CASE STUDIES

State and Local Integration

OVERDOSE DATA2ACTION

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Table of Contents

ACKNOWLEDGMENTS

We would like to acknowledge the following individuals who contributed to the development of this product:

CDC Contributors:

Nida Ali, PhD, MPH
Robyn Borgman, PhD
Aleta Christensen, MPH
Emily Costello, MPH, MSW
Kari Cruz, MPH
Amanda Geller, MPH
Kevin Jefferson, MPH, MS
Cherie Rooks-Peck, PhD, RD

Contributors from OD2A-funded Recipients:

Rhode Island Department of Health:
Rachael Elmaleh
Jennifer Koziol, MPH
Rachel Scagos, MPH
California Department of Public Health:
Christine Fenlon, MSSL
Jacqueline Siukola Tompkins, MPH, CPH, MCHES®

Suggested citation: Centers for Disease Control and Prevention. *Overdose Data to Action Case Studies: State and Local Integration.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2022.

Introduction to Case Studies

The purpose of the case studies project is to capture in-depth information from the Centers for Disease Control and Prevention's (CDC) Overdose Data to Action (OD2A)-funded jurisdictions about current and emerging practices related to overdose prevention and response.

Each of the highlighted jurisdictions is funded through the multiyear (OD2A) cooperative agreement which focuses on understanding and tracking the complex and changing nature of the drug overdose epidemic and highlights the need for seamless integration of data into prevention strategies. Six key topic areas identified for interviews, analysis, and dissemination are listed here. Within each topic, specific activities and programs from various jurisdictions are captured as case studies. Programs and projects were selected based on a thorough review of current OD2A activities. These case studies illustrate overdose prevention and response efforts that can be shared with practitioners as they consider how to adapt interventions to their local context.

- Adverse Childhood Experiences or ACEs
- Harm reduction
- Linkage to care in non-public safety settings
- Public safety-led post-overdose outreach programs
- **State and local integration activities**
- Stigma reduction

State and Local Integration

How does it work?

The drug overdose epidemic in the United States remains a critical public health issue.[1]

The overdose epidemic indicates the need for a comprehensive public health approach enacted through state and local integration and coordination. State and local health departments are uniquely positioned to lead the response as they have the authority to enact policies, deploy programs and resources, and convene partners across multiple sectors to coordinate response efforts. By engaging local health departments, community organizations, coalitions, and community members with state overdose prevention efforts, state and local integration capitalizes on the important and distinct prevention roles of state and local partners. The case studies presented here illustrate what successfully implemented state and local integration looks like. When states and localities work together, they build capacity for cohesive, unified, and collective responses to overdose prevention.[2]

Many strategies and interventions may support state and local integration of overdose prevention activities. For example, localities and states can unify their prevention messaging, which may help increase awareness and decrease stigma by ensuring that residents receive consistent information about overdose prevention. Data sharing allows state and local organizations to contextualize, understand, and coordinate prevention needs across localities, allowing coordinated use of resources, strategies, and interventions to reach those most in need.[3] Coalitions may also support state and local integration by facilitating collaboration between partners from different sectors to design and implement comprehensive and complementary overdose prevention efforts.[4,5]

Case Studies

The following case studies describe two OD2A-funded state and local integration initiatives.

The first describes the **Rhode Island Department of Health's (RIDOH) weekly Surveillance Response Intervention (SRI) calls**: an initiative where information about overdose hot spots is communicated with state agencies and local partners to rapidly respond with integrated efforts that effectively use and disseminate data. The second describes the **California Department of Public Health's (CDPH) Overdose Prevention Initiative (OPI)**: an initiative to prevent lives lost from overdose by funding coalitions statewide to address current and emerging community needs.

CASE 1

Rhode Island's Surveillance Response Intervention Calls

CASE STUDY SNAPSHOT

- The Rhode Island Department of Health (RIDOH) holds weekly Surveillance Response Intervention (SRI) calls where information about overdose hot spots is communicated with state agencies and local partners to rapidly respond with integrated efforts to effectively use and disseminate data.
- The SRI produces weekly reports using 48-Hour Opioid Overdose Reporting System data from hospitals that help identify patient demographics and overdose geographic clusters in near real-time. A public health advisory is disseminated via email if a community exceeds its predetermined overdose threshold. The advisory includes an alert about an increase in overdoses and key community messages and may include a heat map of opioid overdose-related emergency medical services calls (EMS).
- Partners who receive the advisory include substance use treatment providers, recovery centers, harm reduction organizations, Emergency Medical Systems, first responders (fire/EMS, law enforcement), emergency department (ED) staff, pharmacists, prescribers of medication for opioid use disorder (MOUD), faith leaders, regional prevention coalitions, Rhode Island Health Equity Zone (HEZ) leaders, and community advocates.
- The alerts activate mobile outreach teams to hot spots where they visit shelters, food banks, and grocery store parking lots and conduct outreach to local businesses with resources. The teams also distribute print resources in high pedestrian areas within hot spots (e.g., casino bathrooms, bodegas, laundromats).

DESCRIPTION OF PROGRAM

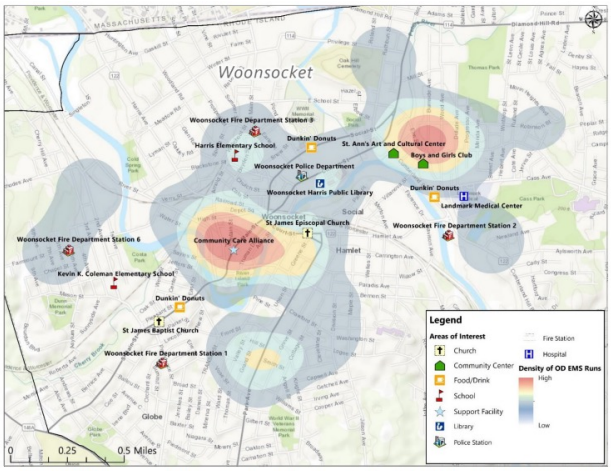
Collecting timely data is a barrier to rapidly responding to the overdose crisis. In 2014, The RIDOH passed an emergency regulation[a] requiring hospitals and EDs to report suspected opioid overdoses within 48 hours. RIDOH started weekly SRI calls with state agency partners in 2017 to identify hot spots, connect with local entities, and to respond with integrated state and local efforts more rapidly. Calls initially involved a small team of RIDOH staff: the project director, one epidemiologist, and the medical director. In 2019, RIDOH continued to support state agency and partner staff via these calls to effectively use and disseminate data for immediate action under the Centers for Disease Control and Prevention's (CDC) OD2A cooperative agreement funding. RIDOH overdose prevention and surveillance staff work closely together to use data to inform community-level action. Each week, they convene

the SRI with a 15–30-minute conference call to discuss recently reported overdose data with partners, including Rhode Island Fusion Center[a] representatives and state behavioral health and law enforcement agencies. The Fusion Center's role with the SRI team is to assist public health and public safety in identifying dangerous narcotics and drugs that have been contaminated with other drugs (e.g., pills contaminated with fentanyl) in certain affected communities within the state. They analyze seizure data provided by the Rhode Island Department of Health's Forensic Drug Chemistry Lab and collaborate with SRI team members to provide timely intelligence and notifications to communities that are experiencing increased overdose activity. Calls are currently closed to other organizations due to data confidentiality. However, to gain context from the field and allow for dialogue with local partners about overdose, prior to each call, RIDOH staff conduct a virtual conference with local prevention partners, including community-based organizations (CBOs) that conduct peer-based street outreach in municipalities experiencing high overdose rates.

SRI currently produces weekly reports using 48-Hour Opioid Overdose Reporting System data from hospitals, which identify patient demographics and overdose geographic clusters in near real-time. In August 2021, Rhode Island released the RIDOH Drug Overdose Surveillance Data Hub,[a] which brings together several data sources available for public access and use. Public health advisories are then disseminated via email if a community exceeds its predetermined overdose thresholds, defined below. These advisories[a] include an alert when overdoses increase, key messages to share with the community, and may also include a heat map of opioid overdose-related EMS calls (see Figure 1).

Overdose rate thresholds in ten regions were initially determined using 2016 emergency department data and based on a formula developed by the epidemiologist working on the project. The thresholds have since been revised based on epidemiolocal updates and new data sources (i.e., EMS, Overdose Detection Mapping Application Program [ODMAP], ethnographic surveillance, and drug seizure data). Regional thresholds were originally determined with 2016 data; however, overdose rate thresholds and alert frequencies are revised every few years to make prevention messaging more actionable, with the latest threshold revision occurring in 2021. A weekly frequency was chosen because urgency is lost

Figure 1. Rapid Response Heat Map of Opioid Overdoses in Rhode Island



Source: Rhode Island Emergency Medical Services Information System (RI-EMSIS); April 1, 2019- June 16, 2019

if alerts are sent too frequently. When a region surpasses its threshold in a week, a RIDOH communications specialist develops a public health advisory with clear directives. The Prevention Team at RIDOH then uses the weekly data to inform municipal-level interventions through discussions with partners, including treatment providers, recovery centers, harm reduction organizations, and EMS to implement a response plan. They also post these public health alerts on RIDOH's social media channels (Facebook, Twitter) and on Nextdoor. When alerted, mobile outreach teams are activated to hot spots where they visit shelters, food banks, and grocery store parking lots and conduct outreach to local businesses distributing resources. They also distribute print resources in high pedestrian areas within hot spots (e.g., casino bathrooms, bodegas, laundromats).

RIDOH also worked with local partners to secure state funding for peer advocates in recovery to provide mobile outreach in a transportation hub/public plaza that is a frequent public overdose hot spot. Monthly data packets, or municipal-level data reports, are provided to these outreach teams. These data reports include updated non-fatal (e.g., ED visits, EMS runs) and fatal (e.g., State Unintentional Drug Overdose Reporting System) overdose data as well as geographic information system heat maps identifying overdose hot spots. The reports' demographic data as well as information on the overdose location and time of day help to inform outreach efforts. In March 2021, a specific hotel in this area was identified as a hot spot, and mobile outreach teams successfully worked with hotel management and staff to distribute harm

reduction supplies and installed a harm reduction vending machine (i.e., vending machines that supply naloxone, sterile syringes, condoms, and other harm reduction supplies) onsite. Additionally, many outreach teams also arrange for safer drug use supplies (sterile needles, naloxone, and fentanyl test strips) via home delivery services, which can be either in person or via mail.

OD2A funds support three organizations that serve regions with a high burden of overdose to implement local prevention activities. As a result, alerts have been more meaningful and impactful. Involving CBOs promotes their engagement, buy-in, and expert contribution. In addition, these organizations formed a multisector Community Overdose Engagement (CODE) collaborative with residents and those disproportionately affected by opioid use disorder and overdose. Each CODE collaborative meets monthly to discuss and implement strategies to increase access to treatment, recovery, and harm reduction services (HRS).

PARTNERS INVOLVED

SRI partners include a state behavioral health agency, state law enforcement, town and city elected officials, and the Rhode Island Fusion Center. Partners who receive the advisory include substance use treatment providers, recovery centers, harm reduction organizations, Emergency Medical Systems, first responders (fire, EMS, law enforcement), emergency departments staff, pharmacists, prescribers of medication for opioid use disorder (MOUD), faith leaders, regional prevention coalitions, Rhode Island Health Equity Zone (HEZ) leaders, and community advocates. This facilitates an efficient, timely, and accurate exchange of information between local and state public safety, public health, and private sector organizations.

BARRIERS AND FACILITATORS TO IMPLEMENTING RHODE ISLAND'S SURVEILLANCE RESPONSE INTERVENTION

Barriers

Data are only valuable if they are used, which requires intervention and outreach from individuals working in the community. Converting alerts into actionable responses was initially difficult because local communities did not have the resources they needed to respond.

The COVID-19 pandemic negatively impacted data quality and individual help-seeking behaviors. The foundation of SRI is data quality, which has been affected by staff changes due to the COVID-19 pandemic; staffing was nearly complete until some were diverted to pandemic initiatives. Further, the COVID-19 pandemic may have negatively impacted the help-seeking behavior of individuals experiencing mental health conditions, substance use disorders, and overdose. During Rhode Island's Stay-At-Home Order in spring 2020, there was a noticeable decline in 911 calls, although overdose fatalities increased and accelerated through September 2020. While it is possible that non-fatal overdoses may have decreased, it is also possible that individuals' fear of exposure to COVID-19 prevented seeking emergency overdose services. In turn, fewer suspected overdose 911 calls led to fewer disseminated alerts. This prompted RIDOH to lower regional thresholds in 2021. RIDOH transitioned to the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) in late 2021. ESSENCE offers advantages, including automation of electronic health records (EHRs) from various hospitals to allow for faster data aggregation (the current process requires manual entering of data).

Partner tensions between harm reduction CBOs and law enforcement are ongoing. For instance, peer-based street outreach teams have reported negative encounters with law enforcement demonstrating fear, bias, and discrimination toward people with substance use disorders, people who experience homelessness, and people with mental health conditions. SRI provides a platform to report these negative encounters; however, law enforcement and harm reduction workers participating in calls do not reflect all law enforcement or harm reduction perspectives. Messages concerning substance use disorders and overdose prevention can be more helpful when they reach all law enforcement personnel to reduce stigma and help them better engage with people with substance use disorders.

Facilitators

SRI activities are facilitated by partner dedication and participation. Consistent call attendance provides an opportunity for rapid partner action. Brief, frequent meetings allow for discussion and understanding of overdose trends within community and illicit drug market contexts. In-person or video calls facilitate relationship-building by allowing partners to see each other. Additionally, the small size of Rhode Island facilitates the creation, facilitation, and maintenance of these partnerships.

Sustainable funding is critical to the success of this work so that CBOs are organized and prepared to respond to alerts. Prior to the availability of large-scale funding streams, the local response was challenged and inadequate because communities did not have the resources to organize effectively. Adequate resources are the key to developing the capacity of organizations, so they can respond effectively.

EVALUATION OF RHODE ISLAND'S SURVEILLANCE RESPONSE INTERVENTION

Rhode Island defines SRI success as the ability to identify overdose trends as they occur so that local communities can respond rapidly. Their evaluation assesses how partners use the data and respond to alerts with community interventions and outreach. Results are shared with partners at regular meetings and are disseminated within the RIDOH to inform calls and alerts and to identify opportunities for improvement.

EXAMPLES OF RHODE ISLAND'S KEY EVALUATION QUESTIONS AND INDICATORS:

Question: How did partners use the information provided by the electronic alert system?

- **Outcome Indicator:** Description of how the rapid response alert data was used by partners

Question: To what extent did key implementers (e.g., CODE collaboratives and street outreach teams) put data into action?

- **Process Indicator:** Number of data packets (municipal-level overdose data reports) offered to street outreach teams
- **Process Indicator:** Description of the OD2A team's technical assistance (TA) to street outreach teams
- **Outcome Indicator:** Description of the street outreach teams' use of data packets

OUTCOMES

Regional advisories have increased credibility and trust between RIDOH and community partners who recognize RIDOH's commitment to supporting the local communities' response to overdose. In 2018, any community receiving three alerts within six weeks warranted a focused response from RIDOH and state partners—this is called a CODE event. RIDOH and state partners would convene with community partners and share local-level data, and support response efforts. Three CODE collaborative events occurred between 2018 and 2019 to respond to an alarming increase in overdose.

Due to the success of CODE, RIDOH issued a Request for Proposal in December 2019 to fund municipalities to develop and implement local overdose action plans informed by multisector collaboratives. RIDOH received, reviewed, and scored the applications, many of which came from HEZ collaboratives located within or serving communities with high overdose. HEZs are geographic areas with significant health disparities that have existing infrastructure to accept funding. Three organizations received subawards with contracts signed in March 2020. At the time of writing, there were five CODE collaboratives funded. Each formed a diverse collaborative representative of the local population, including peer recovery support agencies, prescribers of MOUD, basic needs services (e.g., homeless shelters, food banks), syringe services programs, first responders, and behavioral health organizations. Collaboratives convene at least monthly, and RIDOH prevention staff participate in meetings.

Some CODE collaboratives' strategies include:

- Multimedia public awareness campaign highlighting the danger of contaminated drugs (fentanyl-contaminated drug supply).
- Increased street outreach in overdose hot spots: certified peer recovery support specialists distribute naloxone, sterile syringes, and fentanyl test strips and provide wrap-around services and basic needs to people who use drugs.
- Distribution of 10,000+ free kits of intranasal naloxone to Rhode Islanders at risk of overdose and families and friends of people at risk.
- Increased housing supports for people living within two CODE collaborative project jurisdictions.
- Strategic placement of community health navigators and peer recovery specialists at Rhode Island and Landmark Hospital EDs. Trained ED staff connect patients who have recently experienced an overdose to local treatment and recovery support services.

SUSTAINABILITY

SRI, with CDC's OD2A support, has provided funding, staff, and technical expertise to RIDOH to continue their operations through 2022. Most initial work falls under the epidemiologist and communications staff at RIDOH who develop and disseminate advisories and alerts. Community leader connections are critical once an alert is disseminated. Existing community connections are strong, and funding allows local CBOs to rapidly respond. Alerts will be sustainable when all municipalities have funded CODE collaboratives. The first three years of OD2A allowed time to select community-based organizations and to stand-up projects. Time-limited funding is an ongoing challenge to sustainability when organizations aren't guaranteed future funding.

Rhode Island reports that $5,000–$10,000 per community was helpful to develop an initial CODE plan; however, implementation requires additional funding. RIDOH is providing $150,000 per year to each of three CBOs that participate in CODEs. Seven municipalities developed local needs assessments when CDC provided RIDOH with surge funding ($60,000) in 2019; however, after one year, surge funds were unavailable to further study local needs or to enact interventions.

CASE 2

California Coalitions

CASE STUDY SNAPSHOT

- In 2017, the California Department of Public Health (CDPH) initiated the Overdose Prevention Initiative to prevent lives lost from overdose by funding coalitions statewide to address current and emerging community needs.
- California's coalitions emerged from the action and foresight of a dedicated doctor at the California Health Care Foundation (CHCF), who became a steadfast advocate for overdose prevention after seeing the negative impact of the opioid crisis among her patients. She proposed funding coalitions as a community engagement strategy used by other states engaged in overdose prevention.[6]
- Coalitions are housed in local health departments and nonprofit organizations, such as health collaboratives and county medical societies, and use data to inform community actions and to implement evidence-based interventions.
- Local staff and 40 AmeriCorps Volunteers in Service to America (VISTA) within served counties coordinate with the coalitions with the assistance of four dedicated CDPH project officers. The CDPH also convenes the Statewide Overdose Safety (SOS) Workgroup, which also helps to guide their network of coalitions.
- Coalition funding includes data to action as a required strategy. All funded coalitions use data to inform their programs and to promote program and policy change.
- The California Overdose Surveillance Dashboard[a] provides data on opioid prescribing, overdose deaths, emergency room visits, and hospitalizations by region, substance, and demographics. These data are used to prevent overdose by tracking the epidemic to identify and inform intervention needs.

DESCRIPTION OF THE PROGRAM

The CDPH recognizes that overdose is a complex, multifaceted problem that requires multisectoral solutions. Coalition building is an important strategy used to unite partners from diverse sectors to prevent lives lost from overdose as a common goal. CDPH's Overdose Prevention Initiative (OPI)[a] funds coalitions statewide to address current and emerging overdose prevention community needs. Coalitions are housed in local health departments and nonprofit organizations such as health collaboratives and county medical societies. They use data to inform community actions and to implement evidence-based interventions. Funded coalitions educate the public and increase awareness, expand access to medication for opioid use disorder (MOUD) and naloxone, promote safer prescribing practices and harm reduction services (HRS), and develop local opioid-related policies and procedures.

California's coalitions emerged from the action and foresight of a dedicated doctor at the CHCF, who became a steadfast advocate for overdose prevention after seeing the negative impact of the opioid crisis among her patients. The doctor had the foresight to propose funding coalitions as an emerging tool for overdose prevention throughout California via a partnership between the CHCF and CDPH. Her actions are a testament to how individuals can positively impact overdose prevention.

Because of her efforts, active funding for prevention began in 2016 with 17 coalitions. In 2020, when CDPH was interviewed for this case study, 23 funded coalitions served 32 of California's 58 counties.[a] Coalitions also operate via strategy-directed funding from CDC and, more recently, with assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA). During the same time period, CDPH has invested approximately $1.4 million annually to support coalitions.

Local staff and 40 AmeriCorps VISTA within the counties coordinate with the coalitions with assistance from four dedicated CDPH project officers. The SOS Workgroup (previously the Statewide Opioid Safety Workgroup[a]), convened by CDPH, also helps to inform the network of coalitions. The success of the coalition hinges upon a mentoring network and partnerships between CDPH, local health departments, nonprofits, and VISTA. The California Overdose Prevention Network (COPN) coordinates VISTA volunteers and provides technical assistance (TA) to the coalitions. COPN and CDPH together promote successful prevention strategies and support ongoing capacity development. A learning collaborative approach is fostered by calls and technical presentations for organizations convening the coalitions.

PARTNERS INVOLVED

Coalitions involve partners across sectors, including public health, substance use disorder treatment, health care, law enforcement or corrections, and people who use or have used substances (and their friends and family).

DATA USED TO INFORM THE PROGRAM

The SOS Workgroup, which helps to inform the coalition's work, holds routine meetings to discuss strategy, policy, and data implications for overdose prevention efforts. A key source for these state and local partners is the California Overdose Surveillance Dashboard,[a] a publicly available platform that provides data on opioid prescribing, overdose death, emergency room visits, and hospitalizations by region, substance, and demographics. These data are used to prevent overdose by tracking the epidemic to identify and inform intervention needs. Moreover, CDPH added a data to action component as a required strategy in their recent coalition Request for Applications (RFA). All funded coalitions use data to inform their programs and to promote program and policy change. For example, one coalition responded to data on overdose-related emergency medical services (EMS) calls by building a program for EMS providers to initiate MOUD in connection with doctors to whom patients are later transferred.

BARRIERS AND FACILITATORS TO IMPLEMENTING CALIFORNIA'S COALITIONS

Barriers

Promoting harm reduction strategies and clinician education has been challenging. CDPH notes that contracting with organizations that provide HRS has been particularly difficult during the pandemic. Several organizations were addressing the increased need for clean drug use supplies and naloxone; however, some coalitions lacked community support for HRS, including resistance to naloxone distribution in jails, and experienced difficulties developing relationships with chain pharmacies. In the past, they also reported that academic detailing was challenged by lack of buy-in from health plans and payer systems and legal liability concerns such as paying academic detailers directly.

Data availability to guide interventions lags behind need. Although coalitions use the California Overdose Surveillance Dashboard,[a] they often seek more "real time" data to educate and inform interventions. However, timely data are limited. For instance, data quantifying the impact of the COVID-19 pandemic on overdose were not available at the time of the interview for this write up. Looking ahead, CDPH is working to release preliminary data for coalition use through the State Unintentional Drug Overdose Reporting System (SUDORS) and Rapid Opioid Death Detection (RODD) systems.

COVID-19, wildfires, internet access, and power outages impeded the coalitions' work. Some coalitions could not complete planned work in 2020 due to the COVID-19 pandemic. The transition to virtual work was challenging, and virtual training formats impeded learning because of limited internet access in some communities. The pandemic also negatively impacted CDPH and coalition staff capacity, especially for coalitions operated by local health departments that had to divert staff to the pandemic response. In addition, coalitions were affected by wildfires that caused major and prolonged power outages that affected their ability to submit material to CDPH and to communicate electronically.

Facilitators

Coalitions make use of available data and seek expanded sources such as coroner reports or EMS data, and some have created their own data dashboards[b] to make information freely available in their communities.

Coalitions leverage and braid resources and funding from multiple sources, which promotes sustainability and helps deliver comprehensive and well-supported interventions. For example, coalitions support peer navigators connecting people with substance use disorders in emergency departments to case management and linkage to other types of care by participating in a Department of Health Care Services-funded program. Sustainable funding is a critical component of coalition success and their ability to impart meaningful long-term community change. Braided funding sources include federal agencies, state-based foundations, health insurers, and in-kind donations.

Coalitions benefit from AmeriCorps VISTA National Service Program volunteers. In California, most VISTA volunteers support coalitions and effectively use outside resources to provide community champions and staff. They coordinate meetings and events, conduct community outreach, and provide data analysis and are especially helpful in communities where recruiting and retaining staff is challenging. This is a low-cost support to the coalitions in addition to helping train future public health professionals.

Coalitions worked strategically during the pandemic, providing critical resources that facilitated naloxone distribution and local harm reduction responses to the COVID-19 pandemic. For example, the Northern Sierra Coalition, which covers four rural counties, secured funding from Anthem for public health vending machines that stocked items such as pregnancy tests, syringes with sharps containers, first-aid kits, safer sex kits, nicotine replacement kits, drug deactivation kits, oral health supplies, HIV home tests, and naloxone.

Coalitions creatively share with each other and benefit from having CDPH as a connector. Coalitions have a relationship with CDPH and optimize peer-to-peer sharing using CDPH connections and resources. CDPH helps coalitions share resources such as Spanish language materials and disseminates innovative coalition activities.

Coalitions carried over funds they could not use due to the COVID-19 pandemic. CDPH and program funders encouraged coalitions to revise work plans and to carry-over funding to the next fiscal project year when the COVID-19 pandemic began. This flexibility enabled the coalitions to focus on activities and outreach they could carry out during the pandemic.

EVALUATION OF CALIFORNIA'S COALITIONS

Coalitions participate in regular calls with CDPH and complete semi-annual progress reports. During calls, coalitions may discuss items of concern, including successes, challenges, possible solutions, training and TA needs, and events that CDPH may attend to support local efforts.

In the progress reports, coalitions report on performance metrics[c], current and desired sectoral involvement[d], and various key strategies (e.g., safe prescribing practices, community awareness and education, and local policy development).

EXAMPLES OF CDPH'S EVALUATION QUESTIONS AND INDICATORS:

Question: Did coalitions develop and adopt local opioid-related policies and procedures?

- **Outcome Indicator:** Description of evidence-based practices adopted in multiple organizations and agencies
- **Outcome Indicator:** Description of opioid-related policies and procedures adopted in multiple organizations and agencies

Question: Did coalitions use overdose surveillance and any other data to inform their activities?

- **Process Indicator:** Descriptions of how coalitions use overdose data and other data

Question: How did coalitions progress on the activities in their work plan?

- **Process Indicator:** Descriptions of progress reported on each activity in the coalition's work plan

OUTCOMES

Despite the COVID-19 pandemic, coalitions had many successes, including policy changes. Many of these policy changes focused on MOUD access for justice-involved populations, and others allowed HRS to open in counties for the first time. Specific changes accomplished by coalitions include: law enforcement agreement to refer juveniles to MOUD, Emergency Medical Services adopted practices to leave behind naloxone after an overdose, and expanded MOUD choice within jails to three medication options. In addition, coalitions participated in linkage to care programs, initiated a polysubstance work group, and translated materials into multiple languages to reach wider audiences.

Coalitions found creative ways to work during the pandemic. They shortened or moved to online meetings and used video updates. Some partnered with the private sector to advance prevention and address overdose involving substances other than opioids. For example, the Northern Sierra Coalition started a contingency management program with local businesses and behavioral health to reduce methamphetamine use. Contingency management is an evidence-based approach to reducing substance use in which rewards, in this case, gift cards to local businesses, are given when clients meet use reduction milestones.[8]

SUSTAINABILITY

Funded coalitions are able to organize and quickly intervene with people who use drugs more often than those that are not funded. Most coalitions have paid staff or consultants, including local health department employees who keep the coalitions active. Local health departments that have diversified funding have not needed to use CDPH funds to support these employees, which has allowed them to be flexible with CDPH funding.

While CDPH staff were redirected to respond to the COVID-19 pandemic, coalitions continued to receive informational webinars, TA, coaching-oriented services, and opportunities to share and connect from CDPH's partner, the California Overdose Prevention Network (COPN). The partnership between CDPH and COPN has ensured coalitions receive training, mentoring, technical support, and resources designed to strengthen overdose prevention efforts.

Evaluation Considerations

Evaluators can consider the following as they seek to evaluate similar efforts.

Strategies for successful state and local integration

- Established partnerships between state and local health department staff and community organizations based on mutual trust, respect, and consistent and open communication.
- Partners who represent various sectors, skill sets, and identities to ensure that diverse community voices are heard.[9]
- A powerful leader committed to the work and to adequately funding communities.
- A strategic plan that uses evidence-based strategies and data to address overdose burden that meets the unique needs of the community.
- Shared vision, goals, and leadership that represent members of the group and community.[10,11]
- Long-term funding with multiple streams of funding for local and community-based agencies.
- Supportive policies for harm reduction.
- Assessment(s)[a] conducted to determine the unique assets and needs of the community, including a description of the overdose burden and substance use trends in the community and identification of populations disproportionately affected by overdose to address health disparities based on available data. Consider capacity assessments to help identify what support the coalitions, state, or local entities may need and implement on an annual basis to track progress.

Evaluation method considerations

- Community-based participatory research[12] (CBPR) methods for evaluation[13]
- Informal data collection methods (e.g., meeting minutes) and informal discussions can also be used during routine meetings to understand barriers and facilitators as part of ongoing evaluation.

Additional evaluation questions and indicators to consider

- **Question:** What factors may provide necessary context to understand the overdose epidemic and use of data at the local level?
  - Process Indicators:
    - Description of variation across local subpopulation and factors that influence burden as evidenced within reports of overdose
    - Description of available administrative data (e.g., census data, business registries) reporting economic and health disparities, geography (rural, urban, and lands held within tribal jurisdictions), local cultural and religious values, and availability and access to healthcare
    - Description of efforts to understand and prioritize determinants of health (e.g., personal, social, environmental, and economic factors)
    - Description of organizational capacities of local agencies, including their capacity to partner on prevention efforts using data analyzed by the state (e.g., access to data sources, ability to conduct analyses, and/or ability to interpret and use data provided by the state)
    - Description of facilitators, barriers, and lessons learned in collecting, analyzing, and using existing data to understand the overdose epidemic at the local level

- **Question:** To what extent are relevant data and TA accessible to partners?
  - Process Indicator: Number and types of organizations and populations accessing relevant data, outreach materials, training, or information
  - Process Indicator: Description of partners'/ coalitions' receptivity to and perception of quality of the TA
- **Question:** To what extent are funded partners successfully implementing overdose prevention and response strategies in their communities that range in level of evidence[e] from emerging to well supported?
  - Process Indicator: Description of barriers and facilitators that funded communities or organizations are experiencing with strategy implementation
  - Outcome Indicator: Description of strategies, including level of evidence base, currently implemented by funded partners and their stage of implementation
- **Question:** How are coalitions or partnerships formed, and how do they ensure they represent community needs?
  - Process Indicator: Description of community needs assessments used by coalitions or partnerships
  - Process Indicator: Number and description of organizations consulted in coalition creation

Resources

- Evaluation Profile – Technical Assistance to Disproportionately Affected Communities
- Fundamentals of Evaluating Partnerships

References

1 Hedegaard, H., Miniño, A. M., Spencer, M. R., Warner, M. (2021). *Drug Overdose Deaths in the United States, 1999–2020*. NCHS Data Brief, no 428. Hyattsville, MD: National Center for Health Statistics. https://dx.doi.org/10.15620/cdc:112340

2 Center for Healthcare Strategies. (2018, May). *Combating opioid abuse through a united state and local response: the Ohio governor's cabinet opiate action.* https://www.chcs.org/media/BHBHC-State-Profile_OH_053018.pdf

3 National Research Council (US) Committee on the Review of Food and Drug Administration's Role in Ensuring Safe Food, Wallace, R. B., & Oria, M. (Eds.). (2010). *Enhancing Food Safety: The Role of the Food and Drug Administration*. National Academies Press (US). Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK220385/

4 Janosky, J. E., Armoutliev, E. M., Benipal, A., Kingsbury, D., Teller, J. L., Snyder, K. L., & Riley, P. (2013). Coalitions for impacting the health of a community: the Summit County, Ohio, experience. *Population Health Management*, *16*(4), 246–254. https://doi.org/10.1089/pop.2012.0083

5 Butterfoss, F. D., Morrow, A. L., Webster, J. D., & Crews, R. C. (2003). The Coalition Training Institute: training for the long haul. *Journal of Public Health Management and Practice*, *9*(6), 522–529. https://doi.org/10.1097/00124784-200311000-00013

6 Robinson, A., Christensen, A., & Bacon, S. (2019). From the CDC: The Prevention for States program: Preventing opioid overdose through evidence-based intervention and innovation. *Journal of Safety Research*, *68*, 231–237. https://doi.org/10.1016/j.jsr.2018.10.011

7 El-Bassel, N., Gilbert, L., Hunt, T., Wu, E., Oga, E. A., Mukherjee, T. I., Campbell, A., Sabounchi, N., Gutnick, D., Kerner, R., Venner, K. L., Lounsbury, D., Huang, T., & Rapkin, B. (2021). Using community engagement to implement evidence-based practices for opioid use disorder: A data-driven paradigm & systems science approach. *Drug and Alcohol Dependence*, *222*, 1-9. https://doi.org/10.1016/j.drugalcdep.2021.108675

8 Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). Contingency management for treatment of substance use disorders: a meta-analysis. *Addiction (Abingdon, England)*, *101*(11), 1546–1560. https://doi.org/10.1111/j.1360-0443.2006.01581.x

9 Cramer, M. E., Mueller, K. J., & Harrop, D. (2003). Comprehensive evaluation of a community coalition: a case study of environmental tobacco smoke reduction. *Public Health Nursing (Boston, Mass.)*, *20*(6), 464–477. https://doi.org/10.1046/j.1525-1446.2003.20607.x

10 Center for Community Health and Development. (n.d). *Creating and Maintaining Coalitions and Partnerships*. The University of Kansas. https://ctb.ku.edu/en/creating-and-maintaining-coalitions-and-partnerships

11 Oak Ridge Associated Universities (n.d.). *Coalition-Building Primer.* https://www.orau.gov/hsc/cdcynergy30/ba/Content/activeinformation/resources/Coalition_Building_Primer.pdf

12 Minkler, M., & Wallerstein, N. (Eds.). (2008). *Community-based participatory research for health: From process to outcomes.* (2nd edition). San Francisco, CA: Jossey-Bass.

13 Israel, B., Eng, E., Schulz, A.J., & Parker, E.A. (Eds.) (2005). *Methods in community-based participatory research for health.* (1st edition). San Francisco, CA: Jossey-Bass.

Endnotes

[a] The Centers for Disease Control and Prevention (CDC) cannot attest to the accuracy of a non-federal website. Linking to a non-federal website does not constitute an endorsement by CDC or any of its employees of the sponsors or the information and products presented on the website.

[b] See for instance the San Benito County Opioid Task Force Dashboard[a], the SafeRx Santa Cruz Dashboard[a], or Riverside County's Overdose Dashboard.[a]

[c] CDPH uses Tuckman's (2010) classification system of: Forming- establishing expectations, trust, and shared goals; Storming- building communication skills, identifying power, and reacting to leaders; Norming- working in a collegial atmosphere focusing on problem-solving, consensus, or negotiation; Performing- Accomplishing results uses processes that support collaborative work. Tuckman's, B. (2010). Forming, Storming, Norming and Performing Team Development Model.

[d] Involved sectors include public health, substance use disorder treatment, healthcare, law enforcement or corrections, and people who use or have used substances. Coalitions hope to increase the involvement of people who use or have used substances.

[e] For more information regarding the levels of evidence across the evidence continuum, see the CDC's Guide to the Continuum of Evidence of Effectiveness.