lead to an increase in efforts to address disparities and promote access to care and treatment in communities disproportionately affected by overdose.
Populations	Examples of populations of focus for which an intervention may need to be tailored to address health equity needs include: • Groups disproportionately affected by overdose as well as those previously underserved by overdose prevention programs and the healthcare system • Persons involved in the criminal justice setting, who might be incarcerated, detained, or recently released from incarceration • People experiencing a mental health condition • People experiencing homelessness or unstable housing • Pregnant people • People who lack access to any or adequate health insurance • Specific demographic groups defined by race, ethnicity, gender identity, sexual orientation, and/or age

Data Collection	
Data Sources	• Partner records/logs • Community members (e.g., persons with lived or living substance use experience) • Administrative and/or surveillance data (e.g., client retention tracker)
Data Collection Methods	• Feedback surveys • Focus groups and/or key informant interviews • Records review (e.g., programmatic data or progress reports from sub-grantees) • Secondary analysis (*Although the indicator is qualitative in nature, recipients can use the results of a secondary analysis of surveillance data and report in narrative form as a method.)*
Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., SSPs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Other community-based organizations
Data Use	
Suggested Use	• To better understand if/how a jurisdiction is implementing impactful practices that alleviate barriers to accessing care. • To encourage jurisdictions to think more critically about the integration of health equity in their overdose prevention efforts and how current and future programming could be improved.
Limitations	• "Impact" is subjective for this performance measure and may be interpreted differently. • There may be limited measures of impact during early implementation. • Self-reporting can also result in social desirability bias or providing responses that are deemed socially acceptable. • Hesitancy to report due to the sensitive topic of equity and discrimination.
Examples and Resources	Health Equity & Overdose Prevention Resources • Health Equity and Drug Overdose | Overdose Prevention | CDC • Foundations of Health Equity Self-Guided Training Plan | Health Equity | CDC Considerations for accessing impact (Guides and recipient examples) • CDC Evaluation Profile for Technical Assistance to Disproportionately Affected Communities • COPN Measurement Guide — National Overdose Prevention Network • CDC Overdose Data to Action: Impact of Funded Programs | Drug Overdose | CDC Injury Center

Examples and Resources (continued)	Dashboards for social determinants of health (SDOH • CDC/ATSDR Social Vulnerability Index (SVI) | Place and Health | ATSDR • HHS Minority Health SVI | Office of Minority Health • Census American Community Survey Data
Examples and Resources (continued)	Dashboards for SDOH & Overdose • NORC Overdose Mapping Tool Opioid and Substance Use Disorder Evidence-based Resources • CDC Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States, 2018 • Evidence-Based Practices Resource Center | SAMHSA • NACCHO Health Equity in the Response to Drug Overdose - NACCHO • Drug and Alcohol Use — Evidence-Based Resources - Healthy People 2030 • Strategies | County Health Rankings & Roadmaps
Rationale & Relevance	
Rationale	Studies have shown that hospitals in predominantly Hispanic or non-Hispanic Black neighborhoods have lower rates of referral to common programs that address OUD.[1] Everyone should have the opportunity to access the highest quality of healthcare possible. This requires removing barriers that impede access to care, treatment, and overall wellness. The elimination of racial and ethnic disparities as well as the removal of socioeconomic challenges should be at the forefront of prioritizing health equity in overdose prevention programs. In addition to race and ethnicity, attention should be given to health inequities in all populations, including but not limited to LGBTQIA+, adolescent, aging, sex and gender-based, and immigrant populations.[2]
Relevant Outcome and Strategy	Intermediate outcomes • Enhanced ability of programs to respond to overdose trends for groups disproportionately affected by overdose • Increased equitable delivery and improved access to care/services and long-term recovery among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system
Required Intervention	Incorporating health equity into all interventions is a foundational activity and guiding principle for OD2A: LOCAL.
Setting	Cross-cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. Chang, J. E., Franz, B., Cronin, C. E., Lindenfeld, Z., Lai, A. Y., & Pagán, J. A. (2022). Racial/ethnic disparities in the availability of hospital based opioid use disorder treatment. *Journal of Substance Abuse Treatment*, *138*, 108719. 2. Akuffo, J., Bosco, L., Mandeville, J., & Rudd, J. (n.d.). Health Equity in the Response to Drug Overdose. Retrieved from https://www.naccho.org/programs/community-health/injury-and-violence/overdose/health-equity-drug-overdose-response

HE_Activities

Number of health equity focused overdose prevention activities implemented with OD2A funding

Key Reporting Fields

Primary Unit of Measure	Total count of health equity focused activities
Disaggregates	**Settings** • Health/Clinical (e.g., emergency department, hospitals, clinics, outpatient, inpatient, primary care, pharmacies) • Harm reduction (e.g., SSPs) • Public safety (e.g., criminal justice, EMS) • Other (e.g., schools) ***See definitions below and in glossary***
Reporting Specifications	**Total_HE_Activities** • This is a formula field that will generate a total count of health equity focused overdose prevention activities that occurred in a clinical, harm reduction, public safety, or other settings during the designated reporting period once the disaggregates below are entered into the appropriate fields. **HE_Clinical_Settings** • Enter a whole number for the health equity focused overdose prevention activities that occurred in a health/clinical setting. **HE_HR_Settings** • Enter a whole number that reflects the health equity focused overdose prevention activities that occurred in a harm reduction setting. **HE_Public_Safety_Settings** • Enter a whole number that reflects the health equity focused overdose prevention activities that occurred in a public safety setting. **HE_Other_Settings** • *This disaggregate is optional. If chosen, enter a whole number that reflects the health equity focused overdose prevention activities that occurred in any setting outside of clinical, harm reduction, and public safety.*

Contextual Question	1. Please describe the activities in this performance measure, for whom they were intended, and how the activities were implemented and/or tailored (e.g., linguistically, culturally) for racially, ethnically, and linguistically diverse populations?
Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	**Health equity focused overdose prevention activities** are OD2A-funded activities and interventions designed to reduce barriers to or facilitate access to SUD care and treatment, especially for those who have been underserved by care and treatment programs. The focus of this performance measure is **intentionality,** what interventions have been developed specifically for a population of focus. *Remember you identified populations of focus that have been disproportionately impacted by overdose and who have been underserved by overdose prevention programs.* Essentially, this performance measure is intended to account for health equity interventions you have implemented using OD2A funding or support that were **implemented intentionally** to improve health and reduce inequities **among populations of focus** that you have identified in your jurisdiction. If it's an intervention that broadly serves your jurisdiction but was not intentionally designed or tailored, or you did not intentionally partner with organizations that serve your populations of focus it would not be counted here. Examples of a health equity intervention that could be included: - Distribution of naloxone and overdose prevention education in jails specifically among Black/African American and Hispanic/Latino populations who are disproportionately held on minor drug offenses.

	- Utilize navigators to conduct outreach through homeless service organizations to link non-Hispanic, Black/African American men experiencing homelessness to harm reduction services. - Utilizing Spanish-speaking navigators to reach Hispanic/Latino PWUD. ***See glossary for additional definitions.***
Exclusion	• The following should not be counted as a health equity activity: o If your jurisdiction is composed of majority minority populations but an OD2A-funded activity or intervention is not designed or tailored to specific populations, it's not being intentional. o An OD2A-funded intervention conducted for all PWUD in your jurisdiction.

Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Identifying which groups have been identified in the data (e.g., local, community, program) to have been underserved and/or disproportionately affected by overdose • Determining if harm reduction services are prioritizing and reaching populations underserved by harm reduction programs • Determining if harm reduction activities are being carried out in a manner that is anti-stigmatizing for PWUD, particularly among populations disproportionately affected by overdose and with intersecting identities (e.g., people experiencing homelessness, people who are incarcerated, race, ethnicity, LGBTQIA+) • Assessing if populations who are underserved by overdose prevention programs have equal access to care/services and overdose prevention initiatives
Populations	Examples of populations of focus for which an intervention may need to be tailored to address health equity needs include: • Groups disproportionately affected by overdose as well as those previously underserved by overdose prevention programs and the healthcare system • People involved in the criminal justice setting, who might be incarcerated, detained, or recently released from incarceration • People experiencing a mental health condition • People experiencing homelessness or unstable housing • Pregnant women • People who lack access to any or adequate health insurance. • Specific demographic groups defined by race, ethnicity, gender identity, sexual orientation, and/or age
Data Collection	
Data Sources	• OD2A-funded partner records/logs • Recipient program records/logs
Data Collection Methods	• Records Review • Feedback surveys • Key informant interviews or discussions with partners
Data Collection Partners	• Local health departments • Municipalities • Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., SSPs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Other CBOs

Data Use	
Suggested Use	• To integrate PWLE into the planning and implementation of overdose prevention interventions • To identify new, expand, and strengthen existing partnerships to facilitate implementation and/or tailoring of overdose prevention interventions • To determine the level of health equity integration across prevention strategies
Limitations	• Does not track specific populations disproportionately affected by overdose who are reached by health equity activities • Does not gather whether the health equity activities met the needs of the people that were served • Does not track each instance when a single health equity activity was implemented • Does not assess actual change in health equity or the impact of these activities on disparities experienced by populations disproportionately affected by overdose and underserved by overdose prevention programs
Examples and Resources	Health Equity Background • Social Determinants of Health (SDOH) at CDC • Michigan Safer Opioid Prescribing Toolkit: Health Disparities in Prescribing Opioids • CDC Health Equity and Drug Overdose • NACCHO Identifying the Root Causes of Drug Overdose Health Inequities Integrating Health Equity into Overdose Prevention • NACCHO Integrating Health Equity Into Overdose Prevention and Response: An Environmental Scan • NACCHO Health Equity in the Response to Drug Overdose Training • Strategies to Address the Opioid Epidemic in Black and Hispanic/Latinx Communities • Foundations of Health Equity Training Plan Evaluating Health Equity Interventions • CDC Evaluation Profile for Technical Assistance to Disproportionately Affected Communities • CDC Data & Evaluation For Harm Reduction Programs Dashboards • Drug Overdose Dashboard - MN Dept. of Health

Rationale & Relevance	
Rationale	While increases in overdose deaths are seen across the U.S. and in most populations, recent increases were highest among certain racial/ethnic minority populations, such as non-Hispanic Black (44%) and Native Hawaiian/Other Pacific Islander persons (44%).[1] Systemic racism and its impacts on SDOH have resulted in disparities in access to, linkage to, and retention in treatment for substance use disorders, compounding risk in marginalized populations.[2] To further promote health equity and reduce disparities related to drug overdose, recipients should utilize a health equity lens in the targeted implementation and evaluation of prevention efforts. Activities must be culturally relevant and tailored for racially, ethnically, and linguistically diverse populations to have the most significant impact possible.
Relevant Outcome and Strategy	Short-term outcome • Improved identification of and outreach to people in need of care and services for SUD. Intermediate-term outcomes • Enhanced ability of programs to respond to overdose trends for groups disproportionately affected by overdose. • Increased equitable delivery and improved access to care/services and long-term recovery among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system.
Required Intervention	Incorporating health equity into all interventions is a foundational activity and guiding principle for OD2A-S.
Setting	Cross-cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. Kariisa M, Davis NL, Kumar S, et al. Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. MMWR Morb Mortal Wkly Rep 2022; 71:940–947. DOI: http://dx.doi.org/10.15585/mmwr.mm7129e2 2. National Association of County & City Health Officials. Integrating Health Equity into Overdose Prevention and Response: An Environmental Scan. November 2021. Accessed on October 20, 2023, from Integrating-Health-Equity-Into-Overdose-Prevention-and-Response-An-Environmental-Scan-1-1.pdf (naccho.org).

HR_Encounters

Number of harm reduction service encounters at organizations funded or supported by OD2A

Key Reporting Fields

Primary Unit of Measure	Total count of service encounters
Disaggregates	**Selected harm reduction services:** • Number of service encounters where in-person drug checking occurred, and result was provided back to participant (e.g., use of FTIR/mass spectrometer) **Locations where harm reduction services were provided:** • Zip code(s) where service is delivered. *(Note: this is NOT the zip code of the participant residence)* **See definitions below and in glossary**
Reporting Specifications	**Total_HR_Encounters** • Enter a total count of harm reduction service encounters (e.g., in-person, mail, telephone, online) that occurred at an OD2A-S funded organization during the designated reporting period. **Encounters_with_Drug_Checking** • Enter a whole number for service encounters where drug checking occurred.

Reporting Specifications (Continued)	**ZipCode_By_HR_Service_Site** • Enter the five-digit zip code for each site where harm reduction services (e.g., in-person, mail, telephone, online) were provided. For any service site where services are provided in person, use the brick and mortar location zip code. For services provided via phone or mail, use the address of the brick and mortar location. For mobile-based outreach services, use the zip code of where the outreach encounter happened. For any service sites where zip codes are unknown, provide the total number of encounters that occurred across locations with unknown zip codes in the designated cell for "unknown" within the adjacent cell. **Encounters_with_Drug_Checking_by_ZipCode** • Enter a whole number for service encounters involving drug checking for each zip code provided. When the zip code is "unknown" total the remaining encounters with drug checking and enter a whole number.
Contextual Questions	1. What are the barriers for people accessing harm reduction services in your jurisdiction? 2. What are the facilitators for people accessing harm reduction services in your jurisdiction? 3. What types of services are included? 4. Please estimate the proportion of harm reduction service encounters that occurred: ___ % at brick and mortar locations ___ % via mobile-based outreach services ___ % via mail-based delivery ___ % other (please specify)
Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting). 2. How many OD2A-funded organizations are included in the data submitted?

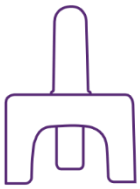
Indicator Details

Description	
Definitions	**Harm reduction service encounters** is an interaction with service providers where a need expressed by a participant is addressed and where services are provided including distributing naloxone through overdose education and naloxone distribution (OEND) programs, providing drug checking services, distributing fentanyl test strips, wound care kits, and safer drug use supplies, offering Hepatitis C and HIV services, and other services provided by harm reduction service providers. **Drug checking** is limited to cases where samples are tested and results are shared directly back to participants (i.e., general drug supply checking and toxicology reports are not considered to be drug checking- related service encounters). This does not include distribution of test strips that would be used offsite. **See glossary for additional definitions**.
Exclusions	Referrals to Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) is not included as a harm reduction service encounter for this measure. Instead, this is captured in the linkage to care – number of referrals performance measure.
Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Identifying communities and/or populations disproportionately affected by overdose. • Identifying to what extent harm reduction services prioritize and reach populations disproportionately affected by overdose and underserved by overdose prevention programs. • Determining if encounters are being conducted/carried out in settings relatively free of stigma. • Identifying which anti-stigma trainings and education are undergone by those who serve people who use drugs (PWUD).
Data Collection	
Data Sources	• Program and sub-contractor records ○ Administrative data (naloxone administration, syringe service partners, clinical partner records) • Survey and interview data
Data Collection Methods	• Administrative records review • Client Surveys • Key informant interviews and discussions
Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., syringe services programs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Other community-based organizations

Data Use	
Suggested Use	• To identify which communities, have the greatest access to harm reduction services. • To ensure harm reduction services are reaching populations underserved by overdose prevention programs. • To understand which types of services are being used most frequently and effectively. • To identify gaps in availability of and access to harm reduction services.
Limitations	• Individual demographic data are not being collected so it may be difficult to look at equitable access. • Individuals may receive services in zip codes different than where they live. • Outcomes of services may not be tracked.
Examples and Resources	Harm Reduction Training Materials • HHS Overdose Prevention Strategy: Harm Reduction Evaluation of Harm Reduction Activities • CDC Data & Evaluation for Harm Reduction Programs • OD2A Harm Reduction Case Studies Harm Reduction with Populations Disproportionately Affected by Overdose • CDC's National Harm Reduction TA Center: Priority Populations Harm Reduction Annual Targets and Reporting Tools • SAMHSA Harm Reduction Annual Targets and Quarterly Progress Reporting Tool • Center for Substance Abuse Prevention (CSAP) Harm Reduction Grant Reporting Tool
Rationale & Relevance	
Rationale	Harm reduction encompasses a set of practical strategies and interventions aimed at reducing negative consequences associated with drug use and is one of the four pillars in the HHS overdose prevention strategy[1]. Harm reduction programs focus on putting people first and focusing on their direct, immediate needs by meeting people where they are. Harm reduction strategies have been shown to reduce overdose, increase treatment entry, reduce drug use frequency, and improve the health of people who use drugs.[2,3,4] These strategies are particularly important for disproportionately affected populations, such as individuals recently released from incarceration and individuals experiencing homelessness, as they are several times more likely to experience an overdose event.[5,6]

Relevant Outcome and Strategy	Strategy 8: Harm Reduction Short-term outcome: • Increased access to harm reduction education and services, including increased distribution of naloxone. Intermediate-term outcome: • Expand utilization of evidence-based approaches to prevent and respond to overdose
Required Intervention	Yes *(Developing and expanding overdose education and naloxone distribution programs that prioritize education and distribution among those who are at the greatest risk of experiencing or witnessing an overdose.)*
Setting	Cross-cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. US Department of Health and Human Services, Overdose Prevention Strategy. (n.d.). Harm Reduction. https://www.hhs.gov/overdose-prevention/harm-reduction 2. Rhodes, T. (2009). Risk environments and drug harms: a social science for harm reduction approach. *International journal of drug policy*, *20*(3), 193-201. 3. Giglio, R. E., Li, G., & DiMaggio, C. J. (2015). Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. *Injury epidemiology*, *2*, 1-9. 4. Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. J Subst Abuse Treat. 2000;19(3):247-252. 5. Massachusetts Department of Public Health. An Assessment of Opioid-Related Deaths in Massachusetts (2013–2014). Boston, MA: Department of Public Health; 2016. http://www.mass.gov/eohhs/docs/dph/ stop-addiction/dph-legislative-report-chapter-55-opioid-overdose-study-9-15-2016.pdf 6. Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B. C., Stringfellow, E. J., Orav, E. J., Singer, D. E., & Rigotti, N. A. (2013). Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. *JAMA internal medicine*, *173*(3), 189–195. https://doi.org/10.1001/jamainternmed.2013.1604

HR_Naloxone



Number of naloxone doses distributed by OD2A funded or supported organizations

Key Reporting Fields

Primary Unit of Measure	Total count of pre-measured naloxone doses distributed
Disaggregates	• Type of funded organization (e.g., Syringe Service Programs, community-based organizations, senior care organizations, faith-based organizations, Emergency Department/Urgent Care, Other healthcare organizations, Police departments, Jails/Prisons, Colleges/Universities, Secondary education, Health Department) • Number of all pre-measured naloxone doses distributed by organization. • Zip code(s) where the organization distributed their doses (Note: if distributed at a brick-and-mortar location like an SSP, use the zip code of the SSP. **This is NOT the zip code of the participant residence**) • Number of all pre-measured naloxone doses distributed by zip code. **See definitions below and in glossary**
Reporting Specifications	**Total_Naloxone_Distributed** Enter a whole number for doses of naloxone distributed by an OD2A funded or supported organization during the designated reporting period. **Type_of_Organization** • This variable has been pre-selected. If data are not available for a particular type of organization, enter 0 for all variables in the adjacent row. **Num_Doses_Distributed** • Enter a whole number for the count of all pre-measured naloxone doses distributed for each type of organization.

Reporting Specifications (Continued)	**ZipCode_By_Nal_Distribution_Site** • Enter the five-digit zip code where the funded organization distributed their doses of naloxone. For any distribution site where the zip code is unknown, provide the total in the adjacent cell. **Num_Doses_Distributed_ZipCode** • Enter a whole number for the count of pre-measured naloxone doses distributed for each zip code. When the zip code is "unknown" total the remaining doses distributed and enter a whole number.
Contextual Questions	1. What are barriers to accessing or receiving naloxone? 2. What are facilitators to accessing or receiving naloxone? 3. How did you use OD2A Funds to distribute naloxone (e.g. staffing to distribute, vending machines)? 4. *This contextual question is optional. Describe mechanisms used to distribute naloxone (e.g., mail in, handoffs).*
Data Quality	1. If you selected "other" type of organizations in the reporting tool, please describe. 2. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	Number of pre-measured **naloxone doses*** distributed free of charge through programs (e.g., via distribution pathways such as direct distribution, leave behind, vending machines, mail delivery, etc.). Each **naloxone dose** should be counted (i.e., if there are 2 doses in 1 kit, count 2 doses) **Doses distributed that should be counted for this measure include all of the following:** • Doses distributed by *health departments* to PWUD across settings (e.g., harm reduction, public safety, clinical) through Community Events, Mobile Vans, and other in-person mechanisms. • Doses distributed by *health departments* to PWUD using mechanisms that do not involve handing Naloxone to individuals in-person (e.g., Vending Machines, Mail, Naloxone boxes, and other) • Doses distributed by *partnering organizations that receive funding or other support through OD2A*. to PWUD across settings (e.g., harm reduction, public safety, clinical) through Community events, Mobile Vans, and other in-person mechanisms. • Doses distributed by *partnering organizations that receive funding or other support through OD2A* to PWUD using mechanisms that do not involve handing Naloxone to individuals in-person (e.g., Vending Machines, Mail, Naloxone boxes, and other) **Actual mg dosage of naloxone varies by application method as well as brand. For measurement and evaluation purposes, a dose is defined based on the specific pre-measured dosage provided. For example, one nasal spray of Kloxxado contains 8mg of naloxone while one nasal spray of Narcan contains 4mg. Both are one "dose". Similarly, intravenous delivery often occurs with an initial injection of .2 mg, then doses may vary if more are required. Each time someone is separately administered naloxone should be counted as a "dose", even if mg dosage varies slightly.* ***See glossary for additional definitions.***
Exclusion	Doses distributed that should NOT be counted for this measure are those that are distributed by organizations that do NOT receive funding or other support through OD2A.

Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Identifying communities and/or populations disproportionately affected by overdose. • Identifying to what extent harm reduction efforts prioritize and reach populations disproportionately affected by overdose and underserved by overdose prevention programs.
Data Collection	

Data Sources	• Administrative, program and sub-contractor records
	  ○ Vending machine logs
	  ○ Acknowledgement of receipt
	  ○ Mailing logs
	  ○ Inventory logs
	  ○ Refill logs
	  ○ Leave behind logs
	  ○ Purchasing logs, invoices, or receipts
	  ○ Dispensing log
	• Administrative data from CBOs
	  ○ Interview data

Data Collection Methods	• Administrative records review • Key informant interviews and discussions
Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., syringe service programs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Other community-based organizations
Data Use	
Suggested Use	• To determine progress towards naloxone saturation • To determine access and saturation for disproportionately affected populations and where gaps may remain. • To determine reach of harm reduction services to populations disproportionately by overdose or underserved by overdose prevention programs. • To understand effectiveness of public education/messaging • To understand effectiveness of provider training/education • To understand the community's preferred location of distribution
Limitations	• Does not separate new kits versus restocking kits. • Does not track where doses are administered. • Does not track overdose reversals. • Possibly small sample sizes.
Examples and Resources	**Naloxone Training Materials** • CDC Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States, 2018 • CDC Evaluation Profile for Naloxone Distribution

Examples and Resources Continued	**Dashboards** • Maine Drug Data Hub- Thematic Dashboard: Naloxone (Narcan®) • West Virginia Naloxone Distribution Dashboard • Minnesota Department of Health, Opioid Mortality Dashboard by County **Naloxone Prescribing Guideline** • King County Naloxone Prescribing Practice Guidelines **Other Federal Programs** • SAMHSA Center for Substance Abuse Prevention (CSAP)
Rationale & Relevance	
Rationale	Naloxone Distribution (ND) is an important harm reduction tool. It can rapidly reverse opioid overdose, improve long-term knowledge regarding opioid overdose and attitudes toward naloxone use and distribution, increased self-efficacy for participants to safely reverse overdose, and reduce population level opioid-related mortality. Knowing the number of naloxone doses distributed free of charge through programs can help measure its saturation in communities and if it is reaching underserved populations to reduce overdose deaths, particularly populations who may be hesitant or unable to obtain naloxone from a pharmacy. An example of a proven strategy is "Take Home Naloxone" in Canada. People were empowered and more confident to respond to an overdose because of the Take Home Naloxone program. Following the program training, service providers reported an increase in client engagement and use of health care services.[1, 2]
Relevant Outcome and Strategy	Strategy 8: Harm Reduction Short-term outcomes: • Increased access to harm reduction education and services • Increased availability of and decreased barriers to care/services, especially for those previously underserved Increased awareness of drug overdose epidemic, harm reduction efforts, and evidence-based approaches
Required Intervention	Yes *(Developing and expanding overdose education and naloxone distribution programs that prioritize education and distribution among those who are at the greatest risk of experiencing or witnessing an overdose.)*
Setting	Cross-cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. Banjo O, Tzemis D, Al-Qutub D, Amlani A, Kesselring S, Buxton JA. A quantitative and qualitative evaluation of the British Columbia Take Home Naloxone program. CMAJ Open. 2014;2(3):E153-E161. doi:10.9778/ cmajo.20140008 Layout 1 (cmajopen.ca) 2. Razaghizad, A. W., Sarah B. Filion, Kristian B. Gore, Genevieve Kudrina, Irina Paraskevopoulos, Elena Kimmelman, Jonathan Martel, Marc O. Eisenberg, Mark J. (2021). The Effect of Overdose Education and Naloxone Distribution: An Umbrella Review of Systematic Reviews. American journal of public health, 111(8), e1-e12. https://doi.org/10.2105/ajph.2021.306306

LTC_Navigators

Number of navigators who link PWUD to care and harm reduction services via warm handoffs

Key Reporting Fields

Primary Unit of Measure	Total count of unique navigators who link PWUD
Disaggregates	Entry points where navigators are primarily located: • Health/Clinical (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction (e.g., syringe services programs) • Public safety (e.g., criminal justice, EMS) • Other *This disaggregate is optional. Number of hours navigators spent on linkage efforts* **See definitions below and in glossary**
Reporting Specifications	**Total_Navigators** • This is a formula field that will generate a total count of unique navigators who link PWUD to care and/or harm reduction services via warm handoffs once the disaggregates below are entered into the appropriate fields. **Nav_Clinical** • Enter a whole number for the navigators located in a health/clinical setting. **Nav_HR** • Enter a whole number for the navigators located in a harm reduction setting. **Nav_Public_Safety** • Enter a whole number for the navigators located in a public safety setting.

Reporting Specifications (Continued)	**Nav_Other** • Enter a whole number for the navigators in any other settings. **Navigator_Hours_Clinical** • *This disaggregate is optional. If chosen, enter a whole number for the total hours navigators have spent on linkage to care or referral efforts in health/clinical settings.* **Navigator_Hours_HR** • *This disaggregate is optional. If chosen, enter a whole number for the total hours navigators have spent on linkage to care or referral efforts in harm reduction settings.* **Navigator_Hours_Public_Safety** • *This disaggregate is optional. If chosen, enter a whole number for the total hours navigators have spent on linkage to care or referral efforts in public safety settings.* **Navigator_Hours_Other** • *This disaggregate is optional. If chosen, enter a whole number for the total hours navigators have spent on linkage to care or referral efforts in any other settings.*
Contextual Questions	1. Describe what types of navigators are included in the data reported (e.g., certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, etc.). 2. Describe methods to support navigators, including average hourly pay, benefits, and additional supports (e.g., trauma, wellness, emotional/psychological support, infrastructure such as a phone) to help retain them.
Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

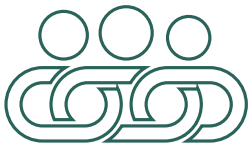
Description	
Definitions	This indicator measures the **number** of navigators utilized to link PWUD to the services they need—care and/or harm reduction services – via warm handoffs and in support of **warm handoffs** (i.e., in-person/video/phone conversations during which the individual, the organization making the referral, and the organization receiving the referral all are present). This is the actual number of navigators supported by OD2A funding, who are engaged in providing a formal connection between PWUD and services, conducting a transfer of care, and time spent in support of linking individuals to care and harm reduction services (e.g., phone calls to identify care options; time spent driving someone to care; paperwork/data entry in support of warm handoffs). **Navigators** are individuals familiar with the local public health landscape and who work directly with PWUD to ensure they have the tools to address barriers to seeking care and who support people accessing SUD treatment and care, as well as support access to other services, such as harm reduction and social supports. **Navigators** could include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link people who use drugs (PWUD) to care and harm reduction services. **Navigators** included in this performance measure must be supported by OD2A funding in some way. Staff support can by paid or unpaid. This may be direct funding or indirect support (e.g., in-kind staff support, coordination of activities across multiple partners, etc.). ***See glossary for additional definitions***.
Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Identifying communities and/or populations disproportionately affected by overdose. • Understanding how much time navigators spend with PWUD who are members of communities and/or populations disproportionately affected by overdose.
Data Collection	
Data Sources	• Program internal administrative data (e.g., timesheets, referral logs) • Subcontractor or partner administrative data • Navigator records or logs • Interview data • Survey data
Data Collection Methods	• Document/data (payroll) review • Key informant interviews or discussions with program managers • Quarterly surveys

Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., syringe services programs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Treatment and mental health facilities • Child and family services • Program staff • Program participants
Data Use	
Suggested Use	• To see where navigators are located across entry points • To use in evaluation efforts to determine if resources should be increased or moved or programs altered in any way • To use in conjunction with surveillance and other available data for programmatic decision making • To track navigation efforts over time in a jurisdiction
Limitations	• Human error in counting hours (duplication, omission, etc.) • Small sample sizes • Does not track how many people are reached
Examples and Resources	**CDC's Navigation Resources** • Evidence-Based Intervention: Patient Navigation • HIV STEPS to Care: Patient Navigation **SAMHSA's Peer Support Resources** • Peer Support Workers for those in Recovery Tools **Professional Quality of Life (ProQOL) Measure to Use with Navigators** • ProQOL Measure
Rationale & Relevance	
Rationale	Evidence for the use of navigators for substance use prevention and recovery is still growing. Using navigators has shown to have positive effects on substance use in recent years. These effects include reduced substance use, reduced re-hospitalization rates, reduced relapse rates, decreased emergency service utilization, increased treatment retention, and increased satisfaction with the overall treatment experience.[1,2,3,4] For example, emergency department patients who received services from substance use navigators were engaged in outpatient addiction treatment within 30 days of emergency department discharge.[5] Tracking navigators and their hours will provide more context on how to best use navigators to support substance use prevention and recovery in OD2A-funded jurisdictions.
Relevant Outcome and Strategy	Strategy 6A: Clinician/Health System Engagement Strategy 7: Public Safety Partnerships/Interventions Strategy 8: Harm Reduction Strategy 9: Community-Based Linkages to Care Short Term outcome: • Increased use of navigators to link PWUD to care and services

Required Intervention	Yes *(Using navigators to facilitate linking people to care and harm reduction services)*
Setting	Cross-Cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. Armitage, E.V., Lyons, H., Moore, T.L. Recovery association project (RAP), Portland, Oregon (2010) *Alcoholism Treatment Quarterly*, 28 (3), pp. 339-357. doi: 10.1080/07347324.2010.488539 2. Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. *Journal of Substance Abuse Treatment*, *63*, 1-9. https://doi.org/https://doi.org/10.1016/j.jsat.2016.01.003 3. Kamon, J., W. Turner. (2013). Recovery coaching in recovery centers: What the initial data suggest: A brief report from the Vermont Recovery Network. Evidence-Based Solutions, Montpelier, Vermont 4. Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Salim, O., & Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence [Review]. *Psychiatric Services*, *65*(7), 853-861. https://doi.org/10.1176/appi.ps.201400047 5. Anderson, E. S., Rusoja, E., Luftig, J., Ullal, M., Shardha, R., Schwimmer, H., Friedman, A., Hailozian, C., & Herring, A. A. (2023). Effectiveness of Substance Use Navigation for Emergency Department Patients With Substance Use Disorders: An Implementation Study. *Annals of Emergency Medicine*, *81*(3), 297-308. https://doi.org/https://doi.org/10.1016/j.annemergmed.2022.09.025

LTC_Referrals

Number of referrals to care and harm reduction services



Key Reporting Fields

Primary Unit of Measure	Total count of unique referrals *Note: If you refer one individual to both MOUD and harm reduction services, you would account for 2 different referrals as you will report by each service. If you refer the same individual multiple times, they would be counted multiple times. This indicator is not counting unique individuals, but rather referral encounters.*
Disaggregates	Types of care/service referrals: • Number of referrals to medications for opioid use disorder (MOUD) • Number of referrals to behavioral health treatment only (without MOUD) • Number of referrals to harm reduction services Demographics of people who are referred: • Race and Ethnicity (American Indian or Alaska Native, Asian, Black, or African American, Hispanic, or Latino, Middle Eastern or North African, Native Hawaiian or Other Pacific Islander, White, Multiracial and/or Multiethnic, Unknown) ***See definitions below and in glossary***

Reporting Specifications	**Total_Referrals** • This is a formula field that will generate a total count of unique referrals to care and harm reduction services once the disaggregates below are entered in the appropriate fields. **Race_Ethnicity** • This variable has been pre-selected. If data are not available for a particular race and ethnicity, enter 0 for all variables in the adjacent row. Note: when the race_ethnicity is marked unknown, this also includes if an individual preferred not to answer. **Ref_MOUD** • Enter a whole number for all referrals to MOUD for each race/ethnicity with available data. **Ref_Behavioral_Trt** • Enter a whole number for all referrals to behavioral health treatment only (without MOUD) for each race/ethnicity with available data. **Ref_to_HR** • Enter a whole number for all referrals to harm reduction services for each race/ethnicity with available data. **Total_Ref_Race_Ethnicity** • This is a formula field that will generate a total count for all referrals to MOUD, behavioral treatment only (without MOUD), and harm reduction services by each race/ethnicity.
Contextual Questions	**Types of Referrals** 1. *This contextual question is optional. If you have other OD2A funded or supported referrals beyond referrals to MOUD, behavioral treatment only (without MOUD), and harm reduction services. Please describe the "other" types of referrals.* **Reporting Partners** 2. Approximately, what % of healthcare facilities (e.g., hospitals, emergency departments, other clinical settings) reported data to your jurisdiction for this performance measure? (If % not available, report total number of healthcare facilities that reported). 3. Approximately, what % of EMS agencies reported data to your jurisdiction for this performance measure? (If % not available, report total number of EMS agencies that reported). 4. Approximately, what % of carceral settings (e.g., prisons and jails), reported data to your jurisdiction for this performance measure? (If % not available, report total number of carceral settings that reported). 5. Approximately, what % of harm reduction settings (e.g., SSPs) reported data to your jurisdiction for this performance measure? (If % not available, report total number of carceral settings that reported).

Meta Data / Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	**A referral** includes any formal connection to treatment options or harm reduction services. This includes referrals made by clinicians, social workers, social service providers, community organizations, law enforcement, navigators, peer support specialists, or other relevant sources, who are supported by OD2A in some way. This may be direct funding or indirect support (e.g., in-kind staff support, coordination of activities across multiple partners). **A formal connection is for an active referral where a provider engages in conversation with the participant about their specific needs and tailors referrals to them (e.g., warm hand-off, scheduling an appointment, making a phone call to establish a connection between the participant and community service provider).* ***See glossary for additional definitions.***
Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Identifying communities and/or populations that are disproportionately affected by overdose. • Assessing if referrals are being provided equitably within populations underserved. • Identifying which services are available in communities disproportionately affected by overdose.
Data Collection	
Data Sources	Overdose prevention and response program data systems: • Existing data from CBOs and clinical partners • Outreach program records • Interview data • Program enrollment or registration records, including from referral and case management systems • Program coordinator activity logs or tracking forms • Reports or notes from other service providers • Referral logs • EMS data • Interview data

Data Collection Methods	• Records review • Case investigations or individual follow-up • Key informant interviews and discussions
Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Harm reduction partners (e.g., syringe services programs) • Public safety partners (e.g., criminal justice, EMS, first responders) • Other community-based organizations • Behavioral health • Referred individuals
Data Use	
Suggested Use	• To identify gaps in and disparities for referrals • To support jurisdiction level research and evaluation efforts • To support resource optimization • To facilitate cross-jurisdictional collaboration
Limitations	• Incomplete records, missing variables, or fields • Duplication of individuals who are referred multiple times • Underrepresentation or incomplete coverage of individuals • Lack of complete data due to data linkage challenges or integration across multiple systems or databases • Inability to track individuals
Examples and Resources	**State Dashboard** • Maine Thematic Dashboard: OPTIONS Initiative **Evaluation Resources** • CDC Evaluation Profile for Linkage to Care Initiatives • SAMHSA's Peer Support Workers for those in Recovery Tools
Rationale & Relevance	
Rationale	The practice of allowing people at high risk for overdose and fatality to choose independently to enter care have proven ineffective, given fears of withdrawal, withdrawal without medication, stigma, and discrimination. Studies have shown PWUD are more likely to agree to treatment following a life-altering event, such as overdose. [1,2,3]

Relevant Outcome and Strategy	Strategy 6A: Clinician/Health System Engagement Strategy 7: Public Safety Partnerships/Interventions Strategy 8: Harm Reduction Strategy 9: Community-Based Linkages to Care Short-term outcomes: • Increased collaboration, coordination, and communication among partners • Increased availability of and decreased barriers to care/services, especially for those disproportionately affected by overdose and those previously underserved by overdose prevention programs and the healthcare system Intermediate outcome: • Increased linkages to care and engagement in care across various settings
Required Intervention	Yes *(Using navigators to facilitate linking people to care and other services)* • *Supporting emergency department linkages via multidisciplinary teams including navigators, broadening the scope from only post-overdose scenarios to also include strategies like focused connections during care for conditions that may represent sequelae of substance use (e.g., skin/soft tissue infections) and enhanced universal screening for SUD (e.g., opioids and stimulants) among patients presenting for other reasons to identify new opportunities to engage in and link to care.)*
Setting	Cross-cutting: this indicator is relevant in all settings including community, public safety, and health systems.
Priority	Core indicator (all jurisdictions are required to report)
References	1. Centers for Disease Control and Prevention. (2023, August 9). Overdose data to action: Evaluation. Centers for Disease Control and Prevention. https://www.cdc.gov/ore/pdf/od2a_evalprofile_linkagetocareinitiatives_508.pdf 2. Langabeer, J., Champagne-Langabeer, T., Luber, S. D., Prater, S. J., Stotts, A., Kirages, K., Yatsco, A., & Chambers, K. A. (2020). Outreach to people who survive opioid overdose: Linkage and retention in treatment. Journal of Substance Abuse Treatment, 111, 11–15. https://doi.org/10.1016/j.jsat.2019.12.008 3. Samet, J. H., Friedmann, P., & Saitz, R. (2001). Benefits of linking primary medical care and substance abuse services: patient, provider, and societal perspectives. Archives of internal medicine, 161(1), 85-91. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/646882

HS_Training

Number of clinicians who received training on implementing the "2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain"

Key Reporting Fields

Primary Unit of Measure	Total count of OD2A-S clinicians trained
Numerator	Count of clinicians trained
Disaggregates	• *This disaggregate is optional. Specialty (e.g., Primary care, Emergency medicine, Hospitalists, Surgeons, OB/GYNs, Neurologists, Dentists, Physical medicine and rehabilitation, Occupational medicine, Pharmacists)* • *This disaggregate is optional. Number of unique clinicians trained* • *This disaggregate is optional. Number of eligible clinicians* • *This disaggregate is optional. Percentage of eligible clinicians trained* ***See definitions below and in glossary***
Reporting Specifications	**Total_Trained** • Enter a whole number for the count of all unique individuals trained on implementing the 2022 CDC Clinical Practice Guidelines for Prescribing Opioids for Pain. **Specialty** *Optional disaggregate: If chosen, select a specialty from the dropdown list for the type of clinicians trained on the 2022 CDC Clinical Practice Guidelines for Prescribing Opioids for Pain.* **Num_Trained** • *Optional disaggregate: If chosen, enter a whole number for the unique clinicians by specialty who are trained on implementing the 2022 CDC Clinical Practice Guidelines for Prescribing Opioids for Pain.*

Reporting Specifications (Continued)	**Num_Eligible** • *Optional disaggregate: If chosen, enter a whole number for all eligible clinicians who could be trained on implementing the 2022 CDC Clinical Practice Guidelines for Prescribing Opioids for Pain.* **Percent_Clinician_Trained** • *This is a formula field that will generate a percentage of clinicians trained when the numerator (Num_Trained) and denominator (Num_Eligible) are entered into the appropriate fields.*
Contextual Questions	1. Describe the trainings including the title, number offered, length, who conducted them, and where the training occurred. 2. This contextual question is optional. What populations are served by the clinicians who were trained? 3. What are barriers to effectively training clinicians on the "2022 CDC Clinical Practice Guideline"? 4. What are facilitators to effectively training clinicians on the "2022 CDC Clinical Practice Guideline"?
Data Quality	1. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	**Clinicians who could be trained**: Clinicians whose scope of practice includes prescribing opioids (e.g., physicians, nurse practitioners and other advanced-practice registered nurses, physician assistants, and oral health practitioners). **Eligible clinicians** that should be counted in this performance measure include: • Any clinician part of a health setting that OD2A funds; or • Any clinician who is served by OD2A-funded or supported partners (e.g., academic detailers, health consortium, other funded training entities)
Definitions (Continued)	**Health settings** are places where people receive health services, care, or examinations related to a physical or mental health concern. Examples can be emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, or pharmacies. **Training** could include group or individualized training, systemwide clinician and clinical care team education, academic detailing or free

	online training, such as the modules outlined on CDC's website.[1] Training could be directly funded or indirectly supported through OD2A funding. ***See glossary for additional definitions.***
Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Understanding if there are clinicians being trained who serve populations underserved by healthcare and pain management and which clinicians may be missing. • Determining how trainings are being offered and if they are accessible to a diverse set of clinicians. • Assessing if all trainings are of high quality.
Data Collection	
Data Source	• Training logs or records
Data Collection Methods	• Document review of administrative/training records and training attendance lists • Discussions with healthcare setting administrators/trainers, partners
Data Collection Partners	• Health/Clinical partners (e.g., (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Trainers
Data Use	
Suggested Use	• To report on progress of clinician training on the "2022 CDC Clinical Practice Guideline". • To evaluate implementation focusing on clinician knowledge and capacity to implement the recommendations in the "2022 CDC Clinical Practice Guideline" (e.g., pre-/post-test). • The measure may be used to understand the extent that various healthcare partnerships are facilitating training on the "2022 CDC Clinical Practice Guideline".
Limitations	• Reliance on the health settings to share this data with the public health department. Strong relationships and data use agreements (DUAs) will need to be in place. • Possible miscounting of some training efforts or individuals.

Examples and Resources	Resources Related to CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain • CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR • Healthcare Administrators: Applying the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain • CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain: Training Other Relevant CDC Trainings • CDC Training for Healthcare Professionals
Rationale & Relevance	
Rationale	CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022[2] synthesizes the most current literature on evidence-based practice, particularly in the use of prescription opioids to treat acute, subacute, and chronic pain. The "2022 CDC Clinical Practice Guideline" can inform healthcare policies and standards that improve the safety and effectiveness of pain treatment, by improving function for patients, improving quality of life for patients experiencing pain, and reducing risks associated with opioid pain therapy. Systemwide clinician and clinical care team education and training are crucial to support practice changes that provide safer and more effective pain treatment.[3] Integrating "2022 CDC Clinical Practice Guideline"-concordant care directly into the clinical workflow via the creation of electronic clinical decision support (CDS) tools and other health IT enhancements (e.g., quality improvement (QI) measures and dashboards) has the potential power to enhance patient-centered care and shared clinical decision-making to support safer opioid prescribing practices and improve pain care and outcomes. Without the proper tools and protocols in place to address overdose risk and manage acute, subacute, and chronic pain, opportunities for intervention are missed, especially among historically underserved populations.
Relevant Outcome and Strategy	Strategy 6: Clinical/Health System Engagement and Health IT/PDMP Enhancement Short-term Outcomes: • Increased clinician awareness of evidence-based practices for pain management Intermediate-term Outcomes: • Expanded utilization of evidence-based approaches to prevent and respond to overdoses • Decreased high-risk opioid prescribing and increased use of the full complement of evidence-based pain care modalities

Required Intervention	Yes (*Educating clinicians on best practices for acute, subacute, and chronic pain including opioid prescribing, as described in the CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022*)
Setting	Health systems
Priority	Core indicator (all jurisdictions are required to report)
References	1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2024, May 7). Health Care Provider Trainings. Available at https://www.cdc.gov/overdose-prevention/hcp/trainings/?CDC_AAref_Val=https://www.cdc.gov/opioids/healthcare-professionals/training/index.html 2. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. 3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2023, September 25). Healthcare Administrators: Applying the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain. Available at https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/healthcare-admin-applying-guidelines.html?CDC_AAref_Val=https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/healthcare-administrators.html

HS_SUD_Protocols

Number of health/clinical settings implementing or improving protocols and/or policies for evidence-based SUD treatment or referrals

Key Reporting Fields

Primary Unit of Measure	Total count of health/clinical settings
Disaggregates	• Number of health/clinical settings where protocols or policies have been implemented/improved for evidence-based SUD treatment • Number of health/clinical settings where protocols or policies have been implemented/improved for evidence-based SUD referrals ***See definitions below and in the glossary***
Reporting Specifications	**Total_Health_Settings** • Enter the total count of health/clinical settings where protocols and/or policies have been implemented/improved for evidence-based SUD treatment and/or referrals. Note this will be the number of unique health settings, regardless of whether they have just one or both types of protocols/policies. **Num_Settings_SUD_Treatment** • Enter a whole number for the health/clinical settings where protocols or policies have been implemented/improved for evidence-based SUD treatment. **Num_Settings_SUD_Referrals** • Enter a whole number for the health/clinical settings where protocols or policies have been implemented/improved for evidence-based SUD referrals.
Contextual Questions	1. Describe how access to MOUD for healthcare settings has changed since implementing policies or protocols. 2. Describe the partnerships for SUD referral with the health settings included in this indicator. What steps were taken to develop and build the partnerships for SUD referrals?

Data Quality	1. What types of health settings are included in the reported data? 2. Describe any issues or concerns that impact the quality of the data shared (e.g., data completeness, data accuracy, facilitators/barriers for collection and reporting).

Indicator Details

Description	
Definitions	**Health/clinical settings** are places where people receive health services, care, or examinations related to a physical or mental health concern. Examples can be emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, or pharmacies. These should be settings where OD2A funding or support are being provided or where partnerships or interventions are taking place. **Implementing protocols and/or policies** would include the implementation of existing or new policies with evidence-based clinical algorithms for referring and treating SUDs. **Improving protocols and/or policies** is done by updating existing protocols and/or policies with evidence-based clinical algorithms for referring and treating SUDs. **A Policy** is a deliberate system of guidelines to guide decisions and achieve rational outcomes. A policy is a statement of intent and is implemented as a procedure or protocol. Policies are generally adopted by a governance body within an organization. **A Protocol** is a system of rules that explain the correct conduct and procedures to be followed in formal situations. A protocol is a code prescribing strict adherence to correct etiquette and precedence. ***See glossary for additional definitions.***
Health Equity	
Considerations	Health equity considerations include, but are not limited to: • Understanding if health systems that provide care for people underserved by evidence-based treatment are being prioritized to implement or improve protocols/policies for evidence-based treatment and referrals. • Identifying if MOUD are readily available and routinely prescribed in health settings that have updated protocols/policies.
Data Collection	
Data Sources	• Health system policies • Program implementation data • Hospital/clinic/practice administrators • Clinic/hospital/practice/treatment facility referral data

Data Collection Methods	• Policy review • Hospital administrators interviews/survey • Hospital staff interviews/survey • Treatment center data request
Data Collection Partners	• Health/Clinical partners (e.g., emergency department, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, pharmacies) • Health departments • Treatment facilities
Data Use	
Suggested Use	• To determine if the most current evidence-based treatment options are available to patients. To determine recommendations for health system policy change. • To determine if there is a pattern in the type of health setting that consistently implements or does not implement protocols and policies for evidence-based SUD treatment or referrals.
Limitations	• Does not ensure how well protocols/policies are followed. • Does not measure patient level outcomes.
Examples and Resources	Resource for Addiction Medicine Clinicians • Addiction Medicine Toolkit • Evidence-Based Strategies for Prevention Opioid Overdose: What's Working in the United States
Rationale & Relevance	
Rationale	• Having protocols and policies in place for SUD referral and treatment helps to ensure more PWUD receive needed evidence-based treatment. Evidence-based SUD referrals and treatment allows clinicians to improve early identification of SUD, increase access to treatment, and increase adherence of patients scheduling appointments and taking medications. In addition, PWUD have better health outcomes and decreased stigma when being treated[1]. Referral to continued evidence-based treatment leads to patients being more likely to achieve remission compared to patients not receiving continued care.[2]
Relevant Outcome and Strategy	Strategy 6: Clinical/Health System Engagement and Health IT/PDMP Enhancement Short-term Outcomes: • Increased clinician expertise and confidence to provide equitable OUD and StUD care Intermediate Outcome: • Increased and improved health system and clinician capacity to provide care for OUD and StUD • Expanded utilization of evidence-based approaches to prevent and respond to overdoses

Required Intervention	Yes (*Training clinicians on screening, diagnosis, and linkage to care and retention in care for opioid use disorder (OUD) and stimulant use disorder (StUD); Building and implementing health system-wide clinical capacity to screen, diagnose, and support (or connect to) longitudinal care for OUD and StUD and support recovery for adults and adolescents.)*
Setting	Health systems
Priority	Core indicator (all jurisdictions are required to report)
References	1. Samet, J. H., Friedmann, P., & Saitz, R. (2001). Benefits of linking primary medical care and substance abuse services: patient, provider, and societal perspectives. Archives of internal medicine, 161(1), 85-91. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/646882 2. Chi, F. W., Parthasarathy, S., Mertens, J. R., & Weisner, C. M. (2011). Continuing care and long-term substance use outcomes in managed care: early evidence for a primary care-based model. *Psychiatric Services*, *62*(10), 1194-1200. https://doi.org/10.1176/ps.62.10.pss6210_1194

Reporting

OD2A-S recipients are expected to report on all performance measures on an annual basis. We have selected a short list of measures we believe are feasible for most recipients to report on. This does not limit what individual health departments want to capture for their use, and individual recipients can examine their capacities to collect, analyze, and disseminate additional performance measure data.

Data collection may be ongoing in each individual health department with partners reporting to health departments monthly or quarterly at minimum to allow for discussion and potential course corrections early on. As part of the performance measures submission, DOP staff at CDC commits to review the data, engage with recipients in discussion of the data, and learn from health departments' experiences and expertise gathered through prior and ongoing efforts to collect data and justify overdose prevention programs. Once data quality is at a sufficient place, CDC will share data reports back to individual recipients with their data for use within their own health department. CDC will use the data along with work plans and APRs to craft case studies and stories to share with CDC leadership, Health and Human Services, and other federal policymakers, as well as with recipients. CDC will find opportunities for mutual learning, growth, and sharing best practices so that we can all learn from each other.

Reporting Process

The current plan is to report performance measure data in the Partner's Portal. The 1 qualitative performance measure, contextual questions, and data quality questions will be submitted directly into the Partner's Portal platform. Data for the 7 quantitative measures along with their disaggregates will be submitted using the Excel reporting tool we developed—the Excel tool will be submitted as an attachment within Partner's Portal. The Excel tool has a tab titled, "Start Here." Please read the information on that tab before entering data.

Please note that CDC is requesting that jurisdictions enter all counts—***please do not suppress small numbers***. All numbers will be available to the CDC OD2A-S Program Evaluation Team, and small counts will not be shared with anyone outside the support team. The CDC OD2A-S Program Evaluation Team will aggregate small counts before any data are shared, and we will consult with recipients on plans to share data. If the count is zero, ***please enter "0"***—please do not leave these cells null or blank to ensure these cells are not mischaracterized as missing data.

Excel Reporting Tool

Performance measures will be reported using the Partner's Portal (see reporting process above). To aid in data collection with your partners and provide a clearer roadmap for data collection including required and optional disaggregates, we have developed an Excel-based tool, OD2A-S Performance Measures Reporting Tool.

Example of OD2A-S Performance Measures Reporting Tool

Number of health equity focused overdose prevention activities implemented with OD2A funding

Data Entry Instructions

Total_HE_Activities: This is a formula field that will generate a total count of health equity focused overdose prevention activities that occurred in a clinical, harm reduction, public safety, or other settings during the designated reporting period once the disaggregates below are entered into the appropriate fields.
HE_Clinical_Settings: Enter a whole number for the health equity focused overdose prevention activities that occurred in a health/clinical setting.
HE_HR_Settings: Enter a whole number that reflects the health equity focused overdose prevention activities that occurred in a harm reduction setting.
HE_Public_Safety_Settings: Enter a whole number that reflects the health equity focused overdose prevention activities that occurred in a public safety setting.
HE_Other_Settings: This disaggregate is optional. If chosen, enter a whole number that reflects the health equity focused overdose prevention activities that occurred in any setting outside of clinical, harm reduction, and public safety.

Please note that CDC is requesting that jurisdictions enter all counts—**please do not suppress small numbers**. If the count is zero, **please enter "0"**—please do not leave these cells null or blank to ensure these cells are not mischaracterized as missing data.

Required	Total_HE_Activities	0

		DISAGGREGATES			
		Required	Required	Required	*Optional*
Jurisdiction	Reporting_Period	HE_Clinical_Settings	HE_HR_Settings	HE_Public _Safety_ Settings	*HE_Other_Settings*
0	0				

Reporting Timeline

Year 1

The time period for the initial performance measuring reporting should account for March 1st-August 31st, 2024, noting that we expect recipients will need some time to set up data use agreements, data collection systems, and prepare data review and cleaning processes. Once recipients obtain data, we anticipate that they will need time for data review and data cleaning; therefore, we have designated a 3-month window of time for data cleaning within each health department before reporting data to CDC by Dec 1, 2024.

After we receive performance measure data, we expect that our team will need time for review and likely will have questions about the data recipients have submitted; therefore, we have included another 3-month window to account for this review period and any discussions between recipients and our team of evaluation science officers. Given that some data might need to be resubmitted, we have accounted for a data resubmission and confirmation window during March 2025.

Years 2-5

Data collection for Years 2-5 will occur in the program year Sept 1 – Aug 31 with reporting submissions due Dec 1st of each year. Time periods included in data submissions are aligned with OD2A program funding cycles. The table below provides the data reporting schedule for all years.

Program Year	Initial Data Submission due from Recipients	Time Period included in Submission	Recipient Data Cleaning and Submission *	CDC Data Review and Discussions with Recipients †	Data Resubmission and Confirmation
1	12/01/2024	3/1/2024-8/31/2024 §	9/1/2024-12/01/2024	12/01/2024-2/28/2025	3/1/2025-3/16/2025
2	12/01/2025	9/1/2024-8/31/2025	9/1/2025-12/01/2025	12/01/2025-2/28/2026	3/1/2026-3/16/2026
3	12/01/2026	9/1/2025-8/31/2026	9/1/2026-12/01/2026	12/01/2026-2/28/2027	3/1/2027-3/16/2027
4	12/01/2027	9/1/2026-8/31/2027	9/1/2027-12/01/2027	12/01/2027 2/29/2028	3/1/2028-3/16/2028
5	6/30/2028	9/1/2027-3/31/2028 ¶	4/1/2028-6/30/2028	7/1/2028-7/31/2028	8/1/2028-8/16/2028

§ Represents partial year data and the initial data submissions, with data less likely to be reportable as recipients address data quality and completeness challenges.

¶ Represents partial year data as the program concludes (end of cooperative agreement period of performance is 8/31/2028).

* Time periods for data cleaning and submission might be reduced as the program matures and recipients gain more experience with the data, and recipients will be encouraged to share data when ready for CDC review.

† Time periods for CDC data review and data reconciliation with recipients might be reduced as the program matures and CDC and recipients gain more experience with the data.

Acronyms

APR: Annual Performance Reports

CBO: Community-based organization

CDC: Centers for Disease Control and Prevention

CoAg: Cooperative Agreement

DOP: Division of Overdose Prevention

DUA: Data Use Agreement

EMS: Emergency Medical Services

FTS: Fentanyl Test strips

HHS: Health and Human Services

LTC: Linkage to Care

MOUD: Medications for Opioid Use Disorder

NEMSIS: National Emergency Medical Services Information System

NOFO: Notice of Funding Opportunity

OD2A-S: Overdose Data to Action in States

OUD: Opioid Use Disorder

OEND: Overdose Education and Naloxone Distribution

PWLE: People with Lived and Living Experience

PWUD: Persons Who Use Drugs

SDOH: Social Determinants of Health

SUD: Substance Use Disorder

StUD: Stimulant Use Disorder

SSPs: Syringe Services Programs

Glossary

Actively engaged individuals: Those who are: 1) fairly compensated for their expertise, 2) able to engage bidirectionally with their organization, and 3) are involved in shaping agendas, priorities, strategies, and decision-making.

Care: Evidence-based treatment for substance-use disorder or opioid use disorder. Care can also extend beyond treatment and include wrap-around services such as mental health care, transportation, peer support, infectious disease care, obstetric care, or harm reduction services that can address barriers to care.

- When discussing linkage to care and services for PWUD, it is the process of connecting people at risk for overdose to evidence-based treatment, services, and supports.

Communities or populations disproportionately affected by overdose: may be a defined geographic region or a disproportionately affected population. High rates for factors such as opioid prescribing, overdose morbidity, overdose mortality, naloxone administration, or a combination of these and other non-public health data, may be used to define disproportionately affected communities or regions.

Drug checking: limited to cases where samples are tested and results are shared directly back to participants (i.e., general drug supply checking and toxicology reports are not considered to be drug-checking related service encounters). This does not include the distribution of test strips that would be used offsite.

Education: refers to overdose prevention and response training such as how to recognize an overdose, proper naloxone use, safe drug use, and safe disposal.

Evidence/practice-based: Describes interventions or practices that have been developed based on high-quality research, professional experiences, and opinions of experts in the field. Practice-based interventions may reflect the preferences, priorities, and values of those who will receive or be affected by the interventions or practices.

Evidence-based SUD Treatment: includes MOUD, cognitive behavioral therapy [CBT], and contingency management.

Harm reduction: A public health approach that focuses on mitigating the harmful consequences of drug use, including infectious disease transmission and overdose, by providing care that is free of stigma and centered on the needs of people who use drugs. Harm reduction programs also offer critical linkages to treatment for substance use disorders and other resources for populations with less access to care.

Harm reduction service encounter: An interaction with service providers where a need expressed by a participant is addressed and where services are provided including distributing naloxone through OEND programs, providing drug checking services, distributing fentanyl test strips, wound care kits, and safer drug use supplies, offering Hepatitis C and HIV services, and other services provided by harm reduction service providers.

Health disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Health inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Health/Clinical setting: Places where people receive health services, care, or examinations related to a physical or mental health concern. Examples can be emergency departments, hospitals, clinics/practices, outpatient, inpatient, treatment centers, primary care, or pharmacies.

Impactful practices: OD2A-funded activities and interventions that reduced barriers to or facilitated access to SUD care and treatment, especially for those who historically have been underserved by care and treatment programs.

Implementing protocols and/or policies: include the implementation of existing or new policies with evidence-based clinical algorithms for referring and treating SUDs.

Improving protocols and/or policies: updating existing protocols and/or policies with evidence-based clinical algorithms for referring and treating SUDs.

Linkage to care: Linkage to care initiatives use nonfatal overdose and other data from different potential data sources—emergency medical services, emergency departments/health systems, justice systems, harm reduction services— to identify people who are at risk for overdose or have recently experienced a nonfatal overdose and link them with evidence-based treatment options, services, and supports. These may include medications for opioid use disorder; harm reduction strategies; and wraparound services, such as transportation to treatment and housing assistance. Linkage to care may occur in a variety of settings, like a doctor's office, emergency room, home, school, and virtually through telephone or online resources, and at any point along the recovery continuum.

Linkage to care using navigators: 1) linkage to evidence-based treatment for SUD to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

Navigators: Individuals familiar with the local public health landscape and who work directly with PWUD to ensure they have the tools to address barriers to seeking care and who support people accessing SUD treatment and care, as well as support access to other services, such as harm reduction and social supports. Navigators could include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived and living experience PWLE, and other individuals who link people who use drugs (PWUD) to care and harm reduction services. Navigators included in this performance measure must be supported by OD2A funding in some way. Staff support can be paid or unpaid. This may be direct funding or indirect support (e.g., in-kind staff support, coordination of activities across multiple partners, etc.).

OD2A supported or funded: Activities do not have to be directly funded with OD2A-S funds but must be supported by OD2A-S funding in some way to be counted in the performance measures. This may be direct funding (e.g., paying for an activity, paying for resources or supplies) or indirect support (e.g., in-kind staff support, surveillance and evaluation support, coordination of activities across multiple partners). Please work with your project and evaluation officer to determine what data should be collected for your jurisdiction.

Overdose education and naloxone distribution (OEND): Training programs aimed to reduce harm and risks associated with life-threatening opioid-related overdose and deaths. The length and content delivered during trainings may vary and can include stigma reduction training. Training on naloxone should cover overdose recognition and response, including the naloxone cascade of care whereby individuals are aware that naloxone is an effective opioid overdose intervention, have access to naloxone, and are trained on how to use naloxone during an overdose event. Training should address norms on possessing naloxone, especially during times of drug use.

Opioid use disorder (OUD): A problematic pattern of opioid use that causes significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria.

Persons with lived or living experience (PWLE) with substance use: Those who identify with having first-hand experience with substance use or using drugs. Lived experience refers to persons who have used drugs and are currently in recovery. Living experience refers to persons who are currently using drugs and may also be commonly referred to as PWUD.

Policy is a deliberate system of guidelines to guide decisions and achieve rational outcomes. A policy is a statement of intent and is implemented as a procedure or protocol. Policies are generally adopted by a governance body within an organization.

Populations of focus can include: Groups disproportionately affected by overdose and those previously underserved by overdose prevention programs and the healthcare system; Persons with lived and living experience with drug use, misuse, SUD, OUD, and StUD, or who experienced an overdose, including but not limited to people who are seeking care and services for OUD and StUD; and persons involved in the criminal justice setting, who might be incarcerated, detained, or recently released from incarceration; people experiencing a mental health condition; people experiencing homelessness or unstable housing; pregnant people; people who lack access to any or adequate health insurance; and specific demographic groups defined by race, ethnicity, gender identity, sexual orientation, and/or age.

Protocol is a system of rules that explain the correct conduct and procedures to be followed in formal situations. A protocol is a code prescribing strict adherence to correct etiquette and precedence.

Public safety is broadly defined to include criminal justice professionals and first responders such as law enforcement, emergency medical technicians, jail/prison personnel, probation/parole officers, prosecutors, and judiciary staff.

Referral: Any formal connection to treatment options or harm reduction services. This includes referrals made by clinicians, social workers, social service providers, community organizations, law enforcement, navigators, peer support specialists, or other relevant sources, who are supported by OD2A in some way. This may be direct funding or indirect support (e.g., in-kind staff support, coordination of activities across multiple partners, etc.).

Service providers: SSPs, CBOs, healthcare clinicians, health departments, treatment facilities.

Social determinants of health (SDOH): The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Stigma: a process where people with certain social identities are labeled, stereotyped, and devalued, leading to discriminatory behavior and internalized shame.

Training: This could include group or individualized training, systemwide clinician and clinical care team education, academic detailing, or free online training, such as the modules outlined on the CDC's website. Training could be directly funded or indirectly supported through OD2A funding.

Treatment: Medical care given to a patient for an illness or injury. Treatment may include medications for opioid use disorder, inpatient rehabilitation, outpatient counseling, and behavioral health care.

Warm handoffs: In-person/video/phone/text/instant messaging conversation during which the individual, the organization making the referral, and the organization receiving the referral all are present.