CASE STUDIES

Public Safety-Led Post-Overdose Outreach

OVERDOSE DATA2ACTION

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

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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

Public Safety-Led Post-Overdose Outreach

How does it work?

People who have experienced a nonfatal drug overdose are at higher risk of fatal overdose than those who have not.[1]

Public safety-led post-overdose outreach has the ability to identify people who are at higher risk, link them to care, and engage them in evidence-based overdose prevention interventions, such as overdose education, naloxone distribution, syringe services programs, and medications for opioid use disorder (MOUD[a]).

Public safety officials (emergency medical services [EMS], fire services, and law enforcement) are often the first to arrive at the scene of a 911 overdose call; therefore, their data systems provide information about people who experience nonfatal overdoses, allowing for outreach after an overdose event.

Public safety-led post-overdose outreach often includes:

- Identifying program participants via EMS, fire, and/or law enforcement data. Privacy is ensured through data use agreements between partners and by contacting participants before conducting outreach to address privacy concerns.[2,3]
- A multidisciplinary team consisting of[4]
  - A health provider (e.g., case manager, peer recovery coach, social worker, counselor) who leads the outreach encounter
  - EMS personnel who assist the health provider in offering information and leave behind naloxone
  - Law enforcement who also assist the health provider (this may involve outreach visits by police being conducted using an unmarked vehicle and the officer wearing plain clothes[3])
- Outreach occurring within a few days of an overdose event[3]
- An outreach encounter at the person's residence or virtually that consists of:[2,4,5]
  - Assessment of needs and risks
  - Use of motivational interviewing[5] to encourage and empower the person to set goals
  - Messages about harm reduction strategies (e.g., overdose prevention, naloxone distribution and administration, and Good Samaritan Laws)
  - Information about local services (e.g., syringe services programs, MOUD, social services)
  - Connection with a peer support specialist for long-term linkage to care and recovery support
  - Leaving behind naloxone and information about local services (e.g., syringe services programs, MOUD, social services)
  - Providing transportation to services
  - Outreach to family and social networks, particularly when the person who experienced overdose is not available
- Follow-up, conducted either in-person or virtually (e.g., via text or phone call), based on participant consent

Evaluations of public safety-led post-overdose outreach programs show that implementing these activities reduced overdose risk for participants through their engagement with health providers, including linkage to treatment with MOUD.[2,5]

Case Studies

The following case studies describe two OD2A-funded public safety-led post-overdose outreach initiatives.

The first describes **West Virginia's statewide quick response team program**, which engages local health departments, EMS agencies, and behavioral health centers to enhance post-overdose linkages to care. The second describes **Franklin County, Ohio's Rapid Response Emergency Addiction Crisis Teams program**, which engages individuals who recently experienced a nonfatal overdose to provide access to treatment and offer harm reduction and other social service supports.

CASE 1

West Virginia's Quick Response Team Program

CASE STUDY SNAPSHOT

- With the support of federal funding, quick response teams (QRTs) are intended to enhance post-overdose linkages to care and increase participation in treatment for opioid use disorder (OUD) with a goal of reducing overdoses.
- The West Virginia Department of Health and Human Resources (WVDHHR) coordinates and provides administrative support to quick response teams implemented by local health departments (LHDs) and other agencies in 33 counties. WVDHHR coordination efforts ensure alignment with their strategic plan,[6] facilitate response expansion based on readiness and need, and reduce duplication of efforts.
- LHDs, emergency medical services (EMS) agencies and behavioral health centers lead QRT implementation, allowing for customization based on resources and needs at the local level. Each QRT includes a peer recovery specialist. Other key partners may include health care workers, law enforcement, emergency responders, faith leaders, and community members.
- After first responders respond to a nonfatal overdose, the QRT initiates contact within 24-72 hours to discuss treatment options. Contact continues through repeated house visits, phone calls, text messages, and other communication routes.

DESCRIPTION OF PROGRAM

West Virginia's statewide QRT program rests on two fundamental components: first, prospective QRTs must have established relationships with both local and state partners yet be able to act autonomously and have established surveillance and evaluation capacity; second, QRTs must demonstrate prior success in linking people to care.

In 2017, a QRT led by EMS in Cabell County, one of West Virginia's counties hit hardest by the opioid overdose epidemic, demonstrated success in following up with about 60% of individuals who experienced a nonfatal overdose and successfully linking about 30% of those individuals to care. In 2018, when looking to enhance linkage to care strategies (e.g., connecting those who have experienced an overdose with substance use disorder [SUD] treatment) in response to high overdose rates, WVDHHR Violence and Injury Prevention Program (VIPP) turned to LHDs as the lead agencies to scale up QRTs. VIPP then funded LHDs to form and deploy QRTs to conduct post-overdose visits and follow up with people who experienced a nonfatal overdose and other individuals at risk of overdose, if the local QRT has the capacity.

State Model

As of March 2021, VIPP is providing administrative oversight to QRTs in 33 counties. CDC's OD2A cooperative agreement with VIPP supports QRTs in nine LHDs, including Berkeley, Boone, Mingo, Marion, Monongalia, Fayette, Logan, Jefferson, and Mid-Ohio Valley, a regional health department spanning six counties. In late 2020, a physician was recruited to assume responsibility for ongoing quality improvement for the program, which includes overseeing the expansion of QRTs.

All administrative oversight for QRTs falls under the authority of VIPP, regardless of the funder (i.e., CDC, Bureau of Justice Assistance, or the Substance Abuse and Mental Health Services Administration), to ensure alignment with the state's strategic plan,[6] reduce duplication of efforts, and enable ongoing operational improvements. To implement QRTs across the state, VIPP creates funding opportunities for local agencies to support the establishment and/or expansion of community-based QRTs in counties with a high burden of opioid overdose deaths. These opportunities are generally open to all counties. Funding is awarded to agencies based on their ability to demonstrate burden using county-level data, readiness to engage with partners, capacity to provide treatment to participants, and support from the county commission. Local data and existing relationships between partners facilitate the establishment of QRTs. To demonstrate community readiness, local agencies must provide letters of support from law enforcement and/or emergency response agencies and at least one community-based organization that provides behavioral health treatment and/or recovery services. Signed memoranda of understanding are expected within 30 calendar days of funding awards.

Local QRTs

The goal of QRTs is to save lives by increasing participation in treatment for OUD and reducing repeat overdoses, harms associated with overdose (e.g., adverse mental health and social outcomes), and overdose deaths. After first responders respond to a nonfatal overdose, the QRT initiates contact within 24-72 hours to discuss treatment options. Generally, EMS shares information for an individual who experienced a nonfatal overdose, typically including those who refused transport to the emergency department (ED), with the QRT. QRTs contact people through repeated house visits, phone calls, text messages, and other communication routes. However, the COVID-19 pandemic led to less in-person communication. QRTs educate those at risk of experiencing an overdose, including those who have experienced an overdose and families of those who are at risk of experiencing an overdose, about SUDs and offer various resources on harm reduction, SUD treatment options, and social services. All QRTs offer linkage to SUD treatment for those who are interested and ready. Other activities vary by county and can include provision of prevention messaging, naloxone and other harm reduction supplies, and screening (e.g., screening, brief intervention, and referral to treatment), and linkage to primary care, withdrawal management and SUD treatment, mental health services, and social services.

Each QRT in West Virginia includes a peer specialist, or an individual who meets the state's certification requirement for a peer recovery support specialist[b], and a coordinator. The team's makeup otherwise varies by county. The team may include some combination of community health workers, EMS personnel, law enforcement, and faith leaders. EMS representatives on the QRT do not provide clinical care; however, they provide on-site, non-emergent care and assessment of the person who experienced a nonfatal overdose, which requires no change in scope of practice. Partnership with EMS agencies is critical, as they supply contact information on potential QRT participants (i.e., people who experienced a nonfatal overdose).

PARTNERS INVOLVED

Local agencies lead QRTs and are supported by WVDHHR. Partners include health providers (i.e., clinicians, case managers, peer navigators, substance use counselors, and community health workers), law enforcement, paramedics, EMS, LHDs, behavioral health centers, and community members.

DATA USED TO IMPLEMENT THE PROGRAM

QRTs primarily use data to identify those who have recently experienced a nonfatal overdose. Local EMS agencies provide contact information for people who recently experienced an overdose to the QRT entity, and the outreach team follows up with them. Per HIPAA's Disclosures for Public Health Activities 45 CFR § 164.512, West Virginia enables disclosure of identifiable information to an entity (i.e., a QRT) that is necessary to lessen or prevent a serious and imminent threat to the health or safety of a person who has experienced an overdose. Once outreach has been conducted, data regarding the QRT is tracked in a centralized software as a service (SaaS) application, which allows users with an

Internet connection to access and use the software and its data to manage QRT cases. Currently, the SaaS vendor has employees in the state to assist QRTs with this data collection by offering technical assistance on using the system and optimizing the data.

BARRIERS AND FACILITATORS TO IMPLEMENTING WEST VIRGINIA'S QUICK RESPONSE TEAM PROGRAM

Barriers

- Some counties experience a lack of buy-in from key partners, such as community members and law enforcement who are not receptive to QRTs, perhaps due to the stigma surrounding SUDs.
- Geography presents access issues given the rurality of some West Virginia communities, resulting in a lack of available staff resources (e.g., SUD treatment providers) for effective QRT implementation.
- The COVID-19 pandemic has affected the implementation process and has caused delays of some activities (e.g., hiring, expanding to other counties).
- First responders may not always notify the administering QRT entity of nonfatal overdoses. Without buy-in from first responders, the community cannot carry out post-overdose outreach.
- Currently, each QRT has a certified peer recovery specialist. As QRTs expand in the state, the need for certified peers will be greater than the existing pool.

Facilitators

- State supports coordination at the local level, which allows the teams to address local-level issues.
- QRTs are funded in counties that demonstrate opioid overdose burden and have existing partnerships and treatment capacity.
- A data disclosure policy that allows for use of EMS data to identify potential QRT participants is critical to outreach efforts.

EVALUATION OF WEST VIRGINIA'S QUICK RESPONSE TEAM PROGRAM:

West Virginia's current evaluation questions with their associated indicators are outlined below:

Question: Was a strategy to identify counties in which to implement QRTs developed?

- **Process Indicator:** Description of strategy to identify counties (e.g., information collected from county decision-makers)

Question: What external factors have impacted the implementation of QRTs? (What were the factors that contributed to program operations [facilitators]? What were the factors that contributed to deviating from or not commencing documented program policies and procedures [barriers]?)

- **Process Indicators:** List of barriers to QRT program implementation by program site and overall, list of facilitators to QRT program implementation by program site and overall

Question: Have best practices been identified for QRTs?

- **Process Indicator:** Description of best practices

Question: To what extent are the QRTs collecting and inputting data?

- **Process Indicator:** Completeness of data collection (description of the extent to which each QRT is collecting requested data into the system provided by the VIPP data vendor)

Question: What is the reach of QRTs in West Virginia?

- **Process Indicator:** Number of new client encounters in each site
- **Process Indicator:** Proportion of people who experienced a nonfatal overdose who are engaged by QRT

Question: What are the outcomes of QRTs?

- **Process Indicator:** Number of naloxone kits distributed
- **Process Indicator:** Number of people offered linkage to SUD treatment
- **Outcome Indicators:**
  - Knowledge of harm reduction strategies (among participants and staff)
  - Proportion of participants who initiate treatment
  - Aggregated county rates of nonfatal overdose[c]

West Virginia also indicated an interest in exploring how involving certified peer recovery specialists impacted the successful implementation of QRTs. This aspect of the program could be evaluated by considering the following evaluation question and indicator(s):

Question: How does the inclusion of certified peers for QRTs affect the success of these programs?

- **Process Indicator:** Description of barriers and facilitators to mandating the inclusion of a certified peer for QRT implementation
- **Process Indicator:** Difference in the proportion of contacted participants who accept outreach from/engage with QRTs with peers and QRTs without peers[d]

OUTCOMES

Anticipated outcomes include:

- **Short-term outcomes:** Increases in local and state capacity for sustainable surveillance and prevention efforts; increased understanding of context, resources, and needs in city/county/state; increased understanding of evidence-based, scalable response approaches; increased focus on groups at highest risk for overdose; and increased naloxone distribution.
- **Intermediate outcomes:** Greater awareness of OD epidemic by state health departments, with respect to burden and resources, including at the city/county level; increased state involvement in local-level prevention efforts; decreased 911 overdose calls; and increased preparedness and response at the local level.
- **Long-term outcomes:** Decreased rate of SUDs; increased rate of SUD treatment use; decreased rate of ED visits due to OD; and decreased drug OD death rate.

SUSTAINABILITY

West Virginia VIPP is evaluating the success of the QRTs and identifying factors that can help sustain them. Identifying additional funding sources for the QRTs is critical for sustainability. To date, West Virginia VIPP has supported QRTs with funds from national organizations, in-kind funding, and programmatic support from local volunteers. QRTs will be expected to demonstrate successful achievement of desired outcomes to ensure continued support from funders and the local community. Expanding insurance coverage for SUD treatment and recovery services, such as peer recovery specialists, may also help sustain this effort and expand it to communities that lack current behavioral healthcare capacities and SUD treatment and recovery options.

CASE 2

Franklin County, Ohio's Rapid Response Emergency Addiction Crisis Teams Program

CASE STUDY SNAPSHOT

- The Rapid Response Emergency Addiction Crisis Teams (RREACT) program engages individuals who recently experienced a nonfatal overdose to provide access to treatment and offer harm reduction and other social service supports (e.g., housing, transportation, food assistance) with the primary goal of overdose prevention.
- The RREACT program is led by the Columbus Fire Department who also owns the data used to identify program participants.
- Key partners include the agencies representing the multidisciplinary RREACT program: a substance use disorder (SUD) clinician, a paramedic, and a law enforcement officer.
- The team reaches out to individuals who experienced a nonfatal overdose within 72 hours of the event. They typically present at individuals' homes without prior notice to improve the likelihood of making a successful initial contact.
- During the home visit, the team conducts a physical health check, reviews withdrawal management and SUD treatment options, discusses harm reduction techniques to prevent the risk of overdose, and leaves behind naloxone. They also leave behind an information packet for the family or friends.

DESCRIPTION OF PROGRAM

In 2016, Franklin County, Ohio, emergency medical services (EMS) responded to more than 3,000 overdose calls demonstrating the need for high-impact OD prevention efforts. One such effort was the development of the RREACT program. Starting in May 2017, a team, comprising a paramedic and social worker, conducted emergency department (ED)-based outreach following a nonfatal OD and transport to the ED. RREACT offered SUD treatment, but patients often refused linkage to care. The team quickly realized that people in the ED may not be ready for care and SUD treatment services immediately following an OD and naloxone administration. They were also unable to reach those who refused transport to the ED, so the post-OD outreach program pivoted.

The specific aim of the revised RREACT program is to provide access to SUD treatment and offer harm reduction and other social service supports to those

who recently experienced a nonfatal OD. In January 2018, RREACT began using 911 call data to follow up with people in the community. They reached out 36-72 hours after release from the ED, when people who have experienced overdose may be more willing to receive information about harm reduction and linkage to treatment, such as medications for opioid use disorder (MOUD). This also allowed RREACT to successfully connect with those who refused transport to the ED.

The Team

Each member of the multidisciplinary RREACT program serves a strategic function: 1) an SUD clinician provides support and case management services, answers questions about treatment; and attends to immediate health needs; 2) a paramedic from the Columbus Fire Department participates in conversations about treatment; and, 3) a plain-clothed police officer ensures the safety of the team. The program serves people who experienced a nonfatal OD, including those who refuse transport to the ED and those who were not engaged while in the ED. The cost associated with forming each RREACT program is approximately $371,500 for the first year, plus additional costs for a vehicle and personnel overtime.

The leadership and team make-up are strengths of the program. While other post-OD outreach programs are traditionally led by law enforcement, RREACT is led by the fire department.[3] RREACT follows up with people in the community and focuses on SUD treatment initiation, roles that might not be best suited for individuals enforcing the law. Both people who use drugs and communities of color may have experienced negative encounters with law enforcement in the past. Any law enforcement measures during outreach can complicate OD prevention efforts and can result in fraught police-community relations.[7] While a police car may draw negative attention and fear, a fire vehicle is met with more interest. Therefore, people may be more willing to engage with RREACT, share information, and disclose their context and needs, which are all critical to a successful outreach encounter.

Program Model

RREACT receives 911 data or referrals from EMS, law enforcement, and community connectors. Within 24-48 hours of an OD event, the team reaches out to individuals who refuse linkage to SUD treatment while in the ED. RREACT typically presents at the person's home without prior notice to improve the likelihood of making a successful initial contact. During the home visit, the team conducts a physical health check, reviews substance use withdrawal management and treatment options, discusses harm reduction techniques to prevent the risk of OD, and leaves behind naloxone. They also leave behind an information packet for the family covering what to expect, withdrawal management and SUD treatment options, harm reduction strategies, naloxone and corresponding training, and the team's contact information for follow-up. They ask about children and caregivers in the home needing social or mental health services and provide linkages to care. The team can make referrals to social service provider agencies such as Franklin County Family & Children's First Council, Central Ohio Area Agency on Aging, Primary One Health, and Southeast Mental Health for linkage to care and resources for all individuals in the home. The goal of the home visit is for the individual to agree to withdrawal management and SUD treatment services and be transported to these services by the team, but many times the initial home visit begins a conversation and plants the seed towards recovery. If the team is successful in placing the person into SUD treatment, they assign a case manager who will actively follow up with the person for 30–90 days and will provide access to wraparound services (i.e., mental health services, healthcare, and social services, as needed) and support to assist with long-term recovery.

PARTNERS INVOLVED

RREACT consists of Columbus Fire, public health, healthcare, law enforcement agencies, and the Maryhaven Addiction Stabilization Center, an SUD treatment provider. Treatment providers are critical partners because treatment initiation and retention are the primary goals of RREACT. Partnership with Maryhaven ensures that treatment plans are attainable, which may be the single most important facilitator of RREACT's ability to link clients to treatment for SUDs/opioid use disorder (OUD). When RREACT started, the treatment provider had a dedicated treatment facility that granted RREACT participants immediate access to care.

DATA USED TO IMPLEMENT THE PROGRAM

Columbus Fire owns 911 data. This is key to making the program work, as program participants are identified through the 911 data. Data is housed by Columbus Fire in a HIPAA secure electronic health record (EHR). The team created this EHR from the ground up using their knowledge of EMS records and is in the process of creating a guide and referral link for use by EMS and law enforcement connected through 911 data.

BARRIERS AND FACILITATORS TO IMPLEMENTING RREACT

Barriers

- Having public health and public safety agencies implement the program can be challenging, as they are often pulled away in response to acute issues in the community (e.g., COVID-19, civil unrest), limiting the resources they can dedicate to RREACT implementation.
- Limitations in assessing the outcomes and impact of the program also exist. People dedicated to conducting data analyses and translating the data are needed.
- All team members are currently funded by grants which have implications for the sustainability of the program if this mechanism becomes unavailable in the future.

Facilitators

In addition to the facilitators mentioned above (led by a fire department, partnership with SUD treatment provider), several other factors facilitate the program:

- The fire department is involved in a variety of community engagement activities, including food drives and drug take-back events, which make RREACT well-recognized and received by the community. Due to COVID-19, RREACT has transitioned to using phone calls and mail to follow up with people. They are still conducting home visits and providing transport using COVID-19 safety protocols, where requested.
- RREACT members are well-trained. Social workers, nurses, paramedics, and police participate in a 40-hour Crisis Intervention Team course[b] (CIT) and receive trainings on victim-witness advocacy, adverse childhood experiences, neurosequential stress response, emergency response, SUDs, mental health, and de-escalation techniques (e.g., mirroring statements, respecting personal space).
- Outside of the COVID-19 pandemic, RREACT did not experience any unexpected challenges and specified that this program is being implemented as intended, largely due to the strong relationships Franklin County has forged with its treatment, social service and healthcare providers, faith organizations, first responders, and law enforcement.

EVALUATION OF THE RREACT PROGRAM

The implementation of RREACT in the first year of OD2A presented an exciting opportunity for Franklin County Public Health (FCPH) to expand their evaluation work to capture the impact of RREACT and to share their innovative approach with other jurisdictions.

Current evaluation questions are outlined below with their associated indicators:

Question: How has the new RREACT program served individuals (e.g., How many referrals has RREACT provided? How many community outreach events has RREACT held?)

- **Process Indicators:**
  - **Number of:**
    - People served by the new RREACT program
    - Follow-up visits conducted and referrals made
    - Trainings and people trained
    - Community outreach events held
    - Transports to treatment or EDs

Question: In what ways has the RREACT program increased referrals to SUD/OUD treatment services in previously underserved regions?

- **Process Indicators:**
  - **Changes over time in number of:**
    - Community partnerships to previously underserved regions
    - Referrals to SUD/OUD treatment services in previously underserved regions

While these indicators provide important data for measuring progress, they are unable to fully capture community perceptions of, reactions to, and experiences with RREACT. As FCPH moved into year two of OD2A, they were interested in understanding the public's and organizational partners' perceptions of and reactions to RREACT and clients' experiences with RREACT and any linked SUD treatment services.

Potential RREACT-specific indicators for FCPH to explore include:

- Changes in reported burnout among service partners
- Changes in attitudes and morale among service partners
- Client satisfaction with service provision
- Description of perceptions of RREACT from recipients and community members

It could also be beneficial to include the following evaluation questions concerning changes in treatment initiation and retention and public perceptions of first responders:

Question: To what extent has engagement with RREACT impacted clients' treatment initiation and retention?

- **Outcome Indicators:** Number and percent of clients who initiated treatment, number and percent of clients who completed recommended treatment

Question: To what extent has RREACT affected the public's perception of first responders?

- **Outcome Indicator:** Description of the public's perception of first responders

OUTCOMES

Anticipated Outcomes

- Short-term outcomes: Increased amount of fatality review data shared with county partners; consistent indicators for dashboards for comparisons across regions developed; increased learning across agencies and jurisdictions; and improved efforts related to prevention, education, and healthcare planning.
- Intermediate outcomes: Greater awareness of OD epidemic by state health departments, with respect to burden and resources, including at the city/county level; increased state involvement in local-level prevention efforts; and increased preparedness and response at the local level.
- Long-term outcomes: Decreased rate of SUDs; increased rate of treatment with MOUD; decreased rate of 911 calls for OD; decreased rate of ED visits due to OD; decreased drug OD death rate.

Additionally, FCPH is hoping to look at new outcomes and evaluation questions that capture differences in SUD treatment initiation and retention by the provision of various support services. Potential outcomes to assess these differences include:

- Change in number of RREACT clients initiating SUD treatment
- Change in number of RREACT clients completing SUD treatment throughout the duration of OD2A

SUSTAINABILITY

The long-term sustainability of RREACT is unclear. However, Columbus is exploring adding the program to the city budget as a component of first-response or direct-response public safety programs and services. This aligns with the community's call to action for restructuring police involvement and redirecting police funding. Partners understand that their operation depends on the willingness of community members to engage. Therefore, the program is focused on garnering a positive reputation in the community and maintaining trusted relationships with community members. To spread information about RREACT, they partnered with the FCPH on their Recovery for Life campaign[b] and participated in community food drives and drug take-back events. Regardless of resources or services available, the public safety worker (e.g., police) training portion of the program is sustainable. Training in trauma-informed care and harm reduction are the foundation of the program and can be replicated in any community.

Evaluation Considerations

Evaluators can consider the following as they seek to evaluate post-overdose outreach programs.

Strategies for Successful Post-Overdose Outreach

- Ongoing community engagement to build trust, buy-in, and support from community members and intended audiences
- Strong relationships with key partners and provider agencies (e.g., fire departments, law enforcement, health care providers, community organizations)
- Established linkages to care (e.g., withdrawal management and substance use disorder [SUD] treatment, transportation services) for individuals post-OD and referral networks for people and their families for additional social services
- Evidence-informed (e.g., ACEs) or promising (e.g., CIT[b]) trainings for teams to engage people post-OD

Overcoming Barriers

- Challenges around conducting face-to-face outreach during the COVID-19 pandemic can be mitigated by engaging individuals post-OD through phone or video conferencing and through implementing existing CDC guidance for vaccination, social distancing, and personal protective equipment.
- Funding and access to additional resources needed for key components of post-OD outreach, such as data analysis and dedicated staff, can be challenges for jurisdictions at the state and local levels. These barriers can be addressed by harnessing evaluation data for decision-making, including prioritizing outreach in areas with higher overdose morbidity rates,

as well as collecting and evaluating the success of these programs for leveraging future funding.

- Obtaining buy-in from key partners, including law enforcement and other public safety officials, elected officials, and community members is critical. The stigma around substance use can thwart efforts to obtain buy-in. Therefore, an understanding of and efforts to address stigma are useful prior to implementation of post-OD outreach programs.

Additional Evaluation Questions and Indicators

Evaluation questions and indicators to consider as jurisdictions think towards the future and how to demonstrate success:

- **Question:** How do a post-OD outreach program, the communities it serves, and its affiliated partners define success? How does this compare with the overall community's definition of success?
  - Process Indicators:
    - Description of what programmatic success looks like for program implementers
    - Description of how the community served by post-OD outreach program defines success
    - Description of how the larger community defines success
- **Question:** To what extent has the post-OD outreach program changed the perception and use of SUD services by individuals who use drugs and communities overall?
  - Process Indicator: Description of post-OD outreach to community members
  - Outcome Indicator: Description of community opinions about post-OD outreach programs (pre-post comparison)
  - Outcome Indicator: Number of individuals initiating SUD and harm reduction services from post-OD outreach program (pre-post comparison)

Resources

- Post-opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts - PubMed (nih.gov)[4,b]
- Post-Overdose Response Programs » North Carolina Harm Reduction Coalition (nchrc.org)[b]
- Public Safety-Led Linkage to Care Programs in 23 States: The 2018 Overdose Response Strategy Cornerstone Project[3,b]

References

[1] Krawczyk, N., Eisenberg, M., Schneider, K. E., Richards, T. M., Lyons, B. C., Jackson, K., Ferris, L., Weiner, J. P., & Saloner, B. (2020). Predictors of overdose death among high-risk emergency department patients with substance-related encounters: a data linkage cohort study. *Annals of Emergency Medicine, 75*(1), 1-12. https://doi.org/10.1016/j.annemergmed.2019.07.014

[2] Scott, C. K., Dennis, M. L., Grella, C. E., Nicholson, L., Sumpter, J., Kurz, R., & Funk, R. (2020). Findings from the recovery initiation and management after overdose (RIMO) pilot study experiment. *Journal of Substance Abuse Treatment, 108*, 65-74. https://doi.org/10.1016/j.jsat.2019.08.004

[3] Formica, S. W., Waye, K. M., Benintendi, A. O., Yan, S., Bagley, S. M., Beletsky, L., Carroll, J. J., Xuan, Z., Rosenbloom, D., Apsler, R., Green, T. C., Hunter, A., & Walley, A. Y. (2021). Characteristics of post-overdose public health-public safety outreach in Massachusetts. *Drug and Alcohol Dependence, 219*, 1-8. https://doi.org/10.1016/j.drugalcdep.2020.108499

[4] Formica, S. W., Apsler, R., Wilkins, L., Ruiz, S., Reilly, B., & Walley, A. Y. (2018). Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts. *The International Journal of Drug Policy, 54*, 43-50. https://doi.org/10.1016/j.drugpo.2018.01.001

[5] Langabeer, J. R., Persse, D., Yatsco, A., O'Neal, M. M. & Champagne-Langabeer T. A. (2020). A framework for EMS outreach for drug overdose survivors: a case report of the Houston Emergency Opioid Engagement System. *Prehospital Emergency Care, 25*(3), 441-448. https://doi.org/10.1080/10903127.2020.1755755

[6] State of West Virginia Department of Health and Human Resources, Office of Drug Control Policy. (2020, January 20). *West Virginia 2020–2022 substance use response plan*. https://dhhr.wv.gov/office-of-drug-control-policy/news/Documents/FINAL%20-%20West%20Virginia%202020_2022%20Council%20Substance%20Use%20Plan_January%2020%2c%202020%20%28as%20filed%29.pdf

[7] Donnelly, E.A, Wagner, J., Stenger, M., Cortina, H. G., O'Connell, D. J. & Anderson, T. L. (2020). Opioids, Race, and Drug Enforcement: Exploring Local Relationships Between Neighborhood Context and Black–White Opioid-Related Possession Arrests. *Criminal Justice Policy Review. 32*(3), 219-244. https://doi.org/10.1177/0887403420911415

Endnotes

[a] MOUDs include, but are not limited to, methadone, naltrexone, and buprenorphine.

[b] 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.

[c] In contexts where data concerning overdose reversals or naloxone administration are not available, evaluators may choose to analyze data concerning nonfatal overdoses in lieu of such data.

[d] West Virginia is considering partnering with another jurisdiction to collect such data and make such comparisons. Note that it is important to exercise caution when comparing data across jurisdictions, accounting for contextual factors and other variables.