PHAST

Public Health and Safety Team

TOOLKIT

Guidance for Data-driven Overdose Response Coordination Among Public Health, Criminal Justice, Law Enforcement, and First Responders

October 2022

ACKNOWLEDGEMENTS

Financial support for this toolkit was provided by the CDC Foundation with a grant from Bloomberg Philanthropies. The toolkit was developed by the US Centers for Disease Control and Prevention (CDC) through an iterative pilot process. The CDC Foundation piloted an initial version of the toolkit in one jurisdiction and version 2.0 in two jurisdictions. The National Association of County and City Health Officials (NACCHO) piloted the PHAST Toolkit version 2.0 in seven jurisdictions through a cooperative agreement (#OT18-1802) with CDC. Findings from the pilots contributed to this toolkit.

The authors would like to thank the following for their contributions throughout the development process.

New York City's RxStat Partners

Content Draft Reviewers and Contributors

- Matt Gladden, CDC
- Larissa Barthen, CDC
- John Volpe, Health Management Associates

NACCHO Pilot Site Implementation Support and Toolkit Review

- All Youth Access, LLC, Stephanie Bradley, PhD
- The Center for Implementation, Sobia Khan, MPH and Maoliosa Donald, PhD
- Health Research Toolbox, LLC, Namrita Singh, PhD
- Strategic Solutions for Schools and Communities Consulting, Phyllis Law

CDC Foundation PHAST Pilot Jurisdictions

- York County, PA
- Allentown, PA
- Manchester, NH

NACCHO PHAST Pilot Jurisdictions

- Douglas County, OR
- Logan and Champaign Counties, OH
- Monongalia County, WV
- St. Louis, MO
- Stratford, CT
- Summit County, OH
- Winthrop, MA

Authors

Stephanie Rubel, Health Scientist, CDC

Sarisa Roe, Lead Evaluator, The CDC Foundation

Stock photos. Posed by models.

TOOLKIT CONTENTS

EXECUTIVE SUMMARY

Opioids are currently the main driver of drug overdose deaths in the United States. Of the approximately 93,000 drug overdose deaths in 2020, approximately 75 percent involved some type of opioid.[1]

Over the course of the overdose crisis, deaths have shifted from primarily being attributable to prescription drugs, to heroin, and now to illicitly manufactured fentanyl and other synthetic opioids, often seen in combination with other substances.[2,3,4,5,6] The overdose crisis continues to evolve, with CDC reporting increases in deaths involving psychostimulants, methamphetamines, and cocaine as well as from natural and semi-synthetic opioids (such as prescription pain medication) in the 12-month period ending in April 2021, during the SARS CoV-2 (COVID) pandemic.[7]

Addressing the overdose crisis requires strong and collaborative multi-sector partnerships within local communities. One critical partnership is between public health and public safety. Each of these sectors offers unique opportunities and resources for effective intervention strategies. Public safety agencies hold real-time data on overdoses, arrests, and emerging drug threats in the community, and have frequent, front-line contact with individuals at high risk of overdosing. Public health agencies bring a data-driven and scientific approach to investigating and responding to public health crises by collecting timely and comprehensive data and using these data to inform and implement locally relevant prevention activities.[8] Each sector can help strengthen and improve the other's efforts to reduce overdose deaths, but a lack of coordination may limit each sector's ability to fulfill its roles. State and local entities working to implement and enhance programs and policies to reduce overdose deaths can partner to bridge knowledge, data, and service gaps through cross-sector collaboration, coordination, and shared accountability. Although many jurisdictions are engaged in multi-sector partnerships to address the overdose crisis, overcoming siloed strategies is challenging. Bridging philosophical and practical gaps between public health and public safety can be particularly difficult, given their different roles, duties, and training.

The Public Health and Safety Team (PHAST) toolkit is a resource developed to help local jurisdictions reduce drug overdose deaths by increasing collaboration and coordination among all sectors, with a particular focus on public health and public safety agencies. While PHAST principles can be applied to states as well, the purpose of focusing on local jurisdictions is to capitalize on near real-time data, which is typically initially collected at the local level.

The PHAST framework is modeled after New York City's RxStat initiative, developed in 2012 to reduce deaths associated with

prescription opioids by leveraging cross-sector near real-time data to inform strategy.[9] PHAST engages multi-sector partners to achieve three primary goals:

1 - Shared understanding of the local overdose crisis,

2 - Optimized jurisdictional capacity, and

3 - Shared accountability for reducing overdose deaths.

These "SOS" goals represent the specific objectives of a PHAST's data sharing and collaboration activities.

The toolkit begins with an introduction and overview, which describes the need for effective partnership among public health and public safety agencies and provides an overview of the PHAST framework and SOS goals. The toolkit is then organized into four modules, each describing a set of key action steps. The action steps and modules are meant to be sequential; however earlier activities may be "revisited" over time depending on the PHAST's needs. For a complete list of action steps, ***see E2 in the Appendix***.

Module 1, Building or formalizing a PHAST, focuses on the steps to forming a new collaborative or expanding and enhancing an existing collaborative. (Note: the term "collaborative" is used to represent any multi-sector team or taskforce.)

Module 2, Collaborative data sharing and use, describes key data sharing and data use strategies to help PHAST members develop a shared understanding of the local overdose crisis. (Note: the term "data" is used broadly to include formal datasets, intelligence, information, lived experience, and observations.)

Module 3, Collaborative problem solving and coordinated interventions, provides PHAST teams with problem-solving strategies and suggested activities to move from "data to action" as partners implement changes that optimize capacity to reduce overdose deaths.

Module 4, Monitoring and maintaining progress, describes how measuring progress on a regular basis can help PHAST members develop and maintain shared accountability for achieving overdose prevention outcomes.

Lastly, the toolkit includes an appendix that provides additional sample materials, resources, tools, and templates that may be useful to jurisdictions.

The activities described in these modules build sequentially upon one another and provide jurisdictions with a broad set of practices and key strategies to coordinate local efforts to reduce overdose deaths. By providing flexible and adaptable strategies, teams can select and customize activities to meet their needs and build upon their strengths.

PHAST engages multi-sector partners to achieve three primary goals.

INTRODUCTION AND OVERVIEW

Why are Public Health and Public Safety Partnerships Critical to Addressing the Overdose Crisis?

Over the past two decades, the overdose crisis in the United States has significantly worsened. Between 1999 and 2019, over 800,000 people have died from an overdose.[10] Opioids are the main driver of the rapidly increasing number of overdose deaths. Of the approximately 93,000 drug overdose deaths in 2020 reported based on provisional data (more than any previous year), approximately 75 percent involved some type of opioid.[11] Compared to data from 2019, these latest numbers represent an approximately 30 percent increase in overdose deaths and an approximately 5 percent increase in the percentage of deaths involving opioids.

Over the course of the overdose crisis, deaths have shifted from primarily being attributable to prescription drugs, to heroin, and now to illicitly manufactured fentanyl and other synthetic opioids, often seen in combination with other substances.[12,13,14,15,16] In fact, since 2012, rates of overdose deaths involving stimulants has been steadily increasing.[17]

To address the ongoing overdose crisis, government officials have described an "all hands" approach to reduce overdose deaths.[18,19] Multiple sectors are needed as this widespread public health crisis intersects with governmental and non-governmental agencies, including behavioral and mental health, medicine, healthcare, criminal justice, law enforcement, treatment, and social services.

However, no one sector can tackle this complex and evolving crisis alone. Individual sectors cannot reduce overdose deaths independently, and a lack of coordination can severely limit each sector's ability to fulfill its roles. Therefore, a strong and collaborative partnership across sectors, particularly between public health and public safety, is critical to addressing this crisis. Both public health and public safety sectors offer unique opportunities and resources for effective intervention strategies: public safety agencies can hold real-time data on overdoses, arrests, and emerging drug threats in the community and have front-line contact with individuals at high risk of overdosing; public health agencies can bring a data-driven and scientific approach to investigating and responding to health crises.

Engaging across sectors allows partners to fully leverage the collective knowledge, data, and skill sets available to them and allows each sector to better understand what happens to the people they serve before, during, and after they interact with them. This creates opportunities to share sector-specific insights and resources for effective intervention strategies and collectively address local needs and service gaps. State and local entities working to implement and enhance programs and policies to reduce overdose deaths may improve their overall success through cross-sector collaboration, coordinated strategic interventions, and shared accountability for their collective efforts. For more information on **why public safety and public health are important partners** in the overdose crisis, ***please see A1 in the Appendix***.

What is PHAST?

The Public Health and Safety Team (PHAST) framework is a set of guiding principles and steps developed to assist jurisdictions in reducing overdose deaths by supporting multi-sector data-sharing and coordinated overdose prevention. The PHAST framework focuses on partnerships among all sectors that work with or impact individuals at risk of overdose, with particular focus on leadership from public health and public safety. A multi-sector overdose prevention partnership, collaborative or taskforce that applies the PHAST framework is referred to as either "PHAST" or "team" throughout this toolkit.

How Should This Toolkit be Used?

The PHAST Toolkit was developed by the CDC Foundation and CDC, with funding from Bloomberg Philanthropies, to assist city, county, or municipal public health and public safety agencies interested in working collaboratively to reduce overdose deaths. Early versions of the toolkit were piloted in 10 diverse jurisdictions between 2019 and 2021. The PHAST framework is meant to be scalable to jurisdictions of any size, location, or urbanicity and can be applied to existing taskforces or collaboratives working on overdose prevention as well as newly formed multi-sector teams. Though it was developed to address the overdose crisis, PHAST could also be applied to other jurisdictional challenges addressed by multiple sectors, such as homelessness and community violence.

This toolkit is designed to be a printable resource that describes key activities for achieving the goals of PHAST. Additional resources and tools to support key activities and offer guidance for more in-depth processes are available on the PHAST website at ***www.PHAST.org***. PHASTs may choose to adapt any of these suggested strategies.

The toolkit is organized in four modules, each describing a set of activities. The first module addresses steps to building or formalizing a PHAST. The remaining three modules correspond to activities designed to help a PHAST achieve one of the three SOS goals. Each module describes key action steps for PHAST members and includes links to additional resources, tools, and templates that can be tailored to your jurisdiction. Modules and action steps are designed to build sequentially upon each other; however, as teams work through each action step and gain new insights, they may find it necessary to "revisit" a previous action step before moving forward.

MODULE 1

Building or formalizing a PHAST – This module focuses on the steps to forming a new collaborative or expanding and enhancing an existing collaborative.

MODULE 2

Collaborative data sharing and data use – This module describes key data sharing and data use strategies to help PHAST members develop a shared understanding of the local overdose crisis.

MODULE 3

Collaborative problem solving and coordinated interventions – This module provides PHAST teams with problem-solving strategies and suggested activities for optimizing capacity among PHAST partners.

MODULE 4

Monitoring and maintaining progress – The module describes how adopting a performance management approach can assist PHASTs in maintaining their collective progress while also ensuring shared accountability for achieving overdose prevention outcomes.

Public health

is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[20] Public health professionals can be medical officers, program managers, researchers, data analysts, program evaluators, or leaders and directors at a health department. They may have experience in clinical healthcare, research, data analysis, evaluation and other areas.

Public safety

encompasses law enforcement officials; criminal justice authorities, such as prosecutors, judges, and those working in correctional settings or in community corrections; and all first responder personnel, including police, fire, and paramedics.

The Appendix includes:

- An overview of why public health and public safety are critical partners
- A list of suggested roles for public safety partners
- A list of suggested roles for public health partners
- Templates, tables, and supplemental tools
- A PHAST logic model
- Real-world examples
- Resources and tips
- A comprehensive list of all PHAST action steps
- A glossary of terms

PHAST Framework Foundation

PHAST combines principles from CompStat[21] (a policing strategy initiated by the New York City Police Department in the 1990s) and public health, both of which use data 1) as a foundation for understanding and monitoring a phenomenon, and 2) to facilitate targeted, action-oriented intervention and problem-solving.

CompStat was the basis of the RxStat initiative in New York City (NYC), which was the first public health and public safety collaborative of its kind, originally developed to tackle the opioid overdose epidemic in NYC in 2012. Both CompStat and RxStat follow four guiding principles, each of which is aligned with public health strategies (See Table 1).

Table 1. CompStat Principles and Comparable Public Health Strategies

CompStat/RxStat Principles	Public Health Strategies	In Simple Terms
Accurate and timely intelligence/information	Epidemiology and public health surveillance	Find out what is known
Effective tactics	Evidence-based interventions	Decide what to do
Rapid deployment of personnel and resources	Public health emergency/rapid response	Act quickly
Relentless follow-up	Scientific monitoring and evaluation	If it works, do more of it; if not, make improvements

Examples of Collaborative Public Health and Public Safety Response Strategies:

- Police officers administering the overdose-reversing drug, naloxone
- 911 Good Samaritan Laws
- Drug court expansion and criminal justice diversion programs
- Introduction of Medication for Opioid Use Disorder (MOUD), also known as Medication-assisted Treatment (MAT), into prison systems or jails
- Linkage to care/"warm handoffs" to safe stations*
- Post overdose outreach by paramedics

**Safe stations are self-referral programs typically operated by first responder agencies including police departments, Sheriff's offices, and fire stations where any individual seeking assistance for substance use disorders can receive immediate access to treatment.*

PHAST Guiding Principles

The PHAST framework relies on four guiding principles that are closely modeled after RxStat. Ensuring all partners agree with and commit to these guiding principles can help align collective action and foster collaboration.

Guiding Principle #1:

The North Star: Reduce Overdose Deaths

A key to maintaining a PHAST is the explicit identification of and commitment to a common goal: reduction in overdose deaths. Multiple sectors, often employing divergent viewpoints and approaches, are united in the principle of the protection of life. This explicit common goal grounds all PHAST work and its partners. When issues or challenges arise that seem intractable, partners can refer to this unifying and simple, but critically important "North Star."

Guiding Principle #2:

Recognition of Opioid Use Disorder as a Chronic, Treatable Disease

Recognizing substance use disorders and overdose as a health issue allows for a shared approach to helping people with opioid use disorder (OUD) gain access to needed treatment and support services, including harm reduction. All partners tackling this crisis can benefit from understanding the neurochemical effects of drug use on a person's brain and why recurrent relapse and repeat overdoses can occur despite negative consequences.[22,23,24] With a shared understanding of OUD as a chronic disease[25] partners can be better equipped to combat stigma and tackle common challenges like compassion fatigue, which can occur among people on the front lines of this crisis, including first responders and healthcare professionals.

Guiding Principle #3:

Responsible Use of Multi-sector Data to Inform Response Strategies

The PHAST framework focuses on strategies for using multi-sector data to gain a comprehensive understanding of the overdose crisis and context and inform response strategies. Aggregate or population-level data are typically used to answer key investigation questions, whereas case-level data are necessary for purposes such as conducting overdose fatality reviews (OFR), post-overdose outreach, or establishing linkages to care.

Responsible use of data is a vital part of the PHAST framework. The public's trust in institutions and agencies serving them can be maintained—and perhaps strengthened—by respecting individual privacy rights, implementing data-sharing agreements, and complying with federal and state-specific data protection laws and regulations.

Guiding Principle #4:

Continuous Improvement

Continuous improvement combines NYC's RxStat Initiative guiding principle of "Relentless Follow-up" with the idea that, "What gets measured gets done." Continuous improvement emphasizes the need to continuously strive for measurable progress, even when faced with challenges. This may require persistence, a willingness to listen to and learn from others, and an openness to try new strategies. Using information and feedback to understand whether you are making measurable progress towards your "North Star" can help a PHAST identify and implement program adjustments to improve processes and outcomes. Continuous improvement can be achieved using a performance management process.

PHAST "SOS" Goals

The PHAST framework is designed to increase the use of available resources within a jurisdiction. In the PHAST framework, data is a key resource that is used to achieve three goals: Shared understanding, Optimized jurisdictional capacity, and Shared accountability – what we refer to in this toolkit as "SOS." SOS goals help ensure that data sharing is purposeful and focused on a specific objective. Achieving each SOS goal relies on the following data-driven strategies and activities: 1) Data analysis and collective interpretation, 2) Collaborative problem-solving and coordinated interventions, and 3) Performance monitoring. For a graphical depiction of this process, ***see the PHAST logic model C1 in the Appendix.***

For example, examining, presenting, and discussing multi-sector data leads to a comprehensive shared understanding of the local-level overdose crisis. As data are shared, public health and public safety stakeholders bring to bear their subject-matter expertise and experience to contextualize and interpret data. They then build upon their shared understanding by strategizing and engaging in collaborative problem-solving to optimize capacity and prioritize interventions. Finally, data are continually used to monitor progress alongside new or expanded interventions. Through ongoing continuous improvement, partners maintain shared accountability by celebrating wins, making course corrections, and holding one another accountable for overdose-related outcomes. Figure 1 lists action steps found in this toolkit that PHAST partners can engage in to achieve each SOS goal.

Figure 1. Overview of the PHAST Framework

Module 2: Collaborative data sharing and use

What do we know?
What is contributing to the problem?

Action steps:

- Review aggregate and case-level data
- Assess shared understanding
- Assess data availability and data gaps
- Improve data access and use
- Establish simple data sharing practices
- Organize presentations by partners or expert guest speakers
- Facilitate data-driven discussion and collective interpretation
- Identify gaps and needs

Module 3: Collaborative problem solving and coordinating interventions

What would help fix the problem?
How can WE implement or improve the solutions?

Action steps:

- Review evidence-based interventions
- Identify existing interventions related to overdose prevention
- Identify interventions to address local gaps, needs, and challenges
- Identify barriers and facilitators for implementing, expanding, or improving evidence-based overdose interventions
- Prioritize interventions
- Identify supports and design changes
- Develop an implementation plan

Module 4: Monitoring and maintaining progress

How will we know if our strategy is effective?
How are we doing?

Action steps:

- Identify indicators of success
- Select performance measures
- Monitor and report on progress
- Celebrate wins and make improvements

BUILDING OR FORMALIZING A PHAST

Module 1

How to structure and organize your overdose prevention multi-sector collaborative

Preventing overdose deaths is possible. By coordinating efforts among diverse governmental and non-governmental agencies, jurisdictions can fully leverage the collective knowledge, data, and skill sets available to them and share insights and resources for effective intervention strategies that are unique to each field. Breaking down silos is not always easy. Therefore, the PHAST framework offers a formal structure and set of steps to help form and sustain these partnerships.

This module includes the following action steps:

- Assess and establish PHAST critical elements
- Determine your PHAST's structure
- Identify and engage partners
- Discuss roles and responsibilities
- Share experiences
- Discuss SOS goals, equity goals, and apply PHAST guiding principles to your work
- Formalize inter-agency partnerships with Memoranda of Understandings (MOUs), Data-use Agreements (DUAs), and Data Sharing Agreements (DSAs)

Assess and Establish PHAST Critical Elements

ACTION STEP CHECKLIST

Who: Leadership team

Do you have the following?

- ☐ **Visible and vocal champions in public health and public safety**
- ☐ **Diverse partner engagement**
- ☐ **Consistent participation, or commitment to consistent participation for new teams**
- ☐ **Designated resources to support a program coordinator and data analyst**
- ☐ **Data access and analytic capability**
- ☐ **Plan for meeting schedule, location, and communication protocols**

Based on your results, you may decide to invest more time in securing the recommended resources before proceeding. Strategies for achieving suggested prerequisites are briefly discussed here.

Securing Resources to Support PHAST Staff

- Existing agency resources may be reallocated to fund these positions or dedicate staff members to the initiative on a part-time basis.
- Additional funding may be needed to support the hire of a data analyst and program coordinator. Consider applying for grants to support these positions. Examples include:

  CDC's Overdose Data to Action (OD2A) Cooperative Agreement (***https://www.cdc.gov/drugoverdose/od2a/index.html***)

  Bureau of Justice Assistance: Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) (***https://bja.ojp.gov/program/cossap/overview***)

  Combating Opioid Overdose Through Community-level Intervention (COOCLI) (***http://www.ubalt.edu/about-ub/offices-and-services/provost/reporting-units/sponsored-research/ondcp_nofa.cfm***)

  Substance Abuse and Mental Health Services Administration (***https://www.samhsa.gov/grants/grant-announcements-2021***)
- Blended and braided funding both involve combining two or more sources (or "streams") of funding to support a program or activity. Braided funding pools, or "comingles," multiple funding streams toward one purpose while separately tracking and reporting on each source of funding.
- ***See A4 in the Appendix*** for tips for securing **data analytic capability.**

Whether you are in the process of forming a multi-sector team for the first time or applying the PHAST framework to an existing taskforce or partnership, the following critical elements are suggested.

We suggest leadership spend time assessing the extent to which their PHAST has these elements in place. Engaging in this process can help identify potential challenges, strengths, and opportunities for renewed commitment or reinvestment, as well as set realistic expectations from the start. Leadership may also choose to discuss strengths and challenges related to each element to help determine what resources can be leveraged and what challenges can be addressed in the short-term and over time.

Table 2. Critical Elements of a PHAST

PHAST Critical Element	Description	Rationale for New and Existing Partnerships
Two visible and vocal champions to serve as PHAST leadership partners: 1 representing public health and 1 representing public safety	A visible and vocal champion is an informed and influential leader who drives the work of a PHAST. They support and encourage multi-sector collaboration by demonstrating mutual respect and appreciation of one another's fields/roles, foster a culture of innovative problem-solving, and inspire commitment to and the pursuit of a shared vision of reducing overdose deaths. Champions provide partners with the motivation, support, and resources to address problems, discuss solutions, and take action.	Organizes new multi-sector partners, agencies, and resources and promotes ongoing engagement and commitment towards the shared vision of reducing overdose deaths in the local community. Creates and fosters an environment that encourages data-driven discussion, innovative problem-solving, and cross-sector collaboration. Drives forward momentum and promotes progress.
Diverse, multi-sector partner engagement	Diverse partner representation helps ensure unique perspectives, approaches, and knowledge are shared as partners work collaboratively to problem-solve and address service gaps. In addition to engaging multi-sector partners representing public agencies and organizations, a PHAST is encouraged to find ways to engage people with lived experiences, community residents impacted by the overdose epidemic, and leaders of community-based organizations. It may be helpful to have a separate community-based meeting or workgroup to facilitate open communication and participation among stakeholders who otherwise may not feel comfortable participating among other PHAST members.	Ensures multiple perspectives are represented. Promotes a culture of inclusion. Ensures local relevance and impact.
Consistent participation	Consistent participation from government and community representatives ensures that meeting time is well spent and decision-making is streamlined.	Ensures continuity and continued momentum. Creates opportunities to build, develop, and strengthen multi-sector partnerships and collaborate with key agency representatives.

Table 2. Critical Elements of a PHAST Cont.

PHAST Critical Element	Description	Rationale for New and Existing Partnerships
Designated resources to support a program coordinator and data analyst	The cost of having a PHAST will vary depending on the number of partners, communication frequency, data analytic capabilities of partner agencies, and existing staff capacity. The cost could include 25-100 percent of a program coordinator's time and 25-100 percent of a mid-level data analyst position. The Program Coordinator serves as the primary point of contact for the PHAST. They play a critical role in managing the administrative components and day-to-day activities of the PHAST as well as supporting the development of the overall team. A data analyst supports the PHAST by preparing data presentations, as well as leading discussions on data interpretation, needs, limitations, and gaps.	Ensures a new PHAST has support for initial team development and existing team has sufficient support to align work with the PHAST framework. Ensures that logistical support, outreach, and administrative needs of the team are provided in a timely, responsive, and consistent manner. Helps to formalize the PHAST.
Data access and analytic capability	Data use is the cornerstone of the PHAST framework. PHASTs may hire an analyst to assist with this role or rely on existing staff capacity.	Existing data-use strategies may be expanded or enhanced. New data-use strategies may be adopted to leverage multi-sector data. Partners are supported in interpreting findings, identifying data gaps and limitations, and holding data-driven discussions.
Plan for meeting schedule, meeting location, and communication protocols	Sharing a proposed meeting schedule, meeting location, and communication protocols with potential partners can help inform partners' decision to join PHAST. The frequency of meetings should reflect the urgency of the overdose crisis while still allowing sufficient time between meetings for required follow-up, decision-making, data collection, preparation and analysis, and meeting planning. At a minimum, monthly meetings are strongly suggested for all partners, with flexibility for interim meetings among the leadership team and various workgroups. To help encourage consistent participation, meeting schedules and location should be consistent, and necessary changes should be communicated well in advance. For **sample meeting agendas** *please see C2 and C3 in the Appendix*.	Encourages consistent partner participation. Helps promote long-term sustainability.

Determine Your PHAST Structure

ACTION STEP CHECKLIST

Who: Leadership team

- ☐ **Establish joint leadership between a public safety and public health representative.**
- ☐ **Determine if an additional co-lead is needed.**
- ☐ **Determine individual roles and responsibilities for each co-lead.**
- ☐ **Fill position of PHAST program coordinator, OR identify individual who will fulfill this role.**
- ☐ **Fill position of PHAST data analyst, OR identify analyst(s) who will fulfill this role.**
- ☐ **If applicable, identify your overdose fatality review (OFR) coordinator.**
- ☐ **If applicable, identify your PHAST workgroups.**

The exact organizational structure of your PHAST will vary depending on existing taskforces and resources already engaged in local opioid overdose response. At a minimum, the following are suggested:

Leadership Team — The leadership team includes both a public health leader – ideally a representative from the local health department or drug overdose prevention division, and a public safety leader – ideally the county sheriff, police chief, or representative from the district attorney's office. Depending on your jurisdiction, it may make sense to have one or two additional leadership members such as a local respected champion of overdose prevention and response. However, this group must be small enough to effectively make joint decisions, and these leaders must be consistently visible to PHAST members.

Once the leadership team is identified, it is important to discuss and determine individual roles and responsibilities for each co-lead. All members of the leadership team must be champions for collaborative overdose prevention. PHAST leaders are responsible for setting expectations for the team, driving collective progress, and facilitating problem-solving and solution-oriented approaches to help partners stay on track towards their shared vision of reducing overdose deaths. They also help to ensure that key programmatic resources are available and in place for effective PHAST implementation. Having well-defined roles and responsibilities can help build accountability and enable PHAST leaders to leverage skills and interests to advance the work of the PHAST.

Representative Partners from Local Agencies and Community Organizations — Multi-sector partners in a PHAST act as a representative of their agency. They are engaged in or highly aware of the day-to-day activities of their own agency personnel and are able to speak with authority regarding potential programmatic and policy changes. The number of multi-sector representatives in a PHAST may vary based on its needs, but partners are expected to commit to convene in person, when possible, on a monthly basis to ensure a successful collaboration.

Data Analyst — Data analysis is a cornerstone of PHAST. Analysts have the ability to clean datasets, de-identify data, run queries and create pivot tables, estimate rates using raw data, and consider data limitations. Analysts participate in PHAST meetings to understand what questions the team needs to answer, the types of data available, and additional data or analytic needs. Analysts may also present or support other presenters of data at team meetings and support the work of each data-driven workgroup.

Program Coordinator — As an ongoing, multi-agency collaboration with a considerable administrative component, a PHAST requires a coordinator to manage meeting logistics, channel inter-agency communications, organize content, work with agency representatives and staff to access data, finalize presentations, and more. The coordinator also serves in a planning role, laying groundwork for upcoming meetings through informal, preparatory conversations with agency representatives between meetings.

Overdose Fatality Review Coordinator – If your jurisdiction already has an OFR team or plans to launch an OFR team, identifying an OFR coordinator up front can help to streamline the communication process between the OFR team and the broader PHAST. Similar to a PHAST Program Coordinator, the OFR Coordinator helps manage meeting logistics, shares and presents information to team members, takes meetings minutes, supports and communicates with subcommittees, and acts as the primary liaison between the OFR team and the PHAST.

Data-driven Implementation Workgroups (for larger jurisdictions with many PHAST partner agencies) – Once the PHAST has begun to regularly explore strategies to support collaborative data sharing and data (See Module 2) and collaborative problem solving (See Module 3), partners may consider developing specific workgroups to address common prevention interventions that span multiple sectors or require coordination. These workgroups seek to optimize jurisdictional capacity by developing and implementing plans based on prioritized improvement strategies identified by the PHAST. Examples of possible workgroups include:

- Improving quality and synthesis of data on non-fatal overdoses
- OFR teams
- Focused naloxone distribution
- Criminal justice diversion
- MOUD in correctional settings and during transitions
- Peer recovery support

Engage With Existing Overdose Prevention Teams

Overdose Fatality Review Team — OFRT

Overdose fatality review (OFR) is a process of conducting a confidential review of a selection of overdose death cases in the jurisdiction. The complete OFR process involves the use of aggregate, population-level data and case-level data to develop a timeline of events and individual as well as contextual factors leading up to each fatal overdose, for the purpose of developing policy and programmatic recommendations to prevent future overdoses. An OFRT is the group of individuals familiar with the cases being reviewed or their contexts, who provide data and participate in confidential data-driven discussions to develop prevention recommendations. The same guiding principles and processes apply to both an OFRT and a PHAST. As a result, jurisdictions conducting OFRs should consider using the PHAST framework to guide their OFR process. Similarly, any jurisdiction implementing the PHAST framework should consider developing an OFRT to conduct overdose fatality case reviews. These case reviews will help inform PHAST partners' comprehensive shared understanding of the local overdose crisis, systems level factors that contribute to fatal overdoses and opportunities for prevention. Regardless of which comes first, PHASTs and OFRs go hand-in-hand; and ideally, one does not exist without the other. Please refer to Overdose Fatality Review: A Practitioner's Guide to Implementation (***https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf***), developed by the Institute for Intergovernmental Research with funding from the Bureau of Justice Assistance and CDC, for specific OFR guidance.

Quick Response Team — QRT

A quick response team is an integrated, first responder and community paramedicine unit comprising law enforcement officers, rescue personnel, healthcare professionals and/or substance use counselors. A QRT is trained to serve as a first responder unit for narcotic-related medical emergencies and, thereafter, to approach and counsel people who have experienced an overdose during their "recovery windows" — the 72 hours immediately following life-threatening drug overdoses — when people who use drugs are thought to be more open to accepting help. Please refer to the following article for an example of a QRT: (***https://www.uc.edu/news/articles/legacy/enews/2017/03/attacking-the-overdose-epidemic-with-community-paramedicine-quick-response-teams.html***)

The Overdose Response Strategy State Teams — ORST

The Overdose Response Strategy (ORS) is a unique collaboration between public health and public safety funded by CDC and the Office of National Drug Control Policy (ONDCP). It was created to help local communities reduce drug overdoses by sharing timely data and innovative, evidence-based strategies. ORS state teams (a public health analyst and a drug-intelligence officer) work together to 1) share data, 2) implement overdose prevention and response strategies, and 3) evaluate public health and public safety strategies. PHASTs can invite their ORS state team to join regular PHAST meetings or may depend on them as an additional resource. Please refer to the ORS website for more information: (***https://www.hidtaprogram.org/ors.php***)

Figure 2. PHAST Organizational Structure

PHAST LEADERSHIP TEAM

Public Health Leader

Public Safety Leader

Overdose Fatality Review Coordinator

Project Coordinator

Data Analyst

Other Government and Community Partners

- Housing/Homeless Services
- Community-based Organizations
- Child and Family Services
- Harm Reduction Non-Governmental Organizations
- People in Recovery
- Large Local Employers
- Education/Schools
- Advocacy
- Transportation

Public Health/ Healthcare Partners

- Behavioral and Mental Health Treatment Agencies / Providers
- Hospitals (Emergency Departments), Health Systems
- Medical Examiner, Coroner
- Payers/Insurance
- Pharmacies
- State Health Department
- Veterans Services

Public Safety Partners

First Responders

- Police
- Fire Departments
- Emergency Medical Services/Paramedics

Criminal Justice

- Police
- Corrections, Probation & Parole
- District Attorney, Prosecutors
- Courts/Judges

Identify and Engage PHAST Partners

ACTION STEP CHECKLIST

Who: Leadership team, PHAST Program Coordinator, OFR Coordinator, and PHAST partners

- ☐ **Determine which sectors/agencies listed in *Table 4: PHAST Partners and Agencies* are not currently represented in your PHAST.**
- ☐ **Identify potential partners from sectors/agencies/cultures/perspectives not currently represented.**
- ☐ **Develop a standardized process for inviting new partners to join PHAST.**
- ☐ **Reach out to new partners to invite them to join PHAST.**
- ☐ **(For existing teams) Re-engage with organizations previously unable to participate.**
- ☐ **Review list of identified currently engaged partners and new partners who have expressed interest to determine if any key organizations or perspectives are still missing. Re-engage as needed.**

PHASTs are encouraged to have diverse partnership representation from those in leadership positions who are able to speak with authority regarding potential programmatic and policy change for their agency. This ensures that meeting time is well spent and decision-making is streamlined. Both public health and public safety partners can play a variety of roles in a PHAST, depending on their area of expertise. For **descriptions of possible roles** for each public safety sector and the public health sector ***please see A2 and A3 in the Appendix.***

PHASTs also are encouraged to engage partners who regularly interact with people at risk of overdose, such as certified peer recovery specialists and other front-line staff who can provide PHAST partners with their unique perspectives of overseeing and carrying out overdose prevention efforts in the community. People in recovery who are involved in advocacy work or have experience working in coalitions or local organizations may also provide PHASTs with unique and invaluable perspectives. These individuals can offer key insights into service gaps, access barriers, and opportunities for improvement.

Leaders of local community organizations that may not be directly involved in overdose prevention or response programs may also be another important group of partners to engage. Often, members of community organizations have insight into existing, accepted, and culturally appropriate interventions and approaches to engaging their community. This may lead to opportunities to adapt formal interventions to be more accessible to and accepted by specific populations and may also provide access to key intervention points before individuals engage with formal prevention, recovery, or treatment systems.

Finally, PHASTs may also prioritize reaching out to potential partners with access to key data sources, such as those from the state or county health department.

Diversity and Inclusion

The PHAST framework is meant to facilitate diversity and inclusion of multiple perspectives. However, prevailing conflict or tension between different sectors or groups can influence individuals' willingness to offer their own or be receptive to others' perspectives. To ensure that all members feel comfortable sharing their perspectives openly and honestly, PHAST leadership may have to structure meetings in ways that ensure universal respect and safety while also maximizing diverse involvement and input. Separate community-based meetings, apart from regular municipal government agency meetings, may be needed. PHAST partners may also be required to participate in cultural awareness or anti-stigma training. The processes of developing a shared understanding of the problem and root causes of the problem and of building trusting partnerships go hand in hand. As one evolves, the other will too, but both may take more time for some partners than for others.

Stigma-reducing Language

The process of developing a shared understanding of the opioid overdose crisis requires time to identify shared terminology upon which the collaborative working relationship will operate. This will likely happen organically over time, but having a process or plan for how to navigate those issues is advisable. Discussing how the use of certain terms can perpetuate myths and stigma may be one way to introduce new ways of thinking and speaking about the opioid overdose crisis and to help foster a shared understanding of non-stigmatizing language for substance use.

Table 3. Alternatives to Stigmatizing Terms and Phrases

Language to Avoid	Language to Use
■ Alcoholic ■ Addict ■ User ■ Abuser ■ Drunk ■ Junkie	■ Person with a substance use disorder
■ Addicted babies/born addicted	■ Babies born with an opioid dependency
■ Drug habit ■ Abuse ■ Problem	■ Substance use disorder or addiction ■ Use, misuse ■ Risky, unhealthy, or heavy use
■ Clean	■ Person in recovery ■ Abstinent ■ Not drinking or taking drugs
■ Substitution or replacement therapy ■ Medication-Assisted Treatment ■ Clean, dirty	■ Treatment or medication for addiction ■ Medication for Opioid Use Disorder/Medication for Alcohol Use Disorder ■ Positive, negative (toxicology screen results)

More information on non-stigmatizing language can be found in the following resources:

- National Institute on Drug Abuse Words Matter: Preferred Language for Talking About Addiction (***https://www.drugabuse.gov/drug-topics/addiction-science/words-matter-preferred-language-talking-about-addiction***)
- Shatterproof (***https://www.shatterproof.org/our-work/ending-addiction-stigma***)
- Canadian Centre on Substance Use and Addiction: Overcoming Stigma through Language (***https://www.ccsa.ca/sites/default/files/2019-09/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf***)
- Indiana University: Combating Stigma (***https://research.impact.iu.edu/our-strengths/social-sciences/end-stigma.html***)

It may be necessary to start a PHAST with just a few key partners who are fully invested in the process. This may include partners who are already part of an existing taskforce or collaborative, colleagues who have collaborated in the past, or even those who have expressed interest in addressing the local overdose crisis. Having visible high-level commitment can encourage engagement from others who may be more hesitant to join and actively participate, including separately elected individuals, such as prosecutors and coroners or medical examiners. Informal dialogue may help to identify and rally individuals working in public health and public safety agencies to generate interest in and support for your PHAST.

Existing teams may also use this opportunity to identify key organizations or perspectives that have been missing from the table, including newly appointed or elected individuals and representatives from new organizations. This may also be an opportunity to re-engage with agencies that were not consistently active or were previously unable to participate.

The following table lists agencies and sectors that leadership may consider inviting to join their PHAST:

Table 4. PHAST Partner Agencies and Sectors

- Behavioral and Mental Health Treatment Agencies/Providers
- Certified Recovery Specialists/ Peer Recovery Specialists
- Hospitals (Emergency Departments), Health Systems
- Community-based Organizations
- Payers/Insurance
- Harm Reduction Non-Governmental Organizations
- State Health Department
- Large Local Employers
- Medical Examiner/Coroner
- Advocacy
- Pharmacies
- Transportation
- Veterans Services
- Police
- Housing/Homeless Services
- Fire Departments
- Child and Family Services
- Emergency Medical Services/ Paramedics
- People in Recovery
- Corrections, Parole & Probation
- Courts/Judges
- District Attorney, Prosecutors
- Education/Schools
- Correctional Healthcare providers
- University Researchers
- ORS Drug Intelligence Officer
- ORS Public Health Analyst
- Drug Free Community Coalitions[26]

Discuss Roles and Responsibilities

ACTION STEP CHECKLIST

Who: Leadership team, PHAST program coordinator, PHAST partners

- ☐ **Develop a PHAST Orientation plan or standardized 'onboarding' process.**
- ☐ **Establish and communicate member roles and responsibilities to partners.**

When potential partners are first invited to participate in PHAST, it is important that they understand their role and responsibilities. Sharing the following information can help potential partners determine their ability to commit to and the degree to which they are able to engage with PHAST activities.

- Proposed meeting schedule and location
- Estimated time commitment (including follow-up work)
- Attendance expectations
- Data-driven workgroup expectations, if relevant
- Communication protocols

Having an orientation plan may be particularly helpful during this process. A standard orientation plan can help ensure that all partners new to PHAST have a basic understanding of the PHAST framework, purpose, and goals, and for existing teams, knowledge of its team members and awareness of its accomplishments, decisions, and identified priority areas. Providing new partners with this information can help them familiarize themselves with the group's objectives and better understand their role within the PHAST.

Each partner's level of engagement in the PHAST will vary based on their individual role, sector, interests, and capacity. This may change over the course of a PHAST. However, PHASTs may consider setting basic attendance expectations and developing protocols for re-engaging partners when they miss a certain number of meetings. This can be monitored using an attendance roster or another tracking template. Understanding the different levels of engagement and how this may change over time can help the PHAST leadership team leverage partner resources, skills, and expertise and align expectations and responsibilities based on each partner's capacity.

Example of Orientation Plan: Monongalia County, West Virginia

The Monongalia County Quick Response Team (QRT) implements a standardized approach to recruiting and orienting new partners to their team. Once a new potential partner is identified, the program coordinator makes contact, briefly tells them about the QRT, and invites them to join the QRT weekly call. If they remain interested after the initial call, they are invited to officially join the QRT; this requires signing a Memorandum of Understanding for data sharing and other administrative tasks to formalize the partnership. To support this process, the QRT developed an information packet that includes: the MOU, types of data/information the QRT collects/shares, naloxone (they provide training if needed), business cards, and the QRT resource guide. To track member engagement, the QRT maintains an updated list of all current and potential members and records if and when an outreach attempt occurred and their current level of participation in the QRT.

Share Experiences

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Partners share information about their individual role/responsibility and experience related to the overdose crisis, what is working, and what challenges they face.**

Before diving directly into sharing data with one another, establishing some level of partnership-building and trust is advisable. For this reason, partners may need to begin by sharing information as opposed to hard data. By information, this means sharing roles, experiences, perceptions, challenges, job requirements, and limitations. Sharing stories about the way the overdose crisis impacts your day-to-day work may be a way to start strengthening trust. Each partner has insights to share.

PHAST Activity

Rose and Thorn

Begin each meeting by opening the floor to partners to share one "rose" or positive relevant experience and one "thorn" or negative, relevant experience related to their work with people at risk of overdose death.

Discuss SOS Goals, Equity Goals, and Apply PHAST Guiding Principles to your Work

ACTION STEP CHECKLIST

Who: Leadership team, PHAST partners

- ☐ **Introduce and discuss SOS goals of PHAST with partners.**
- ☐ **Introduce and discuss PHAST Guiding Principles with partners.**
- ☐ **Ensure all partners are in agreement with the Guiding Principles.**
- ☐ **Introduce and discuss concepts of equity, diversity, and inclusion.**

A key to maintaining a PHAST is a shared acknowledgment of and belief in the four guiding principles and in multi-sector collaboration This can help align collective action, foster collaboration, and maintain progress. The explicit identification of and commitment to a common goal of reducing overdose deaths should ground all PHAST work and its partners. When issues or challenges arise that seem intractable, partners can refer to this unifying and simple, but critically important, "North Star." When progress seems to stall, partners can remind one another that OUD is a treatable disease[27,28] and that overdose deaths can be prevented by implementing data-informed response strategies and committing to continuous improvement. Integrating these guiding principles into the foundation of your PHAST's work can help partners navigate challenges and overcome differences to work as a cohesive and effective multi-sector team.

The Leadership team is encouraged to discuss the SOS goals of PHAST and review each PHAST guiding principle with partners. Inviting questions and having an open discussion on the relevance and suitability of each guiding principle for your PHAST team as well as for each partner's individual role can help to ensure that all partners are in agreement with each guiding principle.

One approach that may help partners work together is a basic understanding of each other's roles in the context of the overdose crisis, including key differences between public health and public safety approaches, unique strengths, and shared commonalities. A more comprehensive understanding can help bridge the gap between diverse sectors. For an additional resource, see **"Why are public health and public safety critical PHAST partners?"** in ***A1 in the Appendix.***

Discussing and incorporating principles of diversity, equity, and inclusion into work processes and standard practices can help a PHAST identify their shared expectations and decide how the PHAST can work towards promoting these principles in their collective actions and decision-making. This may also be an ideal opportunity to introduce partners to the topic of stigma and the use of stigma-reducing language (See ***'Stigma-reducing Language'*** in Module 1).

Incorporating principles of diversity, equity, and inclusion into your PHAST

Open discussion on the relevance and significance of diversity, equity and inclusion in your jurisdiction can help provide context for the local overdose crisis and inform appropriate solutions for all people impacted by the crisis.

PHAST Strategy

Planning for Increasing Equity in your PHAST

The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[29] PHAST partners are encouraged to work together to establish a shared understanding of justice, diversity, equity, and inclusion and identify goals related to these concepts that are meaningful to the team's shared vision. These concepts may be helpful for a PHAST to consider as it seeks to ensure that equity is addressed within and by the team. They may also serve as guideposts for a PHAST as it develops activities and or performance measures in order to remain aligned with an equity approach.

Formalize Inter-agency Partnerships with Memoranda of Understandings (MOUs), Data-Use Agreements (DUAs), and Data Sharing Agreements (DSAs)

ACTION STEP CHECKLIST

Who: Leadership team, PHAST partners, PHAST data analyst

- ☐ **Draft and sign a MOU and DUA (if applicable) to establish mutual support and commitment to ongoing collaboration.**

A memorandum of understanding (MOU) is a formal agreement between two or more parties to establish mutual support, commitment, and shared understanding of their collaboration. MOUs can be used to clearly specify roles and responsibilities of each partner. Leadership may consider formalizing agency partnerships participating in PHAST by establishing a formal MOU.

Similarly, a data use (DUA) or data sharing agreement (DSA) is a formal contract between partner agencies that documents the terms in which data will be shared and how they will be used. These agreements can protect the entity providing the data as well as serve as a channel for communicating data needs and expectations between agencies.

Data Use and Data Sharing Agreements will often include, but are not limited to:

- A list of specific data elements that will be shared (What will be shared?)
- The purpose of sharing these data (Why will it be shared?)
- The intended use of the data (How will it be used?)
- Information about who may receive and use the data (Who will have access to these data?)
- Processes for communication between the person(s) sharing the data and the person(s) receiving the data (Is there a standard process for communication?)
- Method of data sharing (How will it be shared?)
- Data confidentiality and security (How will confidentiality be maintained? What security protocols are in place?)
- Applicability of HIPAA (Are the data elements considered protected health information under HIPAA?)
- Protocols for handling data breaches (What will happen if there is a data breach?)
- Period of agreement (How long is this data sharing agreement in effect?)
- Protocols for using data in publications and presentations (Can the data shared be used in publications and presentations? Are there any restrictions, processes, or protocols that need to be followed?)
- Data destruction (What happens after this project is over? How long will the data be saved?)

MOUs, DUAs, and DSAs should be thoroughly reviewed by each agency's privacy officer, leadership, or legal team to ensure compliance with applicable organization, state, and federal laws and regulations. (For **example MOUs, DSAs and additional resources** to consider please ***see B1-B3 in the Appendix***.)

COLLABORATIVE DATA SHARING AND USE

Module 2

How to Use and Share Cross-Sector Data For Overdose Prevention Among Your Partners

A major goal of a PHAST is to combat the overdose crisis by leveraging all available resources to help local entities bridge knowledge, data and service gaps, and break data silos. The first SOS Goal is to **develop a shared understanding** of the local overdose crisis. The process of developing a shared understanding is also an opportunity for different sectors to learn from one another's experiences with people who have overdosed or are at-risk for overdose as well as directly from people who are in recovery. It may also be an opportunity to learn about the root causes of the opioid overdose epidemic,[30] how opioids affect the human brain,[31] how co-occurring conditions can increase risk of developing opioid use disorder,[32] and of evidence-based treatment and recovery processes.[33]

Collaborative learning enables different sectors that encounter the overdose crisis in different ways to "connect the dots" and understand how various agencies and systems can work together to reduce overdose deaths. In some cases, collaborative learning may reveal that sectors are working at odds with one another, despite sharing the same goal of reducing overdose deaths. With effective facilitation and joint public health and public safety leadership, collaborative learning can highlight each sector's strengths, obstacles, and opportunities for improvements, while also appreciating that everyone is working towards the same "North Star."

This module will address PHAST data and information-sharing activities designed to **develop a shared understanding** of the problem(s), including issues related to

1 - SUDs, overdose trends, and drug supply;

2 - barriers to treatment and recovery services; and

3 - risk factors and predictors associated with drug overdose.

This module includes the following action steps:

- Review aggregate and case-level data
- Assess shared understanding
- Assess data availability and data gaps
- Improve data access and use
- Establish simple data sharing practices
- Organize topical presentations by partners or expert guest speakers
- Facilitate data-driven discussions and collective interpretation
- Identify gaps and needs

Review Aggregate and Case-level Data

ACTION STEP CHECKLIST

Who: All PHAST partners

☐ **Review and discuss the uses for available aggregate and case-level data.**

Both aggregate- and case-level data can be used to answer key questions about the local overdose crisis. Demonstrating an appreciation for the differences between these data types may help address data-related frustrations experienced by some partners. Open discussions about what data are needed for what purposes can help PHAST partners work together to address knowledge gaps and mutually agreed upon solutions to move their work forward.

Table 5 provides examples of how aggregate- and case-level data can be used to answer key questions about the local overdose crisis.

Table 5. Examples of Uses for Aggregate- and Case-level Data

Data	Uses for Aggregate Data (non-identifiable)	Uses for Case-level Data (possibly requiring data use or data sharing agreements)
Non-fatal overdose data from first responders	■ Track overdose rates over time ■ Monitor rates of naloxone administration by first responders ■ Identify high-burden/priority areas, neighborhoods ■ Track enforcement of 911 Good Samaritan Laws (police data on dispositions) ■ Track ambulatory transfer rate post reversal with naloxone	■ Conduct post-overdose outreach/follow-up support for harm reduction and linkage to care ■ Identify overdose-related trends among people: • Under community corrections supervision • Previously incarcerated • Experiencing homelessness • Who have lost custody of a child ■ Track repeat overdoses to focus intervention efforts
Non-fatal overdose data from emergency departments	■ Track overdose rates over time ■ Track numbers of Emergency Department inductions of medication for opioid use disorder	■ Conduct post-overdose outreach/follow-up with harm-reduction services and treatment maintenance
Drug-related arrests	■ Track drug-related arrests by crime level	■ Determine eligibility for pre-arrest diversion
Drug seizures	■ Track drug seizure data by type of substance, quantity, location, poly-substance seizures ■ Monitor for changes to local drug supply	■ Identify, arrest, convict high quantity drug traffickers
Overdose deaths from coroner/medical examiners and death investigation reports	■ Track overdose death rates, trends over time	■ Identify circumstances involved in specific overdose deaths
Overdose fatality case reviews	■ Identify common factors across multiple overdose fatality cases	■ Examine circumstances preceding a fatal overdose; identify service/intervention gaps and opportunities to prevent similar overdose deaths

Case-level data: Overdose fatality reviews (OFR)

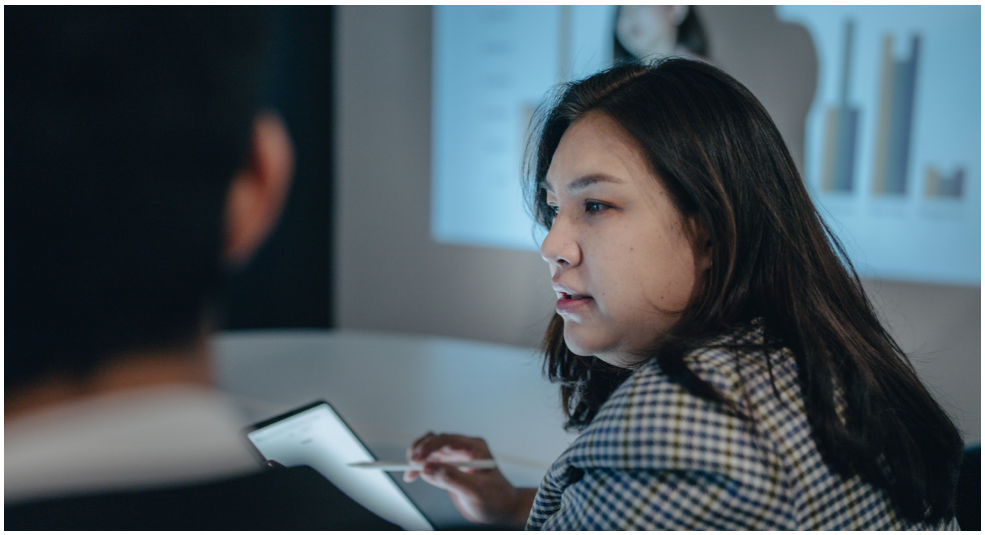
Local OFRs are a process by which a multidisciplinary sub-committee of partners conducts a confidential review of a selection of overdose death cases in the jurisdiction. Unlike aggregate or population-level data, which are commonly used for public health surveillance and to understand the scope of the opioid overdose crisis, OFRs serve a different but complementary purpose. First, the process of conducting an OFR personalizes the local problem for partners; it is far different to consider the true story of a real local individual than it is to consider the crisis in terms of numbers and statistics alone. Second, by examining a decedent's lifecycle in terms of drug use history, co-morbidity, major health events, social-emotional trauma (including adverse childhood experiences), encounters with law enforcement and the criminal justice system, treatment history and other factors, partners are able to identify both agency-level and systems-level gaps, strengths, and opportunities to prevent similar future deaths. By conducting a series of OFRs, jurisdictions begin to see patterns of need and opportunity not only within specific agencies, but "in the space between" where new services or programs could fill a gap or serve as a bridge to an existing resource. Such new programs could include specific "linkage to care" programs, targeted naloxone training and distribution, educational campaigns, mobile MOUD units, or improved continuity of care protocols.

OFRs contribute to the SOS goals when multi-sector partners come together to share information for the purposes of:

1 - Establishing a shared understanding of the problem (examining the decedent's lifecycle),

2 - Identifying opportunities to optimize jurisdictional capacity (identifying needs and opportunities where new services or programs are needed), and

3 - Sharing accountability (assessing and monitoring recommendations that were identified during the OFR process.)



In this way, PHASTs and OFRs complement one another. PHASTs establish the multi-sector partnerships that are fundamental for OFRs and OFRs offer a unique source of data that can reveal opportunities to improve overdose prevention. Recommendations that result from OFRs can be reported to the PHAST on a regular basis and considered alongside other proposals generated through multi-sector collaborative problem-solving activities for prioritization purposes (see Module 3 activity, Prioritize Programs and Strategies).

Recommendations arising from overdose fatality case reviews, rather than individual cases themselves, would be shared with the broader PHAST. In this approach, the PHAST may serve as an OFR Governing Committee and provide leadership and support for implementing recommendations the OFR team has identified. Therefore, while data sharing and confidentiality agreements are needed among members of the OFR team in order to share case-level data, it may not be necessary to have them in place for the broader PHAST. (For a **sample PHAST meeting agenda** integrating OFR findings and recommendations, ***see C2 and C3 in the Appendix.***)

Resource:

As a complement to this PHAST Toolkit, CDC and the Bureau of Justice Assistance funded the development of the ***Overdose Fatality Review: A Practitioner's Guide to Implementation.*** To access the Practitioner's Guide and other OFR resources, visit ***https://www.cossapresources.org/Tools/OFR/Resources***.

What are Adverse Childhood Experiences or ACEs?

Adverse Childhood Experiences, or ACEs, are preventable, potentially traumatic events that occur in childhood (0-17 years) such as neglect, experiencing or witnessing violence, and having a family member attempt or die by suicide. Also included are aspects of a child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use, mental health problems, or instability due to parental separation or incarceration of a parent, sibling or other member of the household.[1,2]

[1]Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. [2]Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. American Journal of Preventive Medicine, 14, 245-258.

How to Integrate an Existing Overdose Fatality Review Team within a PHAST

1. **Use aggregate data to inform OFR case selection**
   - Case selection based on geography: Patterns of overdoses happening in a specific geographic area
   - Case selection based on substance(s) involved: Overdose spike linked to a specific substance
   - Case selection based on specific population characteristics common in many overdoses: For example, post-partem women, recently incarcerated individuals, homeless/housing insecure individuals, people working in a particular industry
2. **Contextualize each case, for example by asking the following questions for every OFR:**
   - What factors contributed to this individual being at risk of fatal overdose?
     - Social determinants of health
     - Adverse childhood experiences
     - Drug threat exposure (e.g., worked in an industry with high drug use, lived in an area with high amounts of drug trafficking)
     - Periods of transition
     - Trauma
     - Non-fatal overdoses
   - What interventions or programs currently exist to mitigate the decedent's identified risks?
     - Which were effective and how could they be further strengthened?
     - Which were not effective for the individual, and why (e.g., access, program integrity, program design)?
     - How can gaps be addressed?
   - What does the individual case have in common with other overdose fatalities in the community?
3. **Bring recommendations developed from OFRs to the PHAST for prioritization, barriers and facilitators discussion, and implementation planning on a quarterly basis or as frequently as needed.**

Case-level data: Linking datasets

Case-level data may also be used for the purpose of linking or combining datasets to investigate population-level overdose risks and trends. For example, partners may want to know how many recent overdose incidents involved individuals on probation or under parole supervision. To answer this question, an analyst would have to combine a dataset of all individuals currently on probation and under parole supervision with a dataset of recent overdose incidents; combining these datasets would require that a common variable found in both datasets, such as the person's name, date of birth, address, or other unique identifier, can be matched. Although in these situations case-level data are not presented to partners, a data-sharing or data-use agreement between the two agencies owning and sharing the datasets may still be needed.

Assess Shared Understanding

ACTION STEP CHECKLIST

Who: All PHAST partners; guest speakers

- ☐ **Review the list of questions in the Resources Table on Substance Use Disorders and the Overdose Crisis (*see E1 in the Appendix*) to assess partners' knowledge.**
- ☐ **Identify learning areas or topics to be discussed in future PHAST meetings.**
- ☐ **For each topic, identify guest speakers or resources to support future learning.**

Assessing partners' shared understanding of substance use disorders (SUDs) and the overdose crisis can help a PHAST determine what knowledge gaps may need to be addressed before effective multi-sector collaboration can take place. Partners may review the following list of questions individually, then as a group to determine areas in which guest speaker presentations, group discussions, or additional resources may be beneficial. Establishing a shared understanding of SUDs and the current overdose crisis provides a foundation from which partners may draw from for future collaborative efforts.

Questions to discuss among all PHAST partners:

What is our current shared understanding (agreement and different perceptions) about the following:

- The **science of drug use and SUDs**. (Do all partners agree that a SUD is a treatable, chronic disease and that overdose is a preventable injury?)
- **Stigma** of SUDs and its impact. (Do we use stigma-reducing language in our discussions?)
- **Harm-reduction** principles. (Do we have a clear vision of what harm-reduction strategies include?)
- **Compassion fatigue** and the need for responder wellness. (Do we know which local frontline workers are at risk of compassion fatigue and what the impact may be?)
- **Social determinants** of the local overdose crisis. (Can we identify social factors that contribute to the current overdose crisis?)
- **Effective substance use treatment, including Medication for Opioid Use Disorder (MOUD)/Medication Assisted Treatment (MAT)?** (What are our shared perceptions about various treatment and recovery strategies?)

For a list of resources on each of these topics, ***please refer to E1 in the Appendix*** to see **Resources Table on Substance Use Disorders and the Overdose Crisis**.

Data Literacy

Data Literacy is the ability to read data, work with data, and communicate about data by putting it in proper context. Establishing data literacy among PHAST partners is a foundational step for building a data-driven team. Reviewing data basics can provide PHAST partners with a foundational understanding of what data are and how they can be collected and interpreted. They can also help make data use more approachable, regardless of members' starting points or backgrounds. Data literacy activities may be especially relevant for those completely new to working with data and can help team members establish a shared understanding of the value of data in their collective efforts. At a minimum, it is important that PHAST partners have basic data literacy skills; therefore, allowing time for partners to ask questions about data that are presented or shared, is critical.

Assess Data Availability and Data Gaps

ACTION STEP CHECKLIST

Who: All PHAST partners; guest speakers

- ☐ **Review and discuss each key investigation question (*see Data Inventory Table in C4 in the Appendix*).**
- ☐ **Identify which partners can answer which questions with the data they have.**
- ☐ **For questions that can be answered, determine how to share and present data to partners at upcoming PHAST meetings.**
- ☐ **For questions that cannot be answered, determine if the data gap is critical to your work. If it is critical, brainstorm potential data sources and develop a plan to reach out to entities who have access to and may be willing to share these data with the PHAST. Also consider what questions may be answered through overdose fatality reviews.**
- ☐ **Update inventory as access to data sources change over time.**
- ☐ **Update inventory as new data investigation questions are identified by the PHAST.**

In addition to establishing a shared foundational understanding of substance use disorders, it is equally as important to develop a shared understanding of the local crisis. Assessing what data are available and what key questions about the local overdose crisis can be answered will help a PHAST identify critical data gaps. Partners may work together to determine which key investigation questions can be answered with available data. By asking and answering key questions, PHAST partners can increase their collective understanding of the local crisis and establish an inventory of available data.

Key Investigation Questions to discuss among all PHAST partners:

- What is the overdose **death rate**, by substance/poly-substances, in our jurisdiction?
- What is the **non-fatal** overdose rate in our jurisdiction?
- **Where** are overdoses happening in our jurisdiction?
- Are we seeing a **spike** in overdoses or overdoses involving a specific type of drug or combination of drugs?
- **Who** is overdosing and in need of treatment and support services?
- What are the local **opioid prescribing practices** and trends?
- What is in the local **drug supply?** (What types of illicit drugs are commonly used? What, if any, adulterants are present in these illicit drugs that have the potential to cause serious health issues?)

Contextual Factors to Consider

For greater situational awareness, PHAST partners may want to review relevant state and local opioid-related policies and regulations including the following:

- Good Samaritan Laws
- Naloxone distribution laws and programs
- Medication for opioid use disorder (MOUD) coverage by payers (Medicaid, Medicare, private health insurers)
- MOUD availability in local jails or regional/state prisons
- Prescription drug monitoring program (PDMP) data (Though access to PDMP data is highly restricted, those with access can report on aggregate analyses)

For each question, members are encouraged to identify which partner (and agency) can answer the question with the data they collect or manage. Although some questions can be answered with multiple data sources, PHASTs are encouraged to identify the most appropriate data source for each question based on data completeness, data quality, data timeliness, and accessibility. Not all data sources need to be used.

If questions can be answered with existing data, partners are encouraged to discuss how to share and use these data with PHAST partners at upcoming meetings.

If questions cannot be answered, but are relevant to the PHAST, partners may brainstorm potential data sources that may be used to answer these questions. For each potential data source, identify the names of local agencies, organizations, or point of contacts that may have access to and be willing to share these data with the PHAST. In addition to agency-level data sources, PHASTs are also encouraged to consider what questions may be answered through overdose fatality reviews and other data use strategies. During this process, partners may work together to identify the highest priority data sources. This will help focus the PHAST's collective efforts to securing what is needed most urgently.

It may not be necessary – or relevant to all PHASTs – to answer every key investigation question. The goal is to consider all possible questions, assess what data are currently available, and identify what data gaps exist. Some data gaps may not be critical for a PHAST and therefore, additional follow-up to secure a potential data source may not be necessary.

The **Data Inventory Table**, (*see C4 in the Appendix*) provides a full list of key investigation questions and offers a structured approach to helping PHAST partners assess current data availability and identify and record next steps for obtaining, sharing, and using local data. By recording a list of available data sources and data sources that are still needed, the PHAST will also have established an up-to-date data inventory. This data inventory can be used to inform PHAST problem-solving efforts or as a reference tool for future collaborative work. Over time, as partnerships evolve and data sharing agreements are finalized, the **Data Inventory Table** may be updated to include these new data sources as well as additional data investigation questions that are relevant to the PHAST.

Tips for Securing Data

PHASTs may encounter data-sharing challenges as potential data sources are identified and explored. Some of these challenges may be related to navigating federal and state protections that govern health-related data. However, as some of these data may fill a critical data gap, efforts to leveraging these data sources should be explored.

1 - Start small and focused. Don't let perfection be the enemy of the good.

2 - Reach out to your state health department when you need to. This is particularly useful if you are identifying overdose spikes. You may need to check with your health department to see if they are detecting a state-wide spike (through state-level syndromic surveillance), because your response will likely be different if it is a local phenomenon versus a state-wide phenomenon.

3 - Consider using data and intelligence gathered from a variety of partners. Harm-reduction providers, treatment providers, youth and family services, and law enforcement personnel all have different insights into the types, severity, and locations of drug use happening in a community. Leveraging all of these sources can help partners understand the overdose crisis and how best to intervene.

4 - Check out the resource: The Toolkit for Leveraging Data Sharing for Overdose Prevention (***https://www.changelabsolutions.org/sites/default/files/2020-07/LeveragingDataSharingforOverdosePrevention_accessible_FINAL_20200707.pdf***) which provides an overview of relevant legal, health, and equity considerations in collecting, using, and sharing overdose-related data.

Improve Data Access and Use

ACTION STEP CHECKLIST

Who: All PHAST partners

Are you currently using or have you discussed the benefits of using the following approaches to address critical data gaps and/or to improve data access and data use?

- ☐ **Data maps/Geographic Information System (GIS) mapping**
- ☐ **New data analysis methodologies or approaches**
- ☐ **New data collection**
- ☐ **Sequential Intercept Mapping**

After working through the key investigation questions listed in the **Data Inventory Table**, a PHAST may discover critical data gaps that may limit their understanding of the overdose crisis, inhibit decision-making, or prevent clear actions from being taken. Depending on available solutions, PHASTs may decide to invite additional partners (with data access) to join their PHAST, request access to new data sources, leverage new visualization, data analysis, or data use strategies, or launch new data collection efforts.

PHAST Strategy:

Data Mapping

Addresses: Issues related to SUDs, overdose trends, drug supply

Data maps, such as the Overdose Detection Mapping Application Program (ODMAP), are a key data visualization tool. Data maps can be useful for presentation purposes to highlight priority geographic areas in need of intervention that may be more quickly and easily understood than a standard data table. Depending on how real-time they are, maps can help identify overdose spikes or high-burden areas that warrant rapid response by public health and public safety officials. They can then highlight potential discrepancies in availability of services and overdose burden. Mapping can also help consolidate data and help local government officials target resources. PHASTs are encouraged to explore how data mapping may be leveraged in their community and identify which partner agencies may already have existing tools, resources, and analysts. Below is a list of data types for which mapping capabilities may be useful to help target resources.

- Non-fatal and fatal overdoses
- 911 overdose calls
- First responder naloxone administration
- Treatment facilities
- Recovery resources
- Harm-reduction services
- Naloxone access (via pharmacies or other service providers)

Example of Data Mapping: Allentown, PA Emergency Medical Services

The following maps were created by the City of Allentown Emergency Medical Services (EMS) to depict the number and locations of EMS encounters with individuals suspected of opioid overdose. Figure 3 shows suspected opioid overdoses for a single month, while Figure 4 shows suspected opioid overdoses for a 12-month period. A comparison of the two maps suggests that suspected opioid overdoses tend to be clustered in a specific area of Allentown and that these "hot spots" appear to remain consistent over time. The information provided by these maps allows the Allentown PHAST to better understand where overdoses are happening and focus their response efforts and prevention services to these high-burden areas.

Figure 3. Suspected Opioid Overdoses, December 2020

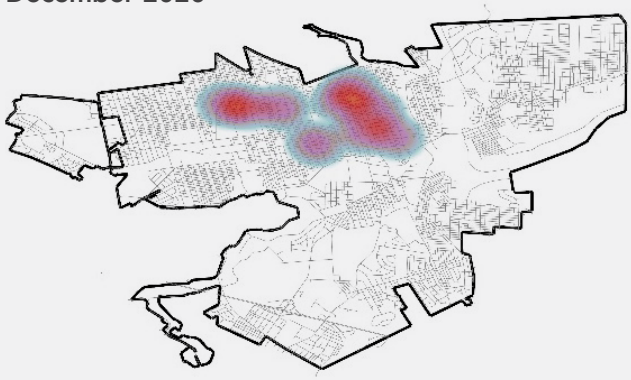
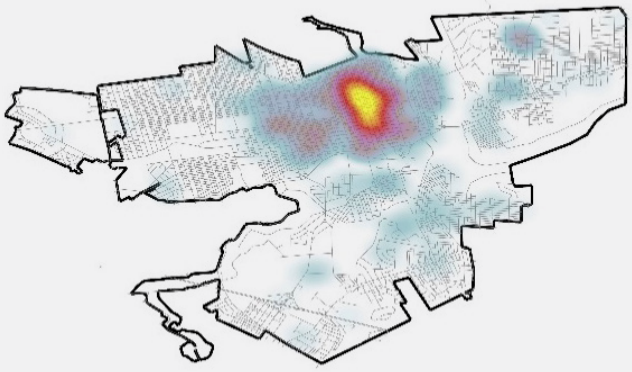


Figure 4. Suspected Opioid Overdoses, January - December 2020



Example of Data Mapping: ODMAP

Historically, law enforcement, fire departments, and EMS rarely shared data among one another and even fewer did so in real time. To tackle this problem, the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) program developed the Overdose Detection Mapping Application Program (ODMAP).

ODMAP is an overdose mapping tool that includes the following features:

- First responders can log overdoses in real time into a centralized database, including whether an overdose incident is fatal or nonfatal, as well as the number of doses of naloxone administered.
- Law enforcement have the option of using an additional form to intake information about individuals involved, initiate an investigation, and enter data about the form and type of drugs.
- Jurisdictions can capture overdose incidents responded to by public safety on a shared data platform.
- The tool can be synced with departments' local data entry platform.

From a law enforcement perspective, the near real-time function of ODMAP allows a department to understand both the current scope of overdoses and trends over time in their jurisdiction, as well as neighboring jurisdictions. Departments can identify hotspots and respond appropriately. The map also has a built-in spike alert notification system and data analytics to help law enforcement and public health identify trends over designated time periods. Departments can overlap overdose data with drug seizure, vacant housing, or other data maps to better understand potential correlates of overdose.

- In Berkeley County, West Virginia, ODMAP data showed that nearly 20 percent of overdoses occurred in a single location, allowing the police department to focus their overdose prevention and response efforts within a small geographic area.
- Law enforcement agencies can also view overdose information from neighboring jurisdictions, which might share a drug supply source. For example, ODMAP data has shown that within 8-12 hours, an overdose spike in Baltimore City was followed by spikes in Anne Arundel County, Maryland; Arlington County, Virginia; Alexandria, Virginia; Berkeley County, West Virginia; and other nearby jurisdictions. This gave public health, police, and others involved in the opioid response important information about a forthcoming overdose spike that they would not have had without this cross-jurisdictional comparison.[34]

PHAST Strategy

Explore New Methodologies and Data Use Approaches

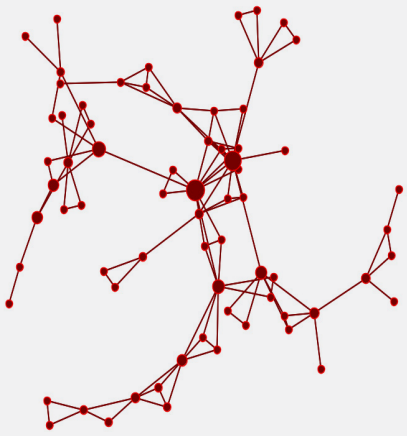
Addresses: Issues related to SUDs, overdose trends, drug supply; Barriers to treatment and recovery services; Risk factors and predictors associated with drug use

Partners may leverage local data analytic expertise to test and apply new methodologies to explore existing data sources. Various analytic approaches may be introduced and discussed during data presentations or while reviewing key investigation questions. Partners may find it helpful to take note of different analytic approaches or methodologies that are introduced during group discussions to revisit and potentially pursue in the future.

Example of Leveraging New Data Analytic Methodologies: Social Network Analysis

The Manchester Police Department in New Hampshire used social network analysis to identify the relationships between individuals involved in overdose incidents to help inform local harm-reduction and person-based intervention strategies. First, police reports of overdose incidents were reviewed, and the names of any individual involved, including persons who experienced the overdose, witnesses, and reporting party were entered into a dataset. Then, connections between all named individuals involved in each incident were graphed using social network analysis software, with circles representing each individual and lines representing the relationships. Results revealed that local overdose incidents involved multiple social networks, many of which were made up of 15 or more individuals, but in some cases, involving 40 or more individuals. Results also revealed a number of "influencers" within each social network: individuals whose involvement in overdoses connected many other individuals within the network. By sharing these findings with local harm-reduction programs, outreach efforts and resources may be better directed towards influencers - individuals at high risk for overdose or individuals likely to be present at future overdose incidents.

Figure 5. A Social Network of 62 Individuals in Manchester, New Hampshire



PHAST Strategy

Expand and Improve Data Collection

Addresses: Issues related to SUDs, overdose trends, drug supply; Barriers to treatment and recovery services; Risk factors and predictors associated with drug use

Partners may determine that new data collection is necessary for answering key quantitative investigation questions. No matter the gap, try to consider the easiest approach to collecting the data. Potential solutions include additional training on existing data collection or data entry practices; improving data entry or coding protocols; adding a survey or interview question to an existing protocol; or partnering with local researchers who will be collecting data related to a topic of interest. When engaging in primary data collection, PHASTs are encouraged to consider:

1 - What human subjects protections must be assured? (Consult with your agency legal team or privacy officer before proceeding to determine if human subjects approval is required.)

2 - What agency would be most appropriate to oversee the collection, maintenance, and management of the data? (PHASTs may consider the possibility of partnering with an outside organization for data collection purposes.)

New data collection efforts can also be focused on qualitative data. These data can provide the needed context and background information that cannot be captured through statistics and rates. Some examples of qualitative efforts include:

- Interviews or informal conversations with people who use drugs as well as with those in recovery
- Exit interviews with those using available overdose prevention interventions (e.g. those in treatment, those engaged through outreach programs and services)
- Surveys asking open-ended questions of people with a history of non-fatal overdose to assess risk factors and readiness for linkage to care
- Surveys asking open-ended questions of members of the public to assess stigma and perceptions of people with opioid use disorder

Finally, novel data collection efforts may also include content analysis of web-based platforms or social media applications, such as Reddit/Subreddits, Google Chats, and blogs to gain insight into beliefs, opinions and behaviors among people who use drugs or about people who use drugs.

PHAST Strategy

Conduct Sequential Intercept Mapping

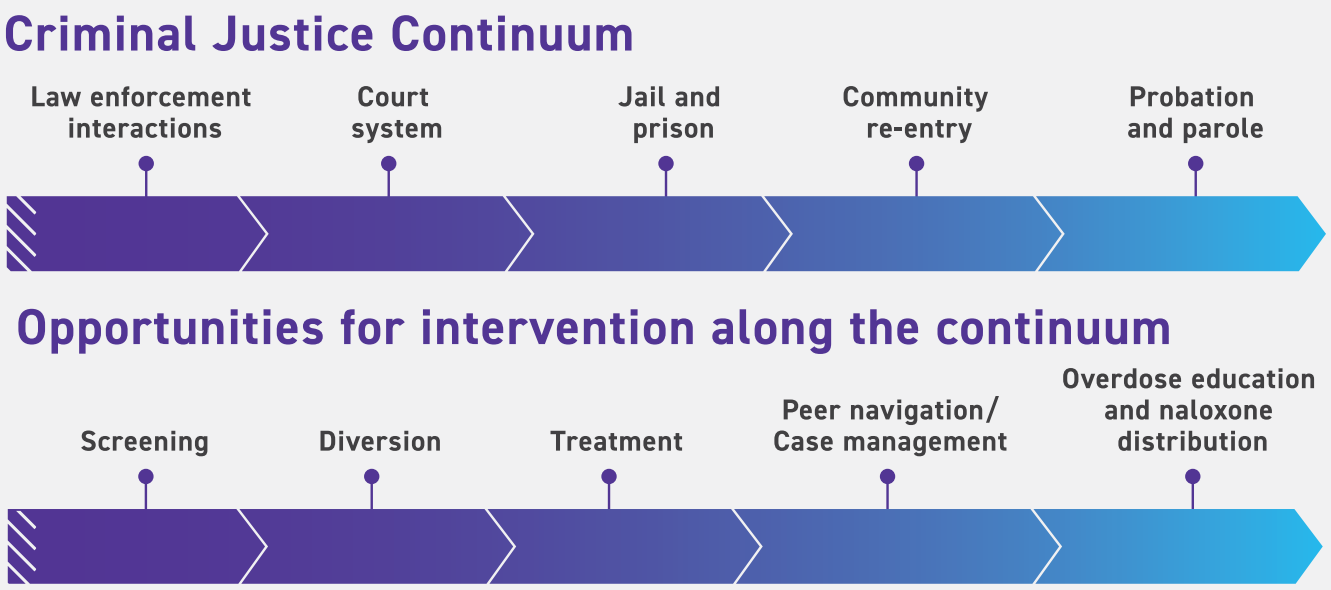
Addresses: Issues related to SUDs, overdose trends, drug supply; Barriers to treatment and recovery services; Risk factors and predictors associated with drug use

Public health, behavioral health, and medical sectors that can provide effective treatment and support services to people with OUD do not often have the partnerships with public safety sectors that are frequently encountering those at risk of overdose death. In fact, many people involved in the criminal justice system report issues with substance use. Thus, it is critical that these sectors build effective partnerships to leverage available opportunities for intervention along the criminal justice continuum.

One framework that was developed to help communities assess available resources and determine service gaps in the criminal justice system is the Sequential Intercept Model (SIM). The SIM was developed in the early 2000s by Mark Munetz, Patricia A. Griffin, and Henry J. Steadman as a conceptual framework to help communities address the disproportionate representation of people with behavioral health issues in the criminal justice system. It is predicated on the idea that "the presence of mental illness should not result in unnecessary arrest or incarceration" and that stakeholders across multiple systems (justice, behavioral health, substance use disorder treatment, etc.) share responsibility for identifying viable alternatives.[35]

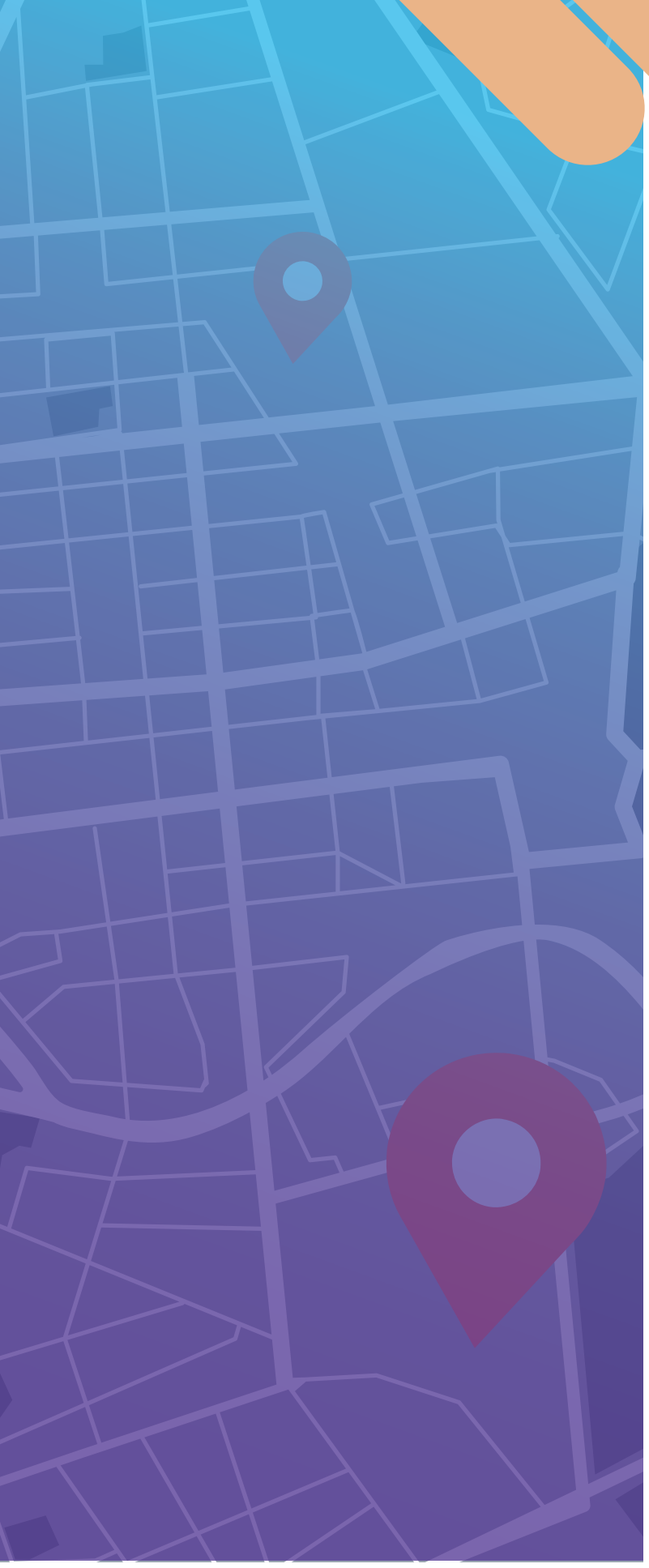
Brinkley-Rubenstein and colleagues expanded upon the SIM by focusing specifically on people who use opioids in the Criminal Justice Continuum of Care for Opioid Users at Risk of Overdose[36], pictured below. Like the SIM, it aims to help communities identify opportunities for 1) screening for OUD and overdose risk, 2) treatment and/or diversion, and 3) overdose prevention and naloxone provision along the different intercept points in the criminal justice system.

Figure 6. Criminal Justice Continuum for Opioid Users at Risk of Overdose



PHASTs may use the SIM and the Criminal Justice Continuum to assess available resources and identify gaps and opportunities for intervention along the criminal justice continuum.

Resource:
The Sequential Intercept Model: (*https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf*)



Example of Sequential Intercept Mapping: Logan County, Ohio

The PHAST team in Logan County, Ohio, in collaboration with partners from Northeast Ohio Medical University (NEOMED), used Sequential Intercept Mapping to identify available resources for OUD treatment, regulation, and prevention along the different intercept points of the criminal justice system. Stakeholders convened for a two-day session facilitated by SIM subject matter experts from NEOMED during which the SIM and different intercept points were introduced; resources, systems, and pathways along the criminal justice continuum were identified and mapped; and potential opportunities for intervention and other solutions were discussed. These efforts culminated in the **"Critical Intervention Points for Change"** intercept map, ***see D1 in the Appendix***. This intercept map has enabled various stakeholder groups to develop more informed and strategic plans, helps drive more coordinated systems change efforts across Logan County, and has been used as a reference tool to initiate discussion on potential new and innovative solutions from various partner perspectives.

Establish Simple Data Sharing Practices

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Identify what types of data are collected by different partner agencies.**
- ☐ **Determine what data can be shared and presented to increase partners' collective understanding of the local overdose crisis.**
- ☐ **Revisit DSAs as needed.**
- ☐ **Establish frequency for how often data will be shared or updated.**
- ☐ **Identify format for data presentations.**

Once a PHAST has identified what data to share and have acquired that data, several strategies may be used to present the data to PHAST partners. Simple data sharing is the most basic and fundamental way data can be used at the local level to develop a shared understanding of the overdose crisis. It usually does not require data use agreements or data transfers, but rather involves each agency or set of agencies that collect data in disparate ways, sharing aggregate data. With the help of your PHAST data analyst(s), partners can learn through data presentation and discussion a) what types of data related to the overdose crisis are collected by different partner agencies, b) what the data reveal about the local crisis, local resources, or potential needs, and c) what data gaps may need to be filled to improve the quality of the data for a specific purpose.

Organize Topical Presentations by Partners or Expert Guest Speakers

ACTION STEP CHECKLIST

Who: All PHAST partners; guest speakers

- ☐ **Organize and conduct topical presentations by partners or expert guest speakers at PHAST meetings.**

PHAST PARTNERS

What questions do you have?
What can you teach others?

PHASTs may also bring in guest speakers who can describe existing programs or interventions already underway in the jurisdiction or elsewhere. After any guest presentation, be sure to leave time for questions and discussion. Part of the collaborative learning process may also involve developing shared terminology, addressing stigma, and learning about local contextual factors as well as existing prevention programs and resources. In addition to presenting on suggested topics listed in the **Resources Table on Substance Use Disorders and the Overdose Crisis** and addressing key investigation questions from the **Data Inventory Table** (For the ***Resource Table please see E1*** and for the ***Data Inventory Table please see C4*** in the Appendix), PHASTs may also consider the following topics:

- Stigma and myths of SUDs
- Local programs or interventions serving people with an SUD
- Data mapping of non-fatal and fatal overdoses, 911 overdose calls, first responder naloxone administration, or available prevention, treatment, and recovery services
- Frequency and location of people experiencing fatal and non-fatal overdoses
- Emerging drug threats and drugs associated with overdoses
- Risk factors associated with overdoses
- Available resources and barriers in the community
- Characteristics of people experiencing overdoses in the community
- Overdose spikes

Facilitate Data-Driven Discussion and Collective Interpretation

ACTION STEP CHECKLIST

Who: All PHAST partners; guest speakers

- ☐ **When data are shared, partners engage in data-driven discussions to collectively identify local gaps and needs.**

PHAST PARTNERS

How would you interpret the data that was just presented? Does it align with your experience?
Do partners interpret the data the same or differently?

Data analysis results and presentations are intended to serve not only as a method of "reporting out" updates to partners but also a catalyst for data-driven discussions. Simply sharing data tables or charts is insufficient without explanation and opportunity for discussion. By examining data as a group, input and perspectives from multiple sectors will help shape the interpretation and contribute to a more holistic understanding of the overdose crisis. Much like pieces of a puzzle that fit together, partners' collective experience and expertise can be used to make sense of discrete data elements and the overall opioid overdose crisis. Data-driven discussions are a helpful way for PHASTs to collectively identify local gaps and needs and define the problems at hand. (See Action Step, "Identify Gaps and Needs"). With a comprehensive understanding, discussions can then move to systems-level problem-solving.

Identify Gaps and Needs

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Following each data presentation or data sharing activity, discuss the suggested questions in this section.**
- ☐ **Identify and record the underlying problem, issue, gap, or need revealed by the data.**
- ☐ **Identify and record implications and actionable insights on the Data Inventory Table (*see C4 in the Appendix*) or another tracking tool.**

As partners share data with one another about the local overdose crisis, one key question to keep in mind is, "What does this mean?" Often, data may reveal gaps, needs, or barriers in the community. In these cases, partners can work together to identify underlying problems or issues that need to be addressed. This step can be seamlessly integrated into data-driven discussions.

To systematically connect the data that are shared during PHAST meetings to a key insight, underlying problem, or community need or gap, PHASTs are encouraged to track insights from each data presentation or key metric shared. PHASTs may expand or modify the **Data Inventory Table** ***(see C4 in the Appendix)*** to include columns such as "What does this mean?" or "What problem does this reveal?"

Following each data presentation or data sharing activity, PHASTs are encouraged to collectively identify:

1 - Underlying problems, issues, gaps, and needs revealed by the data and

2 - Implications and actionable insights.

Suggested discussion questions include:

- What insights can be drawn?
- What are the implications?
- What is the big picture?
- What does this mean for people at risk for overdose in our community?
- Do we have enough information or is more analysis necessary?
- What factors may be contributing to this?
- What additional questions does this raise?

At the end of each discussion, partners should have a shared understanding of local needs, gaps, and barriers relevant to the data that were shared or have identified additional data gaps that need to be filled. By connecting data to its broader implications, data sharing will become more purposeful, partners will be better able to make sense of the evidence, and the PHAST will be primed to connect insights to action.

TIPS

For Facilitation

When asking partners to engage in data-driven discussions and collective interpretation of presented data:

- Allow for uncomfortable silence to give people time to think and speak up. Generally, if you wait long enough, someone will offer an idea. Otherwise, don't be afraid to ask someone a question.
- Highlight or ask partners to share what aspects of the data are expected, unexpected, disappointing, or encouraging.
- Ask partners what factors contributed to the data trends presented.
- Ask partners what questions remain/what is still unknown (this may indicate that further formal or informal data collection is needed in order to make sense of the data).
- Make sure diverse perspectives are brought to bear as you collectively interpret the data.
- Make sure someone is taking notes.

COLLABORATIVE PROBLEM SOLVING AND COORDINATED INTERVENTIONS

Module 3

Filling service gaps and improving overdose prevention

The second SOS goal of a PHAST is optimizing jurisdictional capacity to prevent overdoses.

This module addresses PHAST activities designed to help move partners from data to action, or from a better shared understanding to better implementation of evidence-based interventions. This may sound easy, but it can be challenging to problem solve an issue as multi-dimensional as the overdose crisis. To help PHASTs, this module outlines several simple collaborative processes to identify gaps in programs and services and prioritize areas in need of improvement, expansion, or intervention.

Once your PHAST has prioritized recommendations (including any recommendations informed by overdose fatality reviews), specific implementation steps can be listed, carried out, and reported on as they are completed. Keep in mind that even though we have listed these processes in what looks like a series of steps, some of these processes can occur together or in a different order, depending on what works best for your PHAST.

This module includes the following action steps:

- Review evidence-based interventions and promising practices
- Identify existing interventions related to overdose prevention
- Select interventions to address local gaps, needs, and challenges
- Identify barriers and facilitators for implementing, expanding, or improving evidence-based overdose prevention interventions
- Prioritize interventions
- Identify supports and design changes
- Develop an implementation plan

Some of these action steps are closely connected to and build upon one another. To streamline this process, it is possible to combine these action steps into one or a series of connected meetings.

Review Evidence-based Interventions and Promising Practices

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Share CDC's Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States (*https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf*) with partners and ask them to independently review strategies.**
- ☐ **Collectively review the evidence-based strategies with partners.**
- ☐ **Identify partners in your community who are implementing the strategies.**
- ☐ **Invite identified partners to present on their experiences, lessons learned, and outcomes (if available).**
- ☐ **Discuss opportunities for improving jurisdictional capacity and interventions to prevent overdoses.**

Throughout the evolving overdose crisis, a number of strategies and interventions have emerged through innovation and scientific study. In 2018 CDC published *Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States*[37] in which the authors describe and provide examples of the following evidence-based interventions:

- Targeted Naloxone Distribution
- Medication-Assisted Treatment (also known as Medications for Opioid Use Disorder or MOUD)
- Academic Detailing
- Eliminating Prior Authorization Requirements for MOUD
- Screening for Fentanyl in Routine Clinical Toxicology Testing
- 911 Good Samaritan Laws
- Naloxone Distribution in Treatment Centers and Criminal Justice Settings
- MOUD in Criminal Justice Settings and Upon Release
- Initiating Buprenorphine-based MOUD in Emergency Departments
- Syringe Services Programs (SSP)

Several promising practices, which have some data showing positive outcomes, but do not have enough evidence to support generalizable conclusions, include the following:

- Telemedicine programs to reduce barriers to MOUD access[38]
- Criminal justice diversion programs[39]
- Peer recovery specialist involvement in post-overdose outreach or overdose response/crisis response teams[40], [41]
- Linkage-to-care programs that leverage intercept opportunities with law enforcement and first responders[42]

Across all of the above mentioned strategies, four critical needs identified in the literature are evident:

1 - Increase access to life-saving and harm-reduction measures for people who use drugs.

2 - Divert individuals away from the criminal justice system and offer support services.

3 - Capitalize on intercept opportunities to offer support and access to treatment and recovery.

4 - Provide appropriate health services, including MOUD, to justice-involved populations (JIP) during incarceration and times of transitions.

These four critical areas can serve as an organizing framework to help a PHAST assess multi-sector strengths and opportunities for improved overdose prevention.

Because sectors are used to working in silos, it is helpful to get everyone on the same page and ensure that partners have a shared understanding of all of the overdose prevention programs and practices that already exist within the jurisdiction. Collectively reviewing CDC's Evidence-based Strategies: What's Working in the United States, then working together to identify existing community interventions and discussing jursidictional capacity to prevent overdoses can be an effective approach to gaining a shared undertanding of national and local evidence-based interventions.

A strategy is a plan of action or approach to achieving a goal.[43]

An **intervention** is any set of organized activities supported by a set of resources to achieve a specific and intended result or strategy. Interventions can include direct service interventions, community mobilization efforts, research initiatives, advocacy work, and training programs.[44] **Interventions** are specific approaches to implementing broader **strategies.**

Identify Existing Interventions Related to Overdose Prevention

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ Complete the Inventory of Evidence-based Interventions (*See C5 in the Appendix*).

As PHAST partners discuss the list of evidence-based strategies, develop a list of existing programs and policies in your community that align with those strategies and that directly or indirectly address the four critical needs listed above. (For an overview on evidence-based interventions, please see the text-box on page 56.) Partners may use the **Inventory of Evidence-based Interventions** template included, ***see C5 in the Appendix*** to track interventions currently implemented by partners in the community that align with each area of critical need.

It is helpful to identify what interventions already exist throughout the jurisdiction and what gaps remain.

Select Evidence-based Interventions to Address Local Needs, Gaps, and Challenges

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Discuss how local needs, gaps, and challenges are or are not being effectively addressed through existing evidence-based interventions using the questions listed in Module 2 (Action Step: "Identify Gaps and Needs".)**
- ☐ **Determine if there are important gaps not being addressed at all through any existing interventions. If there are, select new evidence-based interventions that may address these.**
- ☐ **Develop a list of existing evidence-based interventions that can be expanded or improved upon and new evidence-based interventions that can be implemented (*please see C5 in the Appendix* to see how this can be tracked using the Inventory of Evidence-based Interventions template.)**

After the group has reviewed evidence-based interventions for preventing opioid overdose and identified existing evidence-based interventions in the jurisdiction, partners may focus their discussion on how local needs, gaps, and challenges identified through data-driven discussions (See Module 2) are or are not effectively addressed through existing interventions. Partners can also discuss how they may adapt existing interventions to address important gaps or may decide that new evidence-based interventions may be needed. For this action step, partners are encouraged to discuss:

1 - What gaps, needs, and challenges are existing programs designed to address?

- **a -** What are they addressing well? Can local gaps and needs be addressed by expanding the intervention? Are there other benefits to expanding the intervention?
- **b -** What are they not addressing well? Can improvements or adaptations be made to this intervention so that it can better address the problem, need, or gap?

2 - What gaps, needs, and challenges are existing interventions NOT designed to address?

3 - What evidence-based strategies can address these unmet needs and gaps?

4 - Based on this discussion, what existing interventions can be expanded or improved? What new interventions can be implemented?

By the end of this discussion, the PHAST should have a list of existing interventions that can be expanded or improved upon and new evidence-based interventions that can be implemented to address local gaps, needs, and challenges. PHASTs may use the **Inventory of Evidence-based Interventions** template (***see C5 in the Appendix***) to track how existing programs are or are not addressing local gaps, needs, and barriers. The inventory may be expanded or modified to track new interventions that may be considered for future implementation. For each intervention, note whether there is evidence that it is successful or not. If not, a suggestion would be to assess its effectiveness before continuing or expanding the intervention further (see text box below). ***Please see D2 in the Appendix*** to see some real-world **examples of local promising practices**.

What are "evidence-based" interventions and promising practices?

An **evidence-based** public health strategy or intervention is an approach to improving population health that has been shown to be effective across a wide range of settings and people through data, research, and program or policy evaluation. Evidence-based strategies rely on the best available scientific evidence, systematic use of data and information, the application of program-planning frameworks and models, community-engagement, monitoring and evaluation, and dissemination of lessons learned. Implementing evidence-based strategies helps to increase the likelihood of success, improve productivity, and ensure more efficient use of public and private resources to improve population health.[45] On the other hand, **promising practices** include practices assessed through unpublished intervention evaluations that have not been peer reviewed and that demonstrate some evidence of effectiveness, reach, feasibility, sustainability, and transferability.[46]

Please refer to the Appendix for **additional resources** on evidence-based interventions and promising practices.

Identify Barriers and Facilitators for Implementing, Expanding, or Improving Evidence-based Overdose Prevention Interventions

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **For the intervention you have selected, determine what challenges and obstacles you need to overcome (policies, programs, perceptions) and who is experiencing them. Then, determine what changes need to be made to implement/expand/improve that intervention that will help you address these challenges.**
- ☐ **Identify barriers to making each proposed change.**
- ☐ **Identify facilitators to making each proposed change.**
- ☐ **Document proposed changes and their barriers and facilitators.**

Once your PHAST has compiled a list of all new and existing evidence-based interventions that are designed to address your jurisdiction's needs, partners can begin the process of identifying barriers and facilitators for implementing, expanding, or improving each identified intervention. However, depending on the number of interventions your PHAST has selected, it might make sense to prioritize them first then come back to identifying barriers and facilitators for your prioritized interventions.

For example, if your PHAST has identified 10 different interventions, it may make sense to narrow down the list of interventions before you begin the process of identifying barriers and facilitators for each one. On the other hand, if your PHAST has selected three interventions, identifying barriers and facilitators for each might help to inform your PHAST's prioritization process. Generally, you can conduct these steps in whatever order makes sense to your PHAST.

There are many barriers and facilitators in implementation. Barriers are factors that hinder change, whereas facilitators are factors that help to motivate change. A key step in implementation is identifying what those barriers and facilitators are. This will enable people involved in your programs to overcome barriers by picking the right supports,

and to leverage facilitators in your implementation plan. This step is foundational to building an easier pathway to better implementation.

PHAST members may already understand what barriers and facilitators exist to implementing each of the selected interventions. In some cases, understanding barriers and facilitators may also require additional information gathering through new data collection and investigation, interviews, or informal conversations with those who may be more familiar with the issue. For instance, if you have identified that a prevention service is not being used frequently by a segment of the population but through group discussion it is unclear why that is the case, partners may need to investigate reasons before developing an appropriate recommendation. This can occur through new data collection or by simply inviting members of the population segment to join the PHAST and explore barriers and facilitators together.

To begin the process of identifying barriers and facilitators, it helps to first determine who is experiencing the obstacle and what type of obstacle it is – is it a policy issue, a program-related issue, or a perception (e.g., a value or belief)? Then determine who controls those policies or programs, or holds those perceptions. Now you know the focus of your intervention. (Note: There may be more than one obstacle, but try to get to the root cause, if possible.)

For example, if your PHAST is implementing a naloxone distribution program for a specific population, what are the obstacles, limitations, or challenges to this program and who is facing them? What policies, programs or perceptions can be changed to address these obstacles?

The process of highlighting limitations can be uncomfortable because people are used to presenting their work in the best possible light, especially to leadership. However, limitations and challenges are part of every intervention and there is always room for improvement. Here are a few questions to ask stakeholders about existing programs, or about new programs you are considering:

1 - What are some existing or anticipated challenges or obstacles to accessing the services provided through these interventions?

- **a -** Are some populations in your community facing greater access challenges than others? Why? What specific obstacles are known? Do you need more information to understand inequitable access or utilization?

2 - What are some existing or anticipated challenges and obstacles to delivering the services through these interventions?

3 - What happens before and after an individual enters the program (are there transitional or transfer of information needs)?

When discussing these questions consider: **Who** needs to do **what** differently for the intervention to be more effective? **What** can be changed to address these obstacles?

TIPS

For Facilitation

When asking partners to engage in problem solving to address gaps and needs:

- Allow for uncomfortable silence to give people time to think and speak up. Generally, if you wait long enough, someone will offer an idea. Otherwise, don't be afraid to ask someone a question.
- Ask partners to offer any and all ideas that come to mind, just like a brainstorming session; no one is committing to anything just by offering up possible solutions.
- Brainstorm first, then discuss feasibility and pragmatics. Separate brainstorming ideas from barriers or obstacles that may arise.
- Ask partners what questions remain/what is still unknown (this may indicate that further formal or informal data collection is needed in order to find solutions, such as inviting a guest speaker to discuss a particular evidence-based intervention with the group).
- Make sure diverse perspectives are brought to bear as you collect all possible solutions.
- Make sure someone is taking notes.

Once your PHAST has identified what needs to change, the next step is to consider the **barriers** to making each of these changes. These might relate to the design of a program (i.e., who is involved, how it works) or to how people engage with the program (i.e., the capability, opportunity, and motivation of the people delivering, attending, or involved in the program.) When you have barriers related to design, you might need to adapt components of the program. When you have barriers related to engagement with the program, you may need to select supports to help people better interact with it (see section below). Here are a few questions to ask stakeholders about barriers:

1 - What are some existing or anticipated barriers to making each of the identified changes?

2 - Are these barriers related to:

- **a -** How the intervention is designed?
- **b -** How people engage with the intervention?
- **c -** How the intervention is being delivered?
- **d -** Intervention resources and capacity?

Finally, consider **the facilitators** to making each of these changes. What policies or practices may support this change? What factors may encourage behavior change?

Note:
Recommendations identified by OFR teams can be incorporated into this process as well. For more information about OFRs, please refer to the Overdose Fatality Review: A Practitioner's Guide to Implementation at ***https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf.*** PHASTs may use the **Inventory of Evidence-based Interventions** template ***(See C5 in the Appendix)*** to track limitations/barriers and facilitators to existing interventions.

Limitations and challenges are part of every intervention and there is always room for improvement.

Prioritize Interventions

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Develop a set of prioritization criteria.**
- ☐ **Select and conduct a prioritization activity.**
- ☐ **Discuss results with partners.**

A PHAST comprises many different stakeholders with different roles, responsibilities, and priorities. Depending on how many evidence-based interventions you have selected to improve, expand, or implement, you may need to prioritize which to address first.

Prioritization doesn't have to be a time-consuming task, and yet there is a large benefit to prioritization because it helps develop focus. With your PHAST, develop a set of prioritization criteria (e.g., ease of implementation, importance, urgency, or target population.)

Taking a few moments, even 10–15 minutes of discussion time, to get on the same page about how you are prioritizing will ensure a common understanding of how you will collectively tackle this step. Next, it helps to build in an "independent" activity to actually do the prioritization – something that everyone can participate in, so that everyone's voice around the table is heard. Examples include independent voting or ranking with your collective prioritization criteria in mind, anonymous surveys, and group discussion. Further, building in opportunities to discuss the results will help the process and can establish more shared understanding and buy-in.

PHAST Strategy

Conduct a Prioritization Exercise

PHASTs may engage in different types of team activities in order to collectively prioritize decisions. Using a prioritization tool can offer different options for individual teams. One approach is to list all of the selected interventions (for implementation, expansion, or improvement) on an actual or virtual (e.g., Jamboard) whiteboard, and ask PHAST partners to vote for their highest priorities.

Some programs and strategies may easily be addressed by a specific agency or it may be a top priority to one agency. In these cases, a partner may "claim" a program or strategy as a "to do" task to be completed and report back progress at future meetings. This process encourages accountability to the PHAST and a commitment to action.

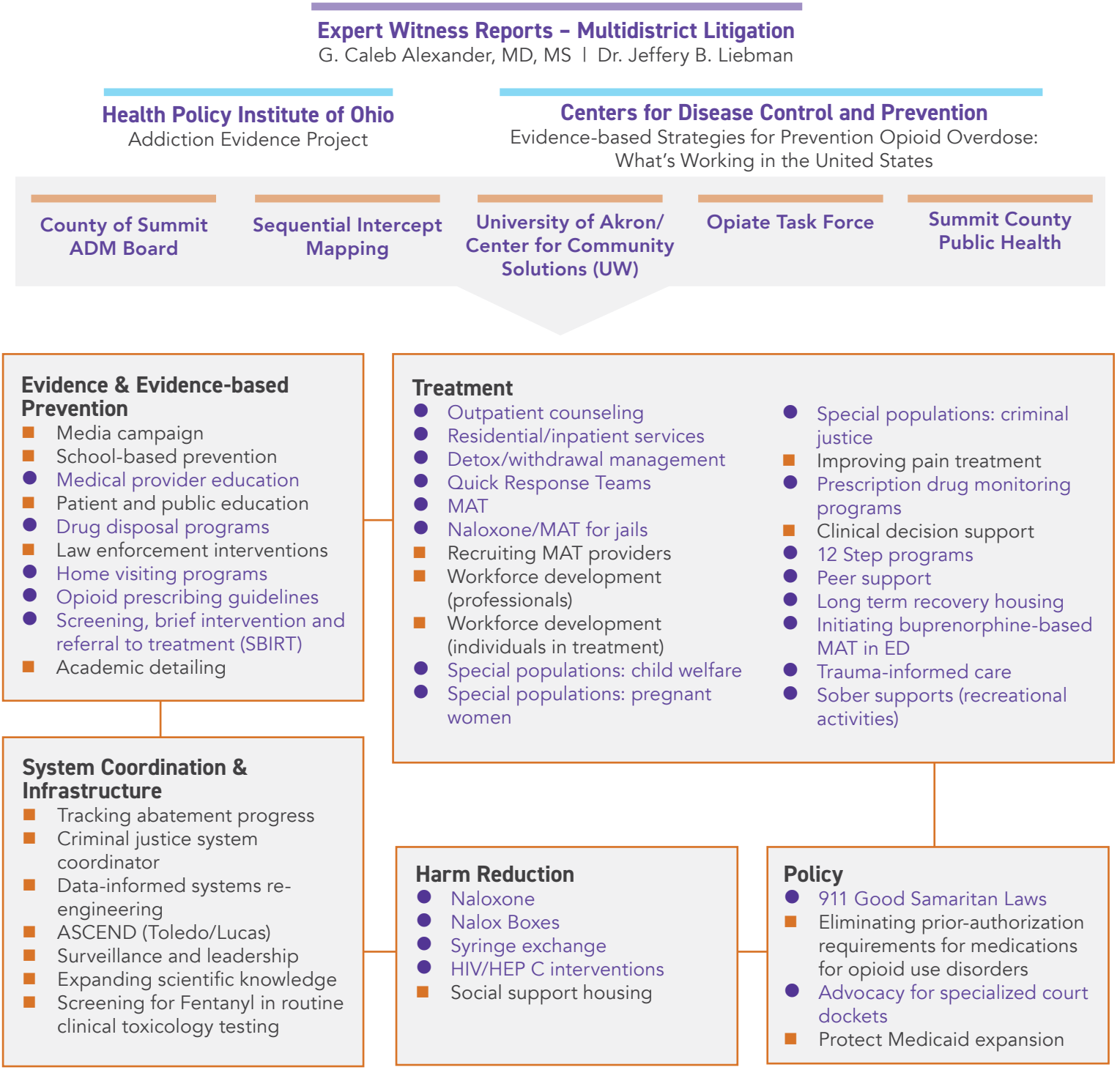
In other cases, interventions may involve multiple agencies or even the creation of a workgroup, or it may involve several activities/action steps. All prioritized interventions and action steps should be assigned to an agency or individual who shall be responsible for reporting on progress at subsequent meetings.

Example of Prioritizing Interventions: Summit County, Ohio

The Summit County PHAST developed two visualization tools to aid their planning and prioritization processes.

The Opiate Framework (Figure 7) depicts all possible overdose prevention and response interventions that could be implemented in Summit County. Interventions are grouped into five distinct strategy areas. Those marked in **purple** indicate interventions in which the county currently has capacity to implement. This is a simple approach to communicating with stakeholders all possible interventions that are or are not in place as well as the extent to which each of the five strategies areas are being addressed.

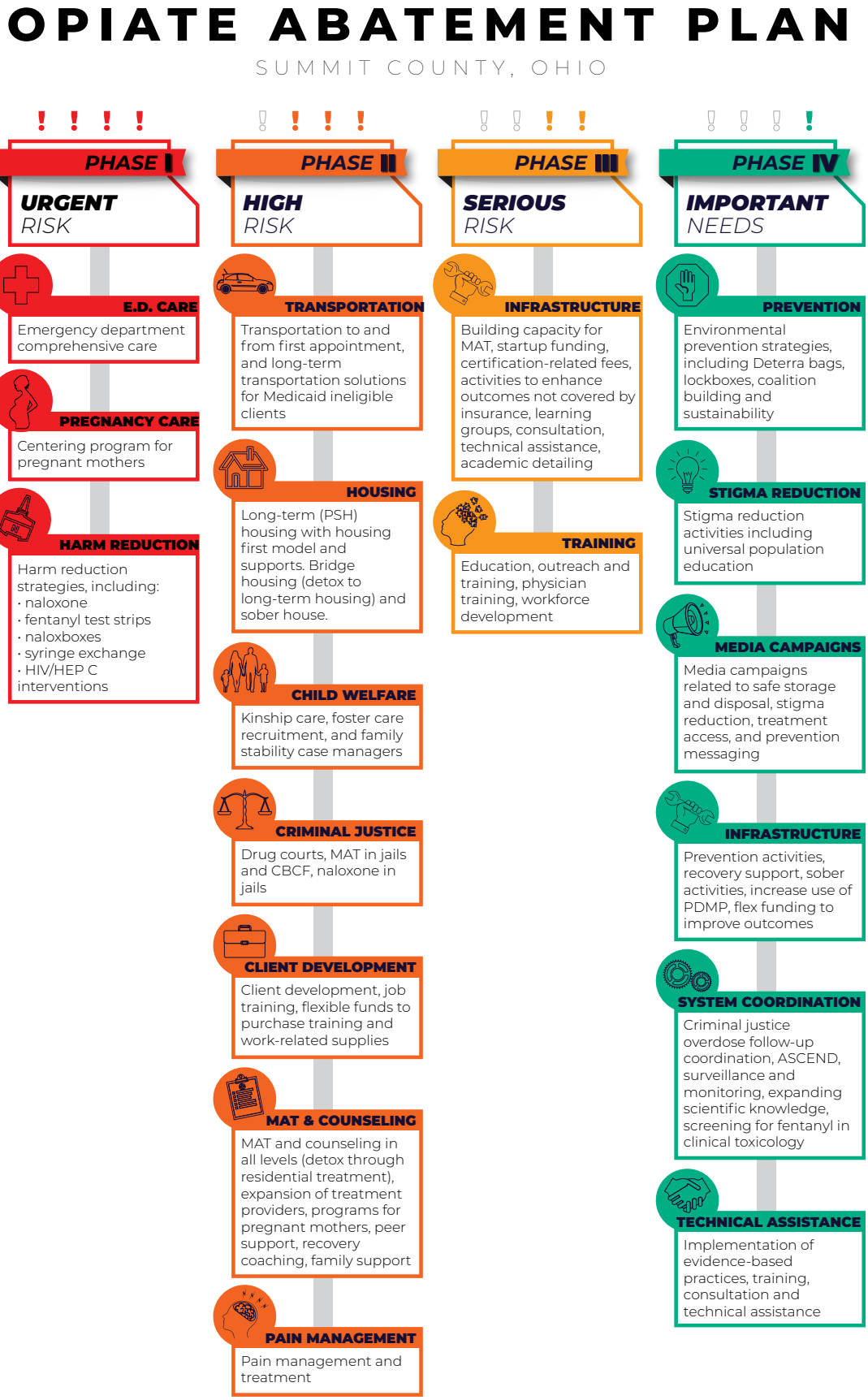
Figure 7. Summit County, OH Opiate Framework



Example of Prioritizing Interventions: Summit County, Ohio

The Summit County PHAST developed two visualization tools to aid their planning and prioritization processes.

Figure 8. Summit County, OH Opiate Abatement Plan



The Opiate Abatement Plan (Figure 8) depicts interventions by level of urgency. Prioritizing interventions by level of urgency enables stakeholders to understand the number of urgent vs. important needs and the sequencing and timeline of current and planned interventions. This tool can aid with long-term planning and discussions related to multi-sector coordination of future interventions.

Identify Supports and Design Changes

ACTION STEP CHECKLIST

Who: All PHAST partners

- ☐ **Discuss and recommend solutions that specifically address barriers to change and leverage facilitators to change.**

After your PHAST has prioritized its evidence-based interventions and examined barriers and facilitators for each, recommendations for how to address these barriers can be generated. If your PHAST identified many barriers, you may use a prioritization activity (as described in the previous step) to help you focus on a few key barriers.

Next, your PHAST is encouraged to recommend solutions that specifically address these barriers. Barriers might indicate that changes are needed to service design (i.e., how the actual program is coordinated/delivered, how information is shared). In this situation, solutions would involve making changes to the intervention itself to ensure that these challenges are overcome (e.g., practice changes, service structure, data sharing agreements between partner organizations, resource allocation). There may also be barriers related to engagement with the program (e.g., more knowledge and skills are needed, attitudes and stigma need to be overcome, certain restrictions need to be lifted through policy). For these types of barriers, you may have to identify and develop supports like education and training provision, opinion leaders, action planning, or policy changes – among many other types of supports.

PHAST Activity

Collaborative Brainstorming

Collaborative brainstorming encourages all partners to offer recommendations to be considered by the group. PHAST partners are encouraged to brainstorm a **list of recommendations** that leverage all available sectors and jurisdictional capacity to address each facilitator and barrier. Ask the entire PHAST, "What would strengthen the intervention?" "What would address these barriers we've identified?" Then invite participants to write on sticky notes as many ideas as they can to improve that program or service in 5 or 10 minutes and at the end put the recommendations up on a shared wall. This way, ideas are anonymous. Discuss the ideas as a group.

Once recommendations and design changes have been discussed and considered, partners may decide to complete another prioritization activity to determine which recommendations or design changes to adopt.

Develop an Implementation Plan

ACTION STEP CHECKLIST

Who: All PHAST partners

☐ **Develop a detailed plan that documents recommendations and design changes chosen by the PHAST.**

For each prioritized intervention, PHASTs are encouraged to develop a detailed plan that documents recommendations and design changes chosen by the PHAST. Implementation plans will typically include the following elements:

- An overarching goal or main barrier to overcome
- Action steps (these will include the supports to address each identified barrier)
    - Where will the program and supports be delivered? (For example, is there a hot spot or key population you want to engage?)
    - Who will do what by when?

Example: Probation and parole officers regularly supervise individuals at risk of overdose. After experiencing repeat overdose incidents among individuals in community corrections, a jurisdiction decides to provide basic motivational interviewing training to its community corrections officers so they can support recovery when opportunities arise. They also enter a data use agreement with local law enforcement so that, when an individual who is under community corrections supervision experiences an overdose, the probation office is notified so that the officer can engage with a rapid response team to offer recovery support.

As part of the implementation plan, partners may also consider discussing performance measures that will help the team monitor and track progress over time. Following the implementation plan helps to ensure that PHASTs stay on track and complete each action step in a timely manner.

An intervention plan can be in the form of a written document, table, or be based on an existing template that is adapted to the PHAST's needs. Providing that the plan contains the basic elements listed above, a PHAST can determine the best option to meet their needs. ***D3 in the Appendix*** includes an **example of an implementation plan** to implement a naloxone leave-behind program.

Following an implementation plan helps PHASTs stay on track and complete each step.

MONITORING AND MAINTAINING PROGRESS

Module 4

How to assess progress and maintain multi-sector momentum

Once interventions are implemented, it is important to monitor progress and understand their impact. Monitoring the impact of interventions helps PHASTs achieve the third and final SOS goal: to establish **shared accountability** for achieving desired outcomes that are beyond the control of any single agency or individual. The only way to know if a PHAST is successful is to measure collective progress toward desired outcomes.

Monitoring collective progress helps jurisdictional leaders and PHAST partners:

- Understand how and why interventions work or don't work
- Understand the extent to which each initiative and strategy is working as intended
- Identify opportunities for improvement or adjustments that may be needed
- Track incremental achievements, which can lead to a sense of shared accomplishment and help drive momentum among stakeholders and other invested partners
- Establish shared responsibility for achieving desired outcomes that are beyond the control of a single entity or individual

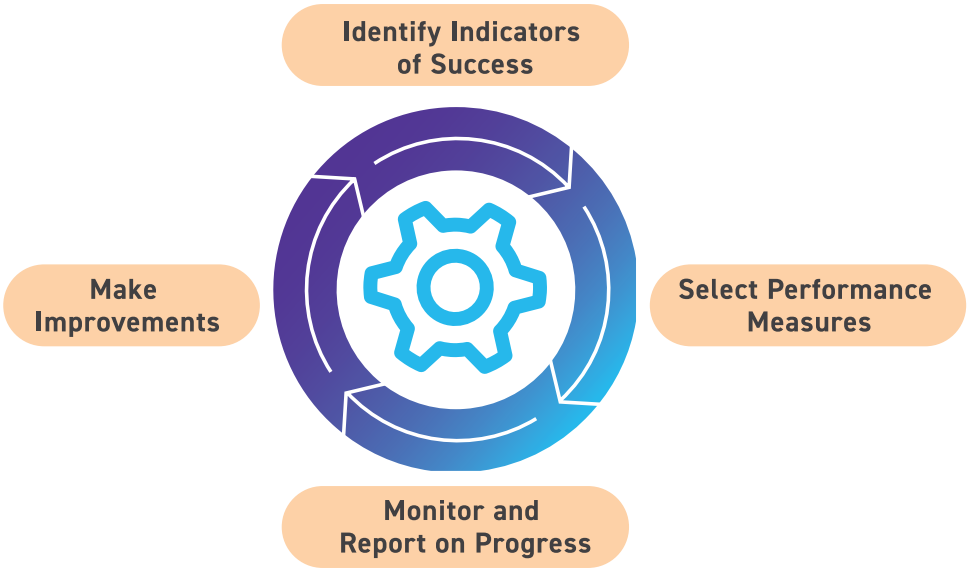
To monitor progress, PHAST follows a continuous performance management cycle (See Figure 9). This module will address each component of this cycle.

Contents of this module:

- Identify Indicators of Success
- Select Performance Measures
- Monitor and Report on Progress
- Celebrate Wins and Make Improvements

Performance management is an ongoing practice of using information and feedback on the work of an organization or activity to improve its process and outcomes.

Figure 9. PHAST Performance Management Cycle



Identify Indicators of Success

ACTION STEP CHECKLIST

Who: All PHAST partners; PHAST workgroup

- ☐ **Determine what interventions you want to monitor.**
- ☐ **Discuss what success looks like for each selected intervention.**

PHAST PARTNERS

How can you measure success?
What is an appropriate "success rate" or "target"?

To begin this process, PHAST partners will first identify what to monitor. This may include any interventions that fall under the purview of PHAST partners or the collective work of the PHAST itself. PHASTs are encouraged to consider:

- Existing interventions led by individual agencies
- Ongoing strategies coordinated across sectors
- Interventions identified through collaborative problem-solving approaches
- Collective PHAST achievements

For each intervention identified, PHAST partners will then discuss and collectively brainstorm **what success looks like**. What is the objective or goal? What do partners hope to achieve through this intervention? Do partners share the same definition of success or does it vary? Do partners' vision of success align with the perspective of community members and those impacted by the intervention? Below are questions to consider that can guide this process. Example responses are included in the column to the right of each corresponding question and are based on a naloxone leave-behind program.

Table 6. Indicators of Success

Questions to Consider	Example Response
"How will we know how well we are implementing the activity?"	Naloxone administration and distribution of leave-behind kits are part of official police protocol in a suspected overdose
"How will we know our activity or intervention is working?"	Police officers administer naloxone in suspected overdose cases they encounter and distribute "leave-behind" kits
"What do we hope to see happen as a result of the activity?"	Increased rate of naloxone administration by police encountering overdoses; distribution of "leave-behind" kits; reduction in fatal overdoses

Select Performance Measures

ACTION STEP CHECKLIST

Who: All PHAST partners; PHAST workgroup

- ☐ **Select performance measures that allow you to determine if your intervention is working as intended.**
- ☐ **Select equity measures.**
- ☐ **Set targets for each performance measure.**
- ☐ **Develop a data collection plan.**
- ☐ **Develop a timeline for reporting/sharing measures.**

PHAST PARTNERS

What data can we collect to monitor success?
For whom is the program working best? Why?
For whom is the program not working as well? Why?
What else do we need to consider?

Although PHAST partners' common goal (or "North Star") is reduced overdose deaths, only assessing overdose rates will not tell you whether or to what extent your interventions are working to contribute to those rates. Similarly, in the pre-arrest diversion program example above, if the indicator of success is a reduction in fatal overdoses, knowing this alone does not provide sufficient information about how the program is working or what specific factors are influencing this outcome.

Performance measures allow us to assess the **capacities, processes, and outcomes relevant to the objective or indicator of success.** In other words, they are the measurable components that influence, are necessary for, and lead to the program's intended objective.

Depending on the size of your PHAST and the number of interventions under your purview, this activity may be assigned to a workgroup focused on the specific intervention. This would allow partners to leverage their expertise, focus their efforts on interventions in which they are most directly involved, and move swiftly. Decisions and results would be reported back to the larger group to ensure all partners are aware of any progress.

Performance measures are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator.

Table 7. Performance Measures

Questions to Consider	Example Response
"What data can we easily access or collect to measure our identified indicators?"	Track the proportion of police who have completed the training; the number of naloxone kits distributed to police; the number of "leave behind" kits distributed; the number and percent of suspected overdose calls in which naloxone is administered by police.
"What are our "best" (based on accessibility/feasibility, and accuracy) measures and data sources?"	Determine based on PHAST partner input and available or easily created data tracking systems.
"What is our target for each measure?"	Determine based on contextual knowledge of partners and baseline data on naloxone administration by police.
"What is our expected timeline for seeing results? How frequently can we measure our success?"	Determine based on partner input and overdose rate.
"What key perspectives should we also consider and collect?"	Collect direct feedback from police officers about the new protocol, including barriers and challenges through conversations.
"What data can we collect to help us understand the equity impact of our intervention? How will we be able to determine if certain groups are more responsive to, or are benefiting more from this intervention than other groups? What groups do we consider?"	Determine based on characteristics of people who have overdosed, people at risk of overdose, and people with OUD in the community.

The only way to know if a PHAST is successful is to measure collective progress toward desired outcomes.

The performance measures your PHAST selects must be aligned with your interventions. Just as there is a **logic model for the PHAST framework** ***(see C1 in the Appendix)***, PHAST partners may find it helpful to develop a logic model for specific interventions to graphically depict how a particular intervention is intended to achieve the desired outcomes (***Please see C6 in the Appendix*** for an example of a **Logic Model for Expanding Naloxone Administration Capacity Among Police Officers**). This will ensure that the measures chosen are aligned with each specific PHAST intervention.

Overdose Prevention Evaluation Profiles

Overdose Prevention Evaluation Profiles were developed by the CDC to support funded entities in designing evaluations by demonstrating how evaluations can be conducted to produce actionable and timely findings. Each profile provides guidance on the type of evaluation questions, indicators, data sources, and data collection methods that may be used to evaluate each of the following types of interventions:

1. Public health surveillance activities with prescription drug monitoring program (PDMP) data and public dissemination of results
2. Linkage to care initiatives
3. Technical assistance to high burden communities
4. Academic detailing
5. Naloxone distribution
6. Overdose communication campaigns
7. Use of PDMP data to inform clinical practice and improve patient safety

Evaluation profiles may be accessed here: ***https://www.cdc.gov/drugoverdose/od2a/evaluation.html***.

Depending on what your indicators of success are, you may want to select both short-term and long-term performance measures. It can be challenging when some changes are intended to produce outcomes that won't be detectable for a long time. To maintain PHAST momentum, data that measures both short-term and long-term outcomes should be considered.

For each performance measure, partners are encouraged to compare the ideal measure to what can be measured and to what data is already being collected. In some cases, selecting a measure that is feasible and easily accessible can help drive the initial momentum of monitoring progress until additional data collection can be conducted. Setting a target for each performance measure will provide context for each measure (e.g., is the number being reported good or bad?) and will help determine if the intervention is on track to meeting its objective. Partners can also consider the timeline for when results are expected as well as how frequently measures should be reported out to the PHAST. This is particularly important if both short- and long-term outcomes are being monitored. Performance measures can and should be developed as part of any implementation plan.

Consider Qualitative Data Collection

When discussing performance measures, PHASTs are also encouraged to consider collecting qualitative data as the work progresses. Partners may plan focus groups, conduct interviews, or hold informal conversations with staff implementing the intervention, people receiving or directly impacted by the intervention, and community members. Considering these perspectives can provide the needed context to better understand the acceptability, accessibility, and impact of the intervention and can help answer questions that arise and cannot be answered through quantitative data alone.

A final consideration during this process is how to measure the equity impact of the intervention or program. That is, how will you determine if the intervention works better for one group of people than another group? How will you know if one group of people is differentially impacted by the intervention? Partners are encouraged to examine program success for various subsets of the target population, looking at variability by race, ethnicity, geography, age, and any other variables related to equity.

For additional resources about Performance Measures and Program Evaluation, visit the ***CDC's Program Performance and Evaluation Office*** (*https://www.cdc.gov/eval/index.htm*)

Monitor and Report on Progress

ACTION STEP CHECKLIST

Who: All PHAST partners; PHAST workgroup; PHAST data analyst

- ☐ Determine how performance measures will be reported out to partners.
- ☐ Assess progress and evidence of success.
- ☐ Assess limitations and challenges.
- ☐ Update the Inventory of Evidence-based Interventions template with identified successes and limitations.

PHAST PARTNERS

What do the data tell us about how we are doing?
Are we meeting our targets? Is it working well for some, but not for others?
Do we need to change anything we are doing?

Once performance indicators and measures have been established and data have been collected, results can be reviewed with PHAST partners on a recurring basis based on the timeline established in the previous step. Partners may choose to work closely with the dedicated PHAST data analyst to review and prepare the data for presentation. During these data presentations, PHAST partners will work together to make sense of the data and collectively decide what, if any, actions need to be taken as a result.

Reporting progress is the documentation of whether standards and targets are met, and the sharing of such information through appropriate feedback channels.

Table 8. Performance Monitoring and Reporting

Questions to Consider	Example Response
"How do we share performance data back to partners in a timely manner for collaborative interpretation of findings?"	Data will be tracked electronically and will be presented to partners in monthly PHAST meetings.
"Based on the measurement data, how are we doing?"	Determine based on performance measures and targets established.
"Were there any unintended consequences?"	Determine based on key informant interviews and/or regular monitoring and discussion of unforeseen events, incidents, and outcomes.
"Who is benefiting from this intervention? Who is being missed? Is everyone receiving the same opportunities or quality of service offered through this intervention or is there variation by race, age group, gender, or other demographic characteristics?"	Determine based on demographic data collected.
"What feedback have we received from front-line staff and people directly and indirectly impacted by this change?"	Determine based on qualitative data collected through informal conversations with police officers.

In some cases, partners may be able to offer additional information not captured in the presentation that can help further contextualize the findings or can bring to light systems-level factors that may contribute to or interfere with success. Based on the findings from your performance measurement and collaborative interpretation of the results, you can update your **Inventory of Evidence-based Interventions** by adding in evidence of success and additional limitations, for which recommendations for improvement should be generated and included in future prioritization efforts.

Once performance indicators and measures have been established and data have been collected, results can be reviewed with PHAST partners on a recurring basis.

Celebrate Wins and Make Improvements

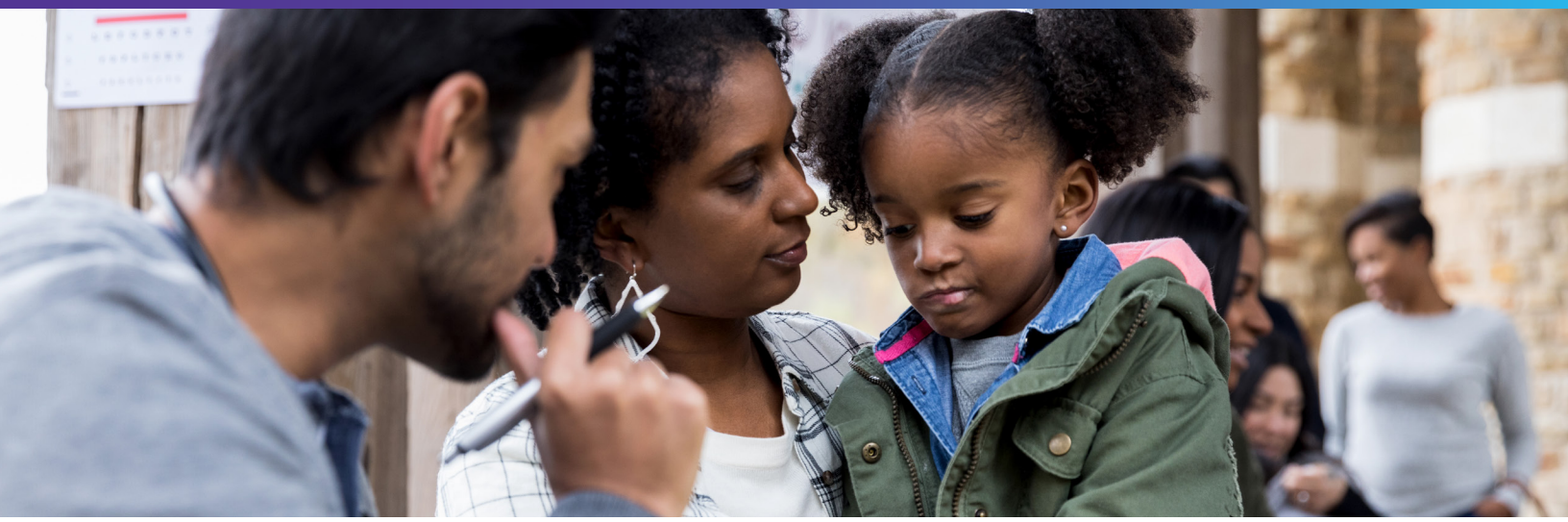
ACTION STEP CHECKLIST

Who: All PHAST partners; PHAST workgroup; PHAST data analyst

- ☐ Determine if targets have been met.
- ☐ Discuss and interpret findings.
- ☐ Identify recommendations for intervention improvements or other needed changes.
- ☐ Celebrate and communicate success.
- ☐ Resume the process of identifying performance indicators and measures to assess any new improvements introduced; collect and review data; and identify new opportunities for improvement.

PHAST PARTNERS

Based on this information, what are we doing well?
What changes should we make to get us closer to our goal of reducing overdose deaths?



Understanding how each intervention is performing against its intended goal allows PHASTs to recognize their collective achievements as well as make needed adjustments and identify opportunities for improvements. This notion is central to the fourth PHAST guiding principle of continuous improvement. The performance measures that are tracked, reviewed, and presented to partners can be used to confirm or challenge decisions and strategies and can help identify potential changes in policy or program direction. It can also help justify investments in specific response strategies, making it easier to secure and sustain funding for successful programs.

Quality improvement is the continuous effort to improve public health and safety policies, programs, or infrastructure based on reviewing and addressing performance standards, measures, and reports.

Table 9. Celebrate Wins and Make Improvements

Questions to Consider	Example Response
"What's working well?" (How do we know?) **"Who is better off and by how much?"** **"How do we share this information?"**	Use data to determine if goals are being met and by how much. Determine if this is a win that could be shared publicly with external partners.
"If results are worse than expected or do not meet the established targets, why?" **"If results are good and are meeting targets, should it be expanded?"** **"How can efforts be sustained or improved?"** **"Are there any unintended consequences that we need to address?"**	Use data to inform decisions about modified, expanded, continued/discontinued activities.
"Is there an opportunity to make improvements?" **"What needs to change to see better results?"**	Use data, including qualitative data collected through informal conversations with police officers, to inform decisions about modified, expanded, continued/ discontinued activities.

Continuing the Process

Because the PHAST performance management approach follows a continuous cycle, once improvements are made, the cycle restarts. Partners once again resume the process of identifying performance indicators and measures to assess any new improvements introduced; collect and review data; and identify new opportunities for improvements. By working together to make incremental improvements informed by data, PHASTs will become more agile and able to respond to community needs and address service gaps. (For **examples of different problem-solving models**, ***please see C7 in the Appendix***).

Although these accomplishments may appear minor, it is important for PHASTs to recognize their collective progress and celebrate these small wins together. Sharing accountability for collective successes helps build positive momentum to achieve continued progress, motivates partners to remain committed to the North Star, and helps to sustain the work of the PHAST.

PHAST Strategy:

Communicating Success

Your PHAST will experience many opportunities to share success stories. These stories may include such topics as sharing your team's priorities, releasing new data, or even highlighting a PHAST member who is experiencing some type of success. The key to successful communication is all about planning.

Example of Monitoring Progress

The Naloxone Distribution in the Allegheny County Jail to Prevent Overdose Data Brief (***https://www.alleghenycountyanalytics.us/wp-content/uploads/2019/02/18-ACDHS-27-NaloxoneACJ-022119_v2.pdf***) describes Allegheny County's efforts to monitor their jail naloxone distribution program. It provides a good example of how multiple sources of data be used to identify key findings, inform next steps and improvement opportunities.

PHAST Appendix

PHAST Appendix

Section	Referenced in Module/Section
A. Building or Formalizing a PHAST	
1. Why are Public Health and Public Safety Critical PHAST Partners?	Introduction
2. Description of PHAST Roles for Public Safety Partners	Module 1
3. Description of PHAST Roles for Public Health Partners	Module 1
4. Tips for Securing Data Analytic Capability	Module 1
B. Data Sharing Agreements	
1. Sample Data Sharing Agreement	Module 1
2. Sample Memorandum of Understanding	Module 1
3. Resources for Developing MOUs, DUAs, and DSAs	Module 1
C. Tables, Tools, and Templates	
1. PHAST Logic Model	Introduction, Module 4
2. Sample PHAST Meeting Agenda	Module 1
3. Sample PHAST Quarterly Meeting Agenda (OFR)	Module 2
4. Data Inventory Table	Module 2
5. Inventory of Evidence-based Interventions Template	Module 3
6. Logic Model for Expanding Naloxone Administration Capacity Among Police Officers	Module 4
7. Problem-solving Models	Module 4
D. Examples	
1. Examples of Critical Intervention Points for Change: Opioid Mapping	Module 2
2. Examples of Local Promising Practices	Module 3
3. Example of Implementation Plan	Module 3
E. Resources	
1. Resources Table on SUDs and the Overdose Crisis	Module 2
2. PHAST Toolkit Action Steps	Modules 1-4
3. Glossary of Terms	Modules 1-4

A1. Why are Public Health and Public Safety Critical Public Health and Safety Team (PHAST) Partners?

The PHAST framework was developed to assist jurisdictions in reducing overdose deaths by supporting data-sharing activities and coordinated overdose prevention through multi-sector partnerships. One critical partnership is that between leadership from public health and public safety agencies. The PHAST toolkit provides guidance to jurisdictions on how to establish and formalize such partnerships. This section describes why public safety and public health are important partners in the overdose crisis.

Why is Public Health an Important PHAST Partner?

Public health professionals can be medical officers, program managers, researchers, data analysts, program evaluators, or leaders or directors at a health department. They may have clinical healthcare, research, data analysis, or evaluation experience. Public health professionals largely operate "behind the scenes," researching and tracking risks and protective factors while working with partners to implement health and safety programs, policies, and interventions. In fact, leveraging partnerships with multiple sectors is one of public health's essential strategies.[47] Through partnerships, researchers and scientists can track and monitor population-level health, disseminate health messages, implement and test programs and policies, and investigate and respond to public health threats. Many public health partners also hold the key to a valuable public health resource – population-level data. In addition, real-time data (as well as insights and observations) from a variety of sources are needed to continuously characterize, track, and adapt to an evolving public health threat, like the opioid overdose crisis.

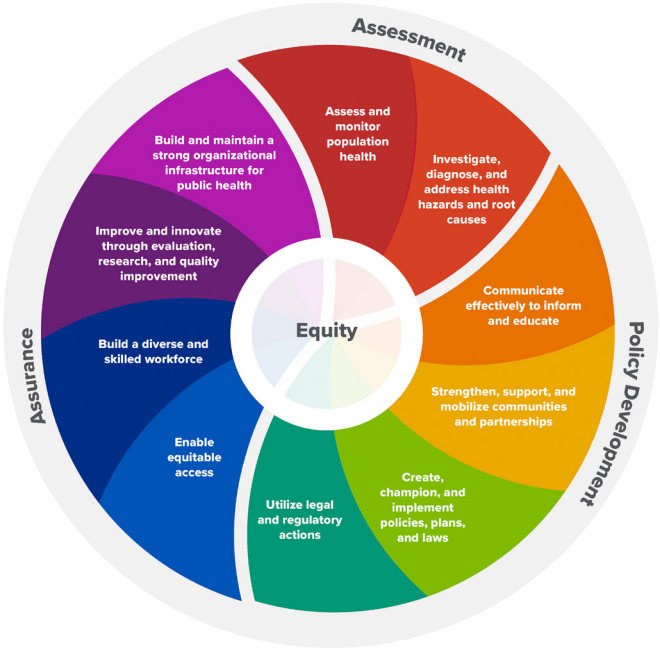
Public Health Skills, Services, and Strategies

Public health's data-driven, scientific approach serves PHAST by ensuring that data interpretations, decisions, and response efforts are informed by the scientific literature and the best available data.

The strength of a public health system rests on its capacity to effectively deliver the 10 Essential Public Health Services:[48]

1. Assess and monitor population health.
2. Investigate, diagnose, and address health hazards and root causes.
3. Communicate effectively to inform and educate.
4. Strengthen, support, and mobilize communities and partnerships.
5. Create, champion, and implement policies, plans, and laws.
6. Utilize legal and regulatory actions.
7. Enable equitable access.
8. Build a diverse and skilled workforce.
9. Improve and innovate through evaluation, research, and quality improvement.
10. Build and maintain a strong organizational infrastructure for public health..

Figure 1. The 10 Essential Public Health Services



Whereas medical clinicians assess the health of an individual through examination and assessment of a patient, public health professionals focus on the collective health of a community's population using a variety of data sources and techniques. As such, many are (or work closely with those who are) trained in scientific methods, data analysis, presentation, and interpretation. They also work closely with direct service providers to implement population-level interventions, including health education and risk communication campaigns as well as other disease or injury prevention strategies. Public health professionals rely heavily on partnerships with healthcare clinicians, community-based organizations, and many other service providers to conduct research and evaluation and to disseminate information and implement evidence-based practices and programs.

Public health also uses performance management strategies to regularly assess progress in meeting public health goals and objectives and identify improvement opportunities. By applying performance management to a PHAST, partners can determine the effectiveness of existing interventions, identify which programs, policies, and practices are moving them, as a group, closer to their desired outcomes, and make systematic improvements to advance health outcomes. This ongoing focus on measuring progress helps keep everyone focused on their common objectives and holds stakeholders accountable for their collective action.

Why is Public Safety an Important PHAST Partner?

Public safety encompasses law enforcement officials; criminal justice authorities, such as prosecutors, judges, and those working in correctional settings or in community corrections; and all first responder personnel, including police, fire, and paramedics. Its core mission includes the protection of the public. Historically, the law enforcement and criminal justice arms of public safety are known for enforcing laws designed to protect the public and issuing penalties to those who break the law. However, there are other contexts where public safety protects individuals, families, and the public absent an underlying criminal or law-breaking matter. Examples include the police role in managing individuals with mental illness or under the influence of drugs or alcohol. With these dual roles, public safety becomes more complicated and multi-dimensional. Specific to the current opioid overdose crisis, local law enforcement officials are among the first responders frequently called upon to respond to persons experiencing a suspected overdose.

Criminal justice authorities overseeing jails and prisons as well as community corrections (parole and probation) are responsible for people who may be at high risk of overdose; a study in North Carolina found that the risk for overdose death in the first two weeks after being released from a criminal justice setting is 40 times higher than someone in the general population.[49] Professionals working within correctional settings must ensure the health and safety of the populations they serve. To fulfill this role, they need to know how to best serve people with opioid use disorder (OUD) while they are in their custody and how to help transition them out of custody.

Prosecutors also play a key role in public safety by working closely with law enforcement to try to curb the drug supply. Because many people who buy and sell or traffic drugs illegally are also living with substance use disorder, prosecutors' roles are multi-faceted. They often have much of the power deciding the fate of a person arrested for drug possession. This critical time can be leveraged to offer defendants health support and treatment as opposed to prosecution and punishment for behaviors that may be attributable to substance use disorders. Pre-booking diversion programs, such as the Law Enforcement Assisted Diversion (LEAD), first developed in Seattle-King County in 2011, have shown positive outcomes related to improved access to health and treatment services, housing, employment and education, reduced recidivism, and cost savings.[50,51] The success of these programs relies on coordination with other sectors.

Law Enforcement Skills, Services, and Strategies

In general, compared to public health's essential strategies, law enforcement tactics are much more "operational," meaning they are actively service- and/or response-oriented. Five core operational strategies of modern law enforcement are: Preventive patrol, routine incident response, emergency response, criminal investigation, and problem solving/community-oriented policing.

- Preventive patrol is the showing of police presence as a deterrent to criminal activity (on the basis that criminals will not commit crimes in the presence of the police).
- Routine incident response is the attendance of police at everyday events, likely to involve no malicious intent, such as minor traffic accidents.
- Emergency response is the attendance by police at events at which there is an immediate and credible threat to life or property, such as an overdose.
- Criminal investigation is the process by which a trail of facts relating to an existing crime is amassed, often leading to an arrest of a person suspected of committing the crime in question.
- Problem solving, also known as community-oriented policing is the use of "organizational strategies [that] support the systematic use of partnerships and problem-solving techniques, to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder, and fear of crime."[52]

A2. PHAST Roles for Public Safety Partners

Any Public Safety Partner can…

- Be a champion for their jurisdiction's PHAST.
- Train and equip frontline staff with naloxone.
- Examine evidence about what works and what doesn't, including but not limited to harm-reduction literature, outcomes for people with substance use disorders (SUDs) in criminal justice settings, and effective treatment for OUD including medications for opioid use disorder (MOUD) (i.e., methadone, buprenorphine, and naltrexone).
- Reduce concern about exaggerated diversion risks associated with introducing agonist treatments (i.e. methadone and buprenorphine) in correctional settings.
- Ensure coordination between drug courts, judges, correctional facilities, and treatment providers to determine appropriate treatment and continuity of care in times of transition and reentry.
- Better understand the evidence that supports medication-based treatment for OUD.
- Engage and learn from individuals who represent multiple perspectives on the opioid crisis including public health, community members, and people who use drugs to ensure that all perspectives are heard and considered when developing intervention strategy protocols.
- Learn about public safety overdose prevention and response efforts in other jurisdictions.
- Collaboratively inform, educate, and empower communities through evidence-based education campaigns, trainings, and tools.
- Strategize with fellow PHAST partners around opportunities for data use and coordinated interventions.
- Discuss enforcement strategies with public health, behavioral health, and treatment providers to minimize conflicting approaches.
- Share and discuss personal experiences and interactions with the opioid overdose crisis among PHAST partners. Provide a safe space to discuss issues related to compassion fatigue and stigma with the goal of helping eliminate barriers in order to save lives.
- Use technology and information systems that can support crisis response and continuity of care for persons with OUD during various intercept points throughout the criminal justice system (See *PHAST Strategy: Conduct Sequential Intercept Mapping* in Module 2 of the PHAST Toolkit)

Public Defenders can…

- Improve the ways agency personnel work with people with substance use disorders (SUDs) through education and training.
- Link people with SUDs to appropriate support services and/or treatment.

Emergency Medical Services (EMS)/Fire can…

- Offer naloxone to families and friends of individuals who previously overdosed.
- Share non-fatal overdose case information with a health partner for follow-up with patient consent.
- Open fire houses as "safe stations" and initiate a linkage to care program.
- Partner with peer recovery specialists to conduct post-overdose outreach.

Correctional Facility Personnel can…

- Implement evidence-based practices in screening for SUDs, monitoring patient symptoms, medication administration and adherence, and outcomes, and treating opioid withdrawal.[53]
- Improve care for people with SUDs while in a jail or prison.
- Start or expand MOUD services within your correctional facilities.
- Implement a SUD treatment program for patients who are pregnant and have an SUD who are currently incarcerated.
- Improve discharge planning and managing the transitions of people with SUDs returning to the community.
- Expand naloxone distribution to families and friends visiting a loved one in local jails.

Law Enforcement (Police/Sheriff) can…

- Co-lead the jurisdiction's PHAST.
- Share seizure and other law enforcement data with partners to understand trends and detect emerging threats.
- Use overdose surveillance tracking systems, such as ODMap to help track real-time overdose data, detect overdose spikes, and inform deployment of resources and priority intervention areas. (See *the Overdose Detection Mapping Application Program* at ***http://www.odmap.org***)
- Enforce/educate the public on 9-1-1 Good Samaritan Laws.
- Provide linkage to care and treatment in encounters with at-risk individuals through pre-arrest/pre-arraignment diversion programs.
- Explore additional ways to support people following a non-fatal overdose.

Courts/Judges can…

- Examine evidence about what works and what doesn't, including, but not limited to, harm-reduction literature, MOUD literature, outcomes for people with OUD in criminal justice settings, and effective treatment for OUD. (See *CDC's Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States* at ***https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf***)
- Align court treatment mandates with professional clinical evaluations and evidenced-based treatment.
- Apply best practices to drug court protocols (See the National Drug Court Institute's Drug Court Best Practice Standards at ***https://www.ndci.org/standards/***).

Prosecutors can…

- Explore implementation of pre-arrest/pre-arraignment diversion and deflection into treatment.
- Develop/expand court diversion into support services and/or clinically appropriate treatment.
- Ensure all court mandates include clinically appropriate treatment levels of care, including MOUD.
- Share seizure and other relevant data to address emerging threats.
- Train and equip frontline staff with naloxone.
- Improve the ways your agency personnel work with people with SUDs through education and training.
- Link people with SUDs to the appropriate support and/or treatment services.

Community Corrections (Probation/Parole) can…

- Share non-fatal overdose case information with a health partner for follow-up with patient consent.
- Improve the ways agency personnel work with people with SUDs through education and training.
- Link people with SUDs to appropriate support services and treatment.
- Respond to substance use violations with referrals to treatment rather than sanctions.

A3. PHAST Roles for Public Health Partners

Any Public Health Partner can…

- Be a champion for their jurisdiction's PHAST.
- Present any established evidence-based practices to reduce overdose deaths. (See CDC's Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States (***https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf***)
- Research and share innovative approaches and strategies shown to be effective in other jurisdictions.
- Examine and share jurisdiction-level data, analysis results, and monitoring trends with partners to consider context and implications of the data.
- Evaluate community-level efforts to reduce overdose deaths by establishing performance measures and encouraging shared accountability for outcomes achieved to help build the evidence base for specific prevention strategies.
- Collaboratively inform, educate, and empower communities through education campaigns and tools.
- Develop technology and information systems that can support crisis response and continuity of care for persons with Opioid Use Disorder (OUD).
- Partner with law enforcement to help foster community trust in local law enforcement.
- Work collaboratively with public safety partners to strategize opportunities for multi-sector interventions.
- Serve as a link between public safety and other sectors including behavioral health and mental health treatment services and the public and private healthcare sector.

Medical Officers can…

- Co-lead the jurisdiction's PHAST.
- Share data related to hospital admissions for overdose and substance use disorder to improve partners' shared understanding of overdose trends, local health needs, and identify emerging threats in the community.
- Inform and educate partners about substance use disorders and effective treatment approaches.
- Mobilize healthcare, behavioral, and mental health providers along with other PHAST partners to identify and solve health problems.
- Develop policies and plans that support community health efforts to reduce overdose deaths.
- Strategize with PHAST partners around opportunities to initiate or expand access to needed health care services.
- Collaborate with partners to evaluate the effectiveness, accessibility, and quality of population-based overdose prevention and OUD treatment services in the community.
- Research and share new insights and innovative solutions to overdose prevention in the community.

Program Managers can…

- Share program data related to overdose prevention, response, and treatment efforts with partners.
- Educate partners on existing evidence-based overdose prevention interventions and strategies in the community and observed successes and challenges.
- Explore opportunities to initiate, expand, or modify existing interventions to address gaps and/or unmet health needs.
- Share insights from frontline staff related to program successes, population-specific needs, and/or opportunities to address gaps and challenges in current programming.

Health Department Leaders and Directors can…

- Co-lead the jurisdiction's PHAST.
- Share data related to overdose and substance use disorders to improve partners' shared understanding of overdose trends.
- Inform and educate partners about evidence-based practices for overdose prevention.
- Mobilize public health and agency staff from other sectors to identify and solve health problems.
- Develop policies and plans that support community health efforts to reduce overdose deaths.
- Collaborate with partners to evaluate the effectiveness, accessibility, and quality of population-based overdose prevention and OUD treatment services in the community.

Researchers, Data Analysts, and Program Evaluators can…

- Analyze, present, and interpret overdose-related data to improve partners' shared understanding of local overdose trends.
- Identify key investigation questions to improve partner's understanding of the scope of the overdose crisis.
- Collaborate with partners to identify and address key data gaps and needs.
- Identify opportunities to improve or enhance data collection, analysis, or presentation.
- Collaborate with partners to identify performance measures, develop logic models, and establish evaluation plans to determine the effectiveness of existing interventions and make systematic improvements to advance health outcomes.
- Research and share new insights and innovative solutions to overdose prevention in the community.

A4. Tips for Securing Data Analytic Capability

Data analytic capability is important because a PHAST uses data and other intelligence gathered by multi-sector partners to gain a shared understanding of the local overdose crisis.

- If a jurisdiction has an existing overdose-related taskforce with a data workgroup, it may be restructured to place a greater emphasis on data analysis and use.
- Some jurisdictions may already have a centralized data analytics team that has access to existing public health or public safety data. Consider partnering with these organizations to gain access to data reports.
- Similar agencies may be able to pool their efforts to analyze data or rely on the best resourced among them to manage the data and conduct analyses, while the others may simply arrange for routine transfer of specific data files (this may require data sharing agreements[54]). For example, in NYC, each of the five counties has an independent prosecutor, but one office uses its resources to prepare the data for all five prosecutor offices. Agencies may also consider sharing an analyst's time across agencies.
- In communities with very limited resources, building data analytics capacity can be a challenge. In these cases, it may be possible to connect with experts at a local college or university or offer internships to graduate students.
- Teams should also consider changing resource needs over time. For example, PHAST activities may yield additional analytic and research needs, calling for additional funding. Agencies with extensive data sources may choose to invest in an internal data analysis unit as they consider new uses for these data. In addition, both quantitative and qualitative research may be needed to explain a local level phenomenon, or a new data surveillance or reporting system may be deemed necessary to help identify and respond to real-time needs. All these possibilities could warrant additional resources. A collaborative plan that lays out why the data would be used by PHAST stakeholders is critical to make the case for additional resources in grant applications.

B1. Sample Data Sharing Agreement

Data Sharing Agreement Template

Data Provider Agency:_____

Street Address: _____

City: _____ State:_____ Zip:_____

Data Recipient Agency:_____

Street Address: _____

City: _____ State:_____ Zip:_____

PURPOSE:

[DATA PROVIDER] and **[DATA RECIPIENT]** are entering into an agreement on **[DATE]** for the purpose(s) of:
[Please provide brief description of how these data will be used, and what the data being shared are being used to accomplish.] This agreement will terminate on **[DATE].**

DATA ELEMENTS:

[DATA PROVIDER] will provide the following information to **[DATA RECIPIENT]:**
Please provide a brief description of the data source and the exact data fields to be shared]

The above-specified data elements will be shared by **[DATA PROVIDER]** to **[DATA RECIPIENT]** on a one-time/recurring basis.
[Please describe whether data will be shared once or periodically over time. If periodically, please describe the frequency in which data will be shared or the process/protocols to determine frequency.]

AGENCY REPRESENTATIVES

[DATA RECIPIENT] will identify the following staff to serve as their "data custodian." The data custodian will have access to the specific data elements identified above, as shared by **[DATA PROVIDER]**. **[Please list staff first name, last name, position, phone, and email as well as identify whether they are the designated data custodian or, if applicable, a possible alternate.]**

This identified data custodian(s) from **[DATA RECIPIENT]** will be responsible for:

1. Receiving the above-specified data elements from **[DATA PROVIDER]**
2. Ensuring that the data are kept secured and that access to and use of the data are consistent with the terms of this agreement.
3. Reporting any compliance issues or data breaches to the **[DATA PROVIDER]** in accordance with the terms established in this Agreement.

[DATA PROVIDER] will identify the following staff to serve as their "data administrator" and alternate points of contact. The data administrator will transmit the specific data elements identified above to **[DATA RECIPIENT]**. Alternatives are possible and are also identified below.
[Please list staff first name, last name, position, phone, and email as well as identify whether they are the designated data administrator, if applicable, a possible alternate.]

This identified data administrator(s) from **[DATA PROVIDER]** will be responsible for:

1. Transmitting the above-specified data elements to **[DATA RECIPIENT]** or granting appropriate access to the designated data custodian.
2. Ensure that the data transmitted to the **[DATA RECIPIENT]'s** agency are consistent with the purpose and terms of this agreement.

All communication between the designated data administer and designated data custodian shall:
[Please describe the standard process for communication between parties; e.g., be providing in writing through email.]

DATA SECURITY AND CONFIDENTIALITY

[DATA PROVIDER] and **[DATA RECIPIENT]** will establish appropriate administrative, technical, procedural and physical safeguards to assure the confidentiality and security of the shared data elements through the following agreements:

1. Data transferred pursuant to the terms of this Agreement shall be utilized solely for the purposes set forth in this Agreement.
2. **[DATA PROVIDER]** will establish and implement secure data transmission to **[DATA RECIPIENT]** by:
   [Please describe the process in which data will be transmitted between the two parties. How will data be shared? Will this transfer occur physically or electronically? What security protocols are in place to maintain confidentiality?]
3. **[DATA RECIPIENT]** will establish the following safeguards to maintain the security and confidentiality of the specified data elements:
   [Please describe how the DATA RECIPIENT will maintain confidentiality and security. What protocols will be in place? How will the data be stored?]
4. The specified data elements provided in this agreement are subject to the laws applicable to the **[DATA RECIPIENT].** Accordingly, **[DATA RECIPIENT]** agrees to maintain, store, protect, archive and/or dispose of the specified data elements in accordance with applicable law.
5. **[DATA RECIPIENT]** and **[DATA PROVIDER]** will follow standard protocols and procedures for the use, management, and custodial responsibilities of data elements that are HIPAA protected.
6. **[DATA RECIPIENT]** will not release data to a third party without prior approval from **[DATA PROVIDER].**
7. Data transferred to **[DATA RECIPIENT]** by **[DATA PROVIDER]** shall remain the property of **[DATA PROVIDER].** Accordingly, **[DATA RECIPIENT]** agrees that at the termination of this contract, all specified data elements shared by **[DATA RECIPIENT]** will be:
   [Please describe process for how data will be returned to [DATA PROVIDER] or describe the process for destroying shared data elements. Consider the time period for when data needs to be returned or destroyed.]

8. If at any time **[DATA RECIPIENT]** or **[DATA PROVIDER]** determines that there has been a breach of security protocols or violation of this Agreement, both Parties shall promptly take reasonable steps as are necessary to prevent any future breaches including:
[Please describe the process for responding to a data breach or security violation.]

REPORTING OF DATA USED IN PUBLICATIONS AND PRESENTATIONS

[DATA RECIPIENT] will not share, publish, or otherwise release any findings or conclusions derived from analysis of data obtained by the **[DATA PROVIDER]** without prior approval from **[DATA PROVIDER.]**

[DATA RECIPIENT] agrees to allow **[DATA PROVIDER]** no more than **[##]** days to review and provide comment for consideration on papers, reports, publications, or presentations that **[DATA RECIPIENT]** plans to submit for publication or presentation.
[Consider if there are any restrictions on how the data or data findings can be used.]

SIGNATORIES

The undersigned individuals represent that they have competent authority on behalf of their respective agencies to enter into the obligations set out in this Agreement. Signature indicates that an understanding of the terms of this Agreement and an agreement to comply with its terms, to the extent allowed by law.

DATA PROVIDER

Signature: _____

Printed Name: _____

Title: _____

Organization: _____

Date: _____

DATA RECIPIENT

Signature: _____

Printed Name: _____

Title: _____

Organization: _____

Date: _____

B2. Sample Memorandum of Understanding[55]

SAMPLE MEMORANDUM OF UNDERSTANDING

INTERAGENCY COORDINATION, COLLABORATION & FUNDING

AGREEMENT ("Agreement") made by and between LEADERSHIP ENTITY A, having its principal office at LOCATION OF LEADERSHIP ENTITY A and the LEADERSHIP ENTITY B and having its principal office located at LOCATION OF LEADERSHIP ENTITY B.

The goal of this memorandum is to outline the collaboration and coordination of efforts between the ENTITY A and ENTITY B in their partnership to reduce overdose deaths within JURISDICTION.

EXPERTISE AND MISSIONS

Add brief overview on each signatory agency. Agency overview, mission, and commitment to addressing overdose, etc.

BACKGROUND & PURPOSE

Whereas, ENTITY A and ENTITY B therefore enter this agreement to maximize public safety and neighborhood/individual wellness through improved joint planning, accountability, coordination and oversight of our overdose reduction efforts.
Whereas, ENTITY A and ENTITY B agree to the following guiding principles to:

1. Support a Public Health/Public Safety collaborative aiming to improve public safety and community wellness.
2. Recognize the respective responsibilities and missions of each agency, and that neither agency is an agent of the other.
3. Acknowledge that booking, prosecuting and jailing individuals committing low-level offenses related to mental illness, drug use, chronic homelessness and other health and wellness issues has limited effectiveness in improving public safety.
4. Agree that people experiencing a health-, mental health-, or substance-related crisis should be supported and managed in the most appropriate manner, and by the most appropriate agency.
5. Acknowledge harm reduction as a proven public health philosophy and intervention for a broad range of health-, mental health-, and substance-related conditions.
6. Recognize and commit to improving racial equity in all initiatives.
7. Encourage information and data sharing when necessary and in the public interest, when in accordance with all applicable federal, state, and local laws, rules and regulations and agency restrictions.
8. Commit to optimize the use of inter-disciplinary training and team building.
9. Commit to measure and evaluate outcomes and impacts toward reaching shared goals.
10. Agree to a partnership approach to policy formulation and public messaging/press as relates to shared programs/initiatives.
11. Ensure that the shared programs/initiatives cited in this document perform in accordance with these agreed upon principles, the terms of this agreement, and any agreed upon policies and procedures governing the specific program.

12. Commit to work across organizational boundaries in achieving these intentions.

NOW THEREFORE, upon the mutual agreement of the parties, it is agreed as follows:

1. **TERM.**
   State the term of the agreement or state it will be in effect until terminated by one or both parties.

2. **SCOPE OF SERVICES.** ENTITY A and ENTITY B shall provide the scope of services as set forth under the current MOUs between the parties, unless terminated earlier by either party in accord with provisions set forth in the respective MOUs.
3. **GOVERNANCE AND OVERSIGHT**
   A. In an effort to ensure that the shared guiding principles and programmatic aims are met, the parties agree to:
      i. Establish a PHAST Leadership Team, an inter-agency oversight body, which will be co-led by the both the Commissioner/Lead Executive of ENTITY A and the Commissioner/Lead Executive of ENTITY B.
         i. The PHAST Leadership Team shall be comprised of the Commissioner/Lead Executive of ENTITY A (or designee), the Commissioner/Lead Executive of ENTITY B (or designee), and a member(s) of each programmatic management team (to be appointed by the respective agency commissioners).

      ii. Have equal authority and decision making for all joint programs/initiatives.

4. **INFORMATION SHARING, CONFIDENTIALITY & RECORD KEEPING**

   A. Information Sharing. PHAST Leadership Team members may request and share information from/with the PHAST, in accordance with applicable laws, rules, regulations and data use agreements, if applicable.

   B. Confidentiality of Records. ENTITY A and ENTITY B agree to hold all individually identifiable information obtained, learned or developed under, or in connection with, this Agreement confidential in accordance with applicable federal, state, and local laws, rules and regulations and, where applicable, ENTITY A and ENTITY B confidentiality procedures. The provisions of this Section shall remain in full force and effect both during and after any termination of this Agreement.

   C. Record Keeping.

      i. ENTITY A and ENTITY B shall retain all books, records and/or other documents relevant to this Agreement for a period of six (6) years after the termination of this Agreement. In accordance with applicable law, rules and regulations, any Federal, State or City auditors and any person duly authorized by the payor (ENTITY A or ENTITY B, as established in any and all Agreements between the parties) shall have full access to, and the right to examine, any books records and documents that are necessary to certify the nature and extent of costs associated with the program.

The provisions of this Section shall remain in full force and effect both during and after any termination of this Agreement.

ii. ENTITY A and ENTITY B shall comply with respective agency record keeping policies and procedures, if applicable.

5. **MEDIA & PUBLIC MESSAGING**. ENTITY A and ENTITY B each agree not to use the name of the other in any public information without permission.

6. **MONITORING AND EVALUATION.** ENTITY A and ENTITY B, under the governing structure outlined in Section 3 (A)(i) above, shall be responsible for monitoring, auditing, and evaluating the joint PHAST services. The parties shall also be responsible for monitoring, auditing, and evaluating that the joint PHAST program initiatives are in accord with the programmatic aims and guiding principles as provided under this Agreement. As to funded initiatives, if applicable, the receiving Department (payee) shall submit program and fiscal reports in the manner and format prescribed by the funding Department (payer).

7. **MODIFICATION AND AMENDMENT.** This Agreement may only be modified and/or amended in writing, as mutually agreed upon by ENTITY A and ENTITY B.

8. **ASSIGNMENT.** ENTITY A and ENTITY B shall not assign, transfer, convey or otherwise dispose of this Agreement to any other person, or the right to execute it, or the right, title or interest in it or any part of it, or assign, by power of attorney or otherwise, any of the monies due or become due under this Agreement, without the prior, written consent of both Commissioners.

9. **TERMINATION**.

A. This Agreement may be terminated:
   i. Without cause, by either party upon sixty (60) days' written notice to the other party.

B. Program Termination. In the event that a program/initiative is to be terminated and there are contractual funding agreements in place, the payee will submit a program close-out plan and a proposed close-out budget to the payer within thirty (30) days prior to closing, unless the program is terminated under section 9 (A) of this Agreement.

10. **CIVIL ACTIONS.** The parties recognize that during civil actions against PHAST and the JURISDICTION and in criminal prosecution, attorneys for the parties involved have attempted to subpoena PHAST records in the possession of JURISDICTION Agencies that they could not lawfully obtain directly from PHAST. The parties agree that when they are in receipt of a subpoena duces tecum for PHAST records contained in the joint PHAST program/initiative databases, the receiving party shall notify the Legal Bureau or Office of General Counsel of the other agency. In a matter where the City is a party, the receiving party shall also notify the Law Department or other City legal oversight entity.

11. **NOTICES.** All notices and requests under this Agreement by either party shall be in writing and directed to the address of the parties as follows:

    Notices to ENTITY A shall be mailed to: Notices to ENTITY B shall be mailed to:

12. Nothing in this Memorandum shall be interpreted to restrict the ability of any signatory to exercise any procedure right or remedy available to it by law.

13. **Entire Agreement**. This MOU represents the whole agreement of the parties hereto with respect to the subject matter contained herein. No other agreement, oral or written, regarding the subject matter of this Agreement will be deemed to exist or to bind any of the Parties or to vary any of the terms contained herein.

IN WITNESS WHEREOF, the parties hereby execute this Agreement on the date set opposite their respective signatures.

ENTITY A

_____

NAME
Authorized Public Safety
Leader Affiliation

Dated: _____

_____

NAME
Authorized Public Safety
Leader Affiliation

Dated: _____

B3. Resources for Developing MOUs, DUAs, and DSAs

Disclaimer: 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.

Centers for Disease Control and Prevention
Standards to Facilitate Data Sharing and Use of Surveillance Data for Public Health Action
(***https://www.cdc.gov/nchhstp/programintegration/sc-standards.htm***)

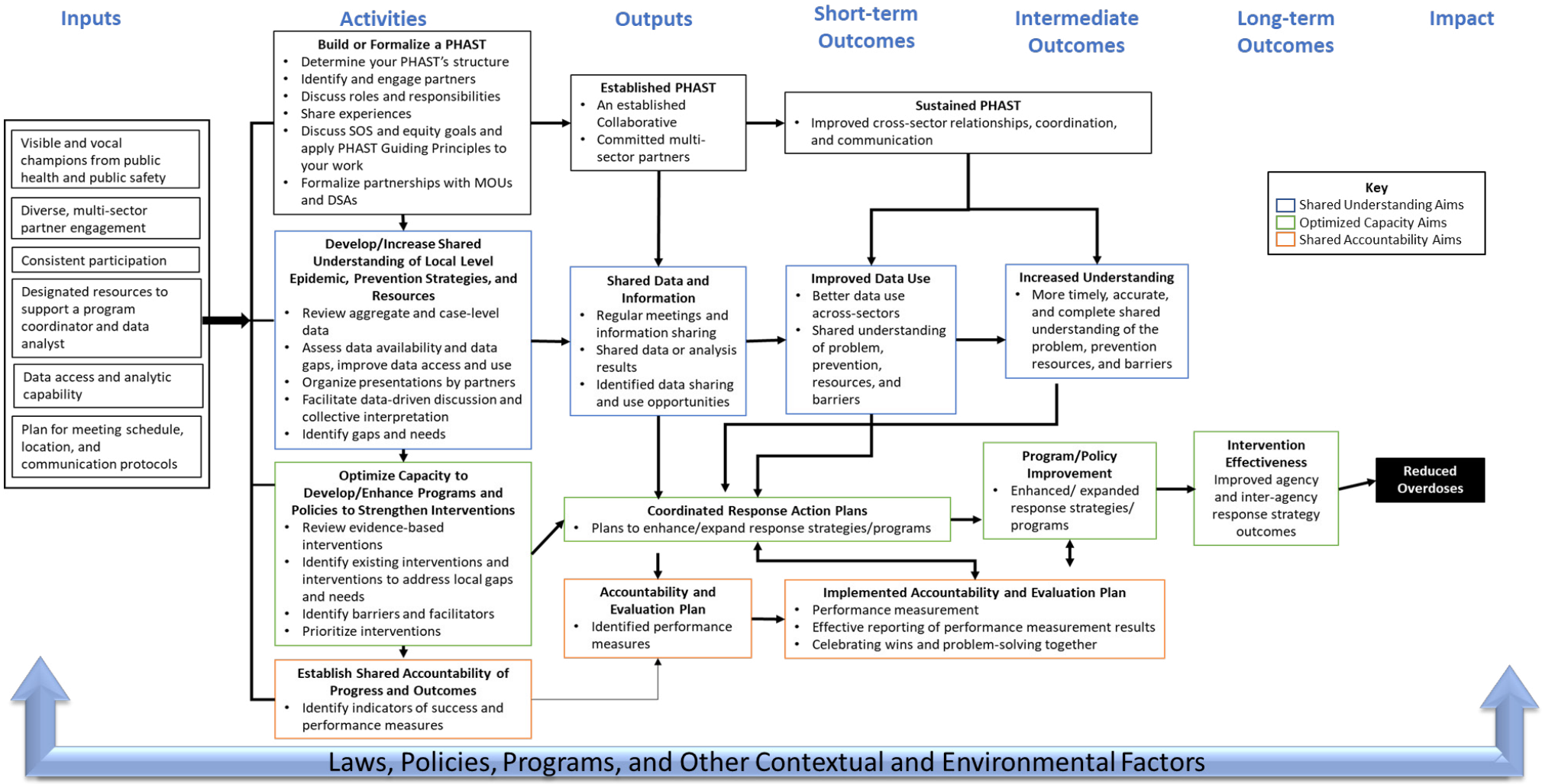
Community Tool Box
Understanding and Writing Contracts and Memoranda of Agreement
(***https://ctb.ku.edu/en/table-of-contents/structure/organizational-structure/understanding-writing-contracts-memoranda-agreement/main***)

Actionable Intelligence for Social Policy
Introduction to Data Sharing and Data Integration
(***https://www.aisp.upenn.edu/wp-content/uploads/2020/06/AISP-Intro-.pdf***)

Leveraging Data Sharing for Overdose Prevention
Legal, Health and Equity Considerations (ChangeLab Solutions June 2020)
(https://www.changelabsolutions.org/sites/default/files/2020-07/LeveragingDataSharingforOverdosePrevention_accessible_FINAL_20200707.pdf)

Centers for Disease Control and Prevention
Leveraging Prescription Drug Monitoring Program (PDMP) Data in Overdose Prevention and Response
(https://www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf)

C1. PHAST Logic Model



C2. Sample PHAST Monthly Partner Meeting Agenda

Date
Time
Location
[Special Building Entry Instructions] (if necessary)

Time	Agenda Item	Facilitator/Presenter
5 mins	Partners Sign-in	Coordinator
10-15 mins	Presentation on overdose data – These could be standing templates that are created (data placemats, handouts, or PowerPoint).	Coordinator/Leadership Team
-	• Data presentation of overdose deaths/total deaths from past month or past 6-12 months	Coroner/Health Department
-	• Simple report out on any other non-fatal overdose data	Health Department
-	• Simple report out on naloxone administration data	Health Department
-	• Simple report out on any criminal justice/corrections/ community corrections data	Criminal Justice/Corrections/ Probation & Parole
-	• Simple report out on law enforcement data	Sheriff/Police Chief
-	• Simple report out on any emergency medical services or hospital data	Hospital/EMS/Health Department
25 mins	Program/initiative Presentation (rotate monthly) • Program name • Key stakeholder agencies/partners implementing the initiative • Purpose/objectives • Measures of success – how we will know if it's working • Results (if any) • Challenges/barriers (could be anticipated)	Lead person in charge of program/ initiative
30 mins	Q&A/Discussion – coordinator or leadership team have questions prepared ahead of time in case other attendees do not have any. • What would make this initiative easier to implement? What might get in the way? What happens before? What type of follow-up is needed? • What recommendations/strategies arise (note those requiring follow-up, and assign person responsible for reporting out progress at next meeting's News to Share)	Member of PHAST Leadership team or Coordinator
10 mins	Updates on previous meeting's "follow-up items" and News to Share (from any partners)	Coordinator/All Partners
5 mins	Reminder of next meeting's date and agenda items	Coordinator

C3. Sample PHAST Quarterly Overdose Fatality Review (OFR) Summary and Recommendations Partner Meeting Agenda

Date
Time
Location
[Special Building Entry Instructions] (if necessary)

Time	Agenda Item	Facilitator/Presenter
5 mins	Partners Sign-in	Coordinator
10-15 mins	Presentation on overdose data – These could be standing templates that are created (data placemats, handouts, or PowerPoint).	Coordinator/Leadership Team
-	• Data presentation of overdose deaths/total deaths from past month or past 6-12 months	Coroner/Health Department
-	• Simple report out on any other non-fatal overdose data	Health Department
-	• Simple report out on naloxone administration data	Health Department
-	• Simple report out on any criminal justice/corrections/community corrections data	Criminal Justice/ Corrections/Probation & Parole
-	• Simple report out on law enforcement data	Sheriff/Police Chief
	• Simple report out on any emergency medical services or hospital data	Hospital/EMS/Health Department
25 mins	Overdose Fatality Review Team Update and Discussion • Number of cases reviewed since last report-out • Of cases reviewed: Shared risk factors for overdose, including any patterns and trends • Of cases reviewed: Intervention and systems-level failures and gaps • Describe process for how cases were/are/will be selected (Is there a need to reexamine case selection criteria? Have recent overdose data revealed spikes in key geographic areas, involving specific substances, or a specific population?) • New recommendations • Updates: Recommendation workplan, progress, and status updates	OFR Coordinator

Time	Agenda Item	Facilitator/Presenter
30 mins	Q&A/Discussion – coordinator or leadership team have questions prepared ahead of time in case other attendees do not have any. • What gaps and needs have been revealed through the data? • How do recommendations proposed by the OFR team address local gaps and needs? How do they align with other recommendations or strategies that have emerged during this meeting? Are there other recommendations that can be made? • Which recommendations should be prioritized based on the PHAST's prioritization criteria? • What are the barriers and facilitators to implementing prioritized recommendations? What would make this intervention easier to implement? What might get in the way? What happens before? What type of follow-up is needed? • What are next steps? Is more partner engagement needed? Are partners ready to develop an implementation plan? (note those requiring follow-up, and assign person responsible for reporting out progress at next meeting's News to Share)	Member of PHAST Leadership team or Coordinator
10 mins	Updates on previous meeting's "follow-up items" and News to Share (from any partners)	Coordinator/All Partners
5 mins	Reminder of next meeting's date and agenda items	Coordinator

C4. Data Inventory Table

Key Investigation Question	How is this information typically used?	Who (name/ agency) has the data to answer this question?	If data are available	If data are unavailable		Additional questions	Possible data sources to consider
			How will this data be shared with PHAST?	List potential data sources to explore	Current status or updates		
What is the opioid-involved overdose death rate in our jurisdiction?	To track cases of overdose death longitudinally	*Example: Chief Lee from City Fire Department*	*Example: Chief Lee will present annual and monthly data at each PHAST meeting using simple data presentation.*			*Example: Is it possible to examine data by age group?*	Confirmed: State Unintentional Drug Overdose Reporting System (SUDORS), which captures detailed information on toxicology, death scene investigations, route of administration, and other risk factors that may be associated with a fatal overdose Local and state health departments Provisional: National Vital Statistics System (provisional counts for drug overdose deaths occurring within the 50 states and the District of Columbia.) The counts represent the number of reported deaths due to drug overdose occurring in the 12-month period ending in the month indicated.
Where are overdose deaths happening in our jurisdiction?	To determine geographical high-burden areas and target interventions			*Example: Contact agencies in County using ODMAP. (County Police, County Department of Public Safety, Office of the County District Attorney)*	*Example: Chief Lee will lead outreach and will report back in April.*		Medical examiner/coroner suspected overdose data Overdose Detection Mapping Application Program (ODMAP), an overdose mapping tool that provides real time suspected overdose data in local and surrounding jurisdictions

Key Investigation Question	How is this information typically used?	Who (name/ agency) has the data to answer this question?	If data are available	If data are unavailable		Additional questions	Possible data sources to consider
			How will this data be shared with PHAST?	List potential data sources to explore	Current status or updates		
What is the non-fatal overdose rate?	To track non-fatal overdose occurrences longitudinally (for surveillance)						State health department's syndromic surveillance data (from emergency departments) – does not include individuals who decline transfer to emergency department post overdose
Are we seeing a spike in overdoses or overdoses involving a specific substance or specific combination of substances?	To identify spikes for early detection of emerging threats and rapid response						Coroners observations/reports Increase in 911 calls related to overdose Sharp increase in EMS treating suspected overdoses and reversing opioid overdoses with naloxone (May be tracked and monitored through ODMAP) Hospital Emergency Departments report large numbers of overdoses presenting Police report increase in illicit drug seizures or rapid increases in illicit drug seizures containing a new type of synthetic opioid such as fentanyl analogs, or synthetic opioids that may be new to this region/jurisdiction. Medical examiners/coroners noting a sharp increase in overdose deaths

Key Investigation Question	How is this information typically used?	Who (name/ agency) has the data to answer this question?	If data are available	If data are unavailable		Additional questions	Possible data sources to consider
			How will this data be shared with PHAST?	List potential data sources to explore	Current status or updates		
Who is overdosing and in need of care, treatment, support services? What is the breakdown of race, ethnicity, and gender? How do overdoses vary by individual neighborhood, city, or zip code?	To target interventions and response efforts by population						State health department's syndromic surveillance data (from emergency departments) EMS/Emergency responder data Client records from harm-reduction service providers Treatment service requests Medical examiner/coroner suspected overdose data (may be an entry-point to connect with family or friends who may be at risk of overdose or a way to identify high-risk populations) Inmate release information (to provide further supports to this high-risk group)
What are the limitations in the current overdose prevention services? Who has the least access to treatment or recovery support services? Do access barriers vary by region? Population? Insurance? Age group? Other factors?	To improve effectiveness of interventions aimed at reducing overdose; To identify equity issues in access						Treatment service records including waitlists, retention, and reasons for drop out Community surveys and client records by harm-reduction providers Pharmacy records on naloxone distribution Focus groups or interviews with community members impacted by the overdose crisis and people in recovery

Key Investigation Question	How is this information typically used?	Who (name/ agency) has the data to answer this question?	If data are available	If data are unavailable		Additional questions	Possible data sources to consider
			How will this data be shared with PHAST?	List potential data sources to explore	Current status or updates		
What are the local trends in illicit drug use?	To identify treatment and harm-reduction needs						Law enforcement drug seizure data Community surveys by harm-reduction providers
What is in the local drug supply? What types of illicit drugs are commonly used? What types of illicit drugs are being seized by law enforcement? Are there any adulterants present in these illicit drugs that have the potential to cause serious health issues?	To anticipate increased risks among people who use drugs						Law enforcement drug seizure data, possession arrests Community surveys by harm-reduction providers
What are the local opioid prescribing practices/trends?	To anticipate potential risks among people who use prescription opioids, benzodiazepines, etc.						Prescription Drug Monitoring Program (PDMP) data

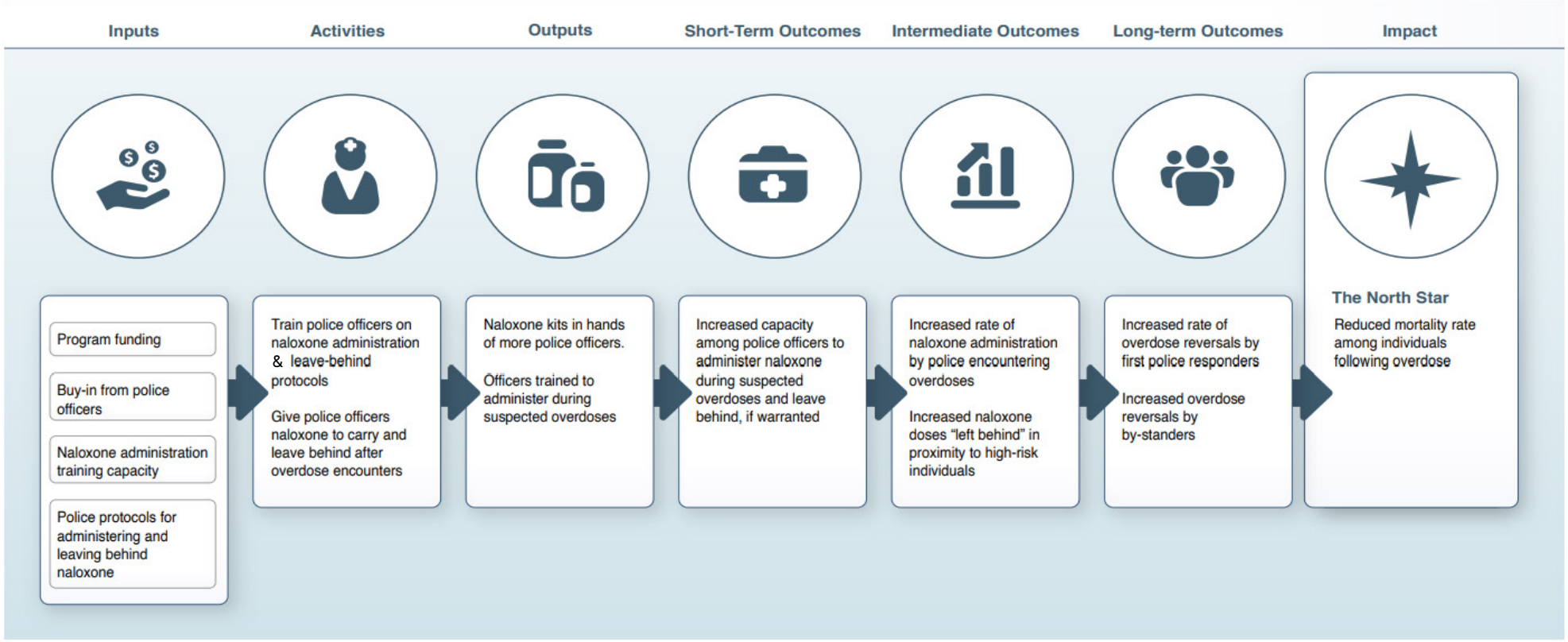
Key Investigation Question	How is this information typically used?	Who (name/ agency) has the data to answer this question?	If data are available	If data are unavailable		Additional questions	Possible data sources to consider
			How will this data be shared with PHAST?	List potential data sources to explore	Current status or updates		
What opioid overdose prevention programs or interventions are currently available? What efforts have the community taken to prevent overdoses? How well do they align with evidence-based practices? (Please refer to Module 3: Review Evidence-based interventions and promising practices)	To determine potential service gaps and opportunities for coordinated interventions						Local health departments Local advocacy organizations Behavioral health agencies, treatment providers, and medical providers
What are the different "pathways" to treatment in our community? What happens to people before, during, and after we interact with them?	To determine potential service gaps and opportunities for coordinated interventions						Local health departments Local advocacy organizations Behavioral health agencies, treatment providers, and medical providers Surveys with people who have received treatment and are in recovery Interviews or focus groups with community members impacted by overdoses
What is driving the overdose epidemic in our jurisdiction?	To identify root causes and drivers in the local community						

C5. Inventory of Evidence-based Interventions Template

PROGRAMS/ INTERVENTIONS	**Program Description (include programmatic goals)**	**Organization in Charge**	**Geographic Reach**	**Populations Served**	**What Local Gap, Need, or Challenge Does this Address?**	**Evidence of Success (How well is it addressing a gap, need or challenge?)**	**Limitations/ Barriers**	**Facilitators**
Harm Reduction (e.g., SSPs[1], Overdose Education and Naloxone Distribution, Drug Testing)								
Program 1								
Program 2								
Diversion (e.g., Pre-arrest diversion, safe stations, 911 Good Samaritan Laws)								
Program 1								
Program 2								
Support for/access to treatment and recovery (e.g., Safe stations, pre-arrest diversion, post-overdose outreach, quick response/overdose response teams, Buprenorphine initiation, telemedicine, peer recovery programs)								
Program 1								
Program 2								
Opioid use disorder health services for justice-involved populations (e.g., MOUD[2] provided during incarceration, services before and during re-entry, probation or parole)								
Program 1								
Program 2								

1 Syringe Services Programs
2 Medication for Opioid Use Disorder

C6. Logic Model for Expanding Naloxone Administration Capacity Among Police Officers



C7. Problem-solving Models

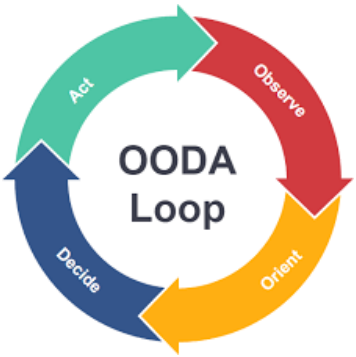
Moving from data to action requires partner engagement and commitment to developing a shared understanding of the local-level overdose crisis, identifying obstacles and challenges, and strategizing and implementing solutions. This problem-solving process can be distilled into four key steps:

1. Making sense of the data to understand local needs (What do we know?)
2. Determining priorities to address gaps and needs (What should we do?)
3. Design, adapt, and implement an intervention (Act quickly)
4. Monitor progress and outcomes (If it works do more of it; if not, make improvements)

These four steps are embedded in many problem-solving models some PHAST partners may already be familiar with. Therefore, a PHAST may find it helpful to describe the problem-solving process using these existing models or processes. Here, we describe three examples.

OODA Loop

The **OODA Loop** is an iterative 4-step model to aid decision-making that stands for "Observe, Orient, Decide, and Act." It was originally developed as a strategy among fighter pilots to make quick, rational decisions based on observations, allowing for rapid adjustments and adaptations. It is most commonly used by the military and law enforcement.



- **Observe** – Collect data and consider new sources of information. What are the gaps in the system? What does it mean? Is this part of a larger pattern?
- **Orient** – Analyze, evaluate, and prioritize the information. What conclusions can you draw? How are you approaching the information? Is there a different way of looking at the information?
- **Decide** – Determine what is the most appropriate response based on the information you have. What intervention might address this gap? What is your hypothesis?
- **Act** – Implement your intervention. Test your hypothesis. Was it correct?

Once the first loop is complete, you gather observations to understand the impact and consequences of your intervention and the cycle restarts.

PDSA Cycle

Plan, Do, Study, Act or PDSA is an iterative 4-step model for rapid process improvement and testing change originally developed to drive improvement in business and manufacturing. Its use has since expanded to include a variety of sectors, including public health.

- **Plan** – What problem are you trying to solve? What solution do you want to test? What do you expect to happen? What data are you going to collect? How will you know if it's working?
- **Do** – Implement the intervention; collect data.
- **Study** – Analyze data. What did you learn? Was it successful? How do you know?
- **Act** – Make adjustments. If it works, do more of it; if it didn't work, do something differently.

The decision made in the "act" phase determines the next planning phase. If the intervention works, you may re-examine its impact over time while also identifying additional improvements that can be made. If the intervention was unsuccessful, you may choose to develop a different plan to reach your desired outcome. In both scenarios, the cycle continues.

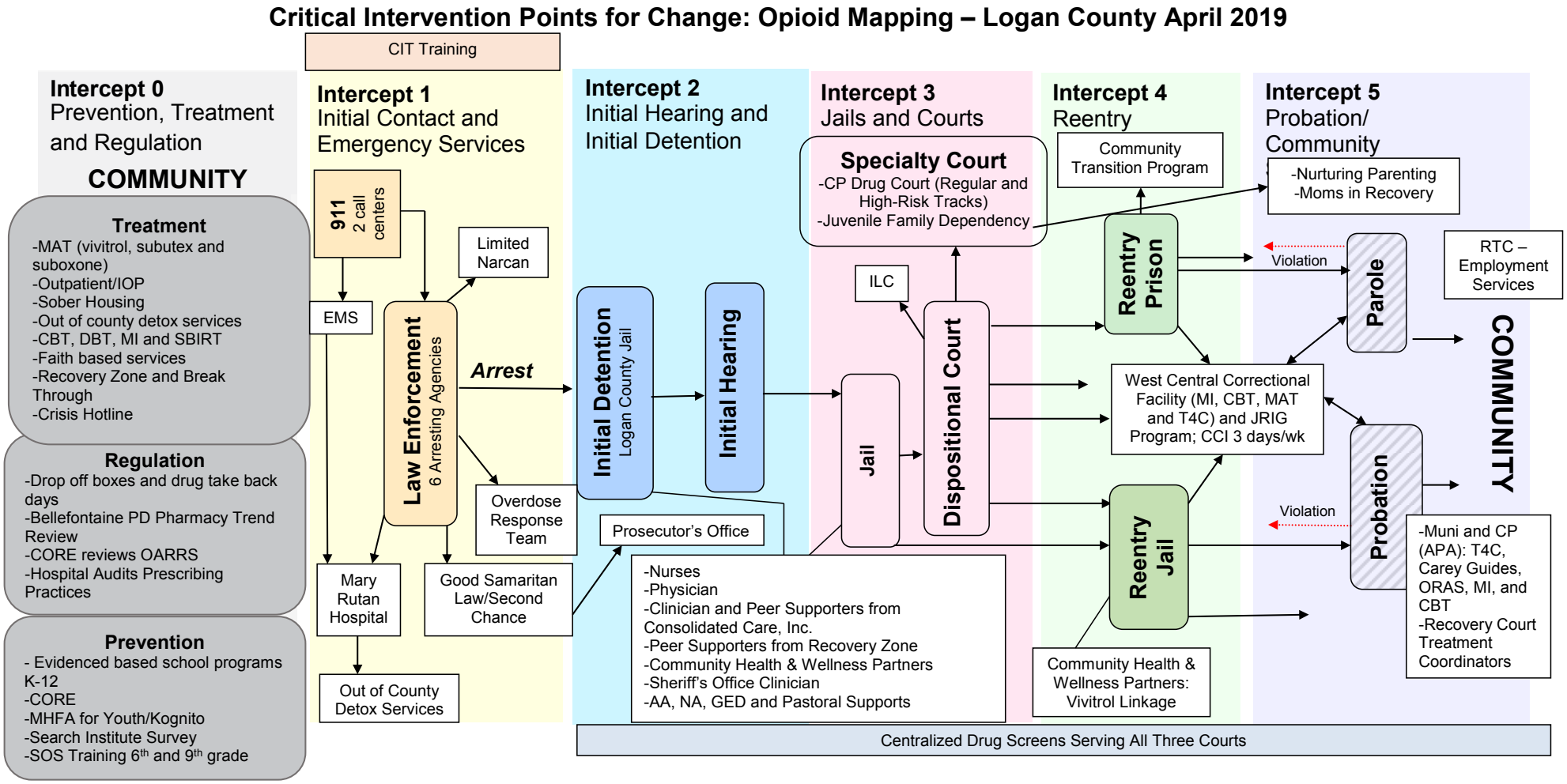
SARA Model

The SARA model grew out of problem-oriented policing and is a common problem-solving strategy that forms the basis of many police training programs.

- **Scanning** – Identify and prioritize problems that need to be addressed. Determine scope of the problem.
- **Analysis** – Develop an understanding of the problem, its root causes and factors that lead to it. Identify any additional data that is still needed.
- **Response** – Select and implement an intervention to address the identified problem.
- **Assessment** – Collect and analyze data to determine if the intervention was successful.

Similar to the OODA Loop and the PDSA Cycle, information collected in the Assessment phase can be used to inform the next Scanning phase leading to a decision to change the response, improve data analysis, or redefine the problem.

D1. Critical Intervention Points for Change: Opioid Mapping – Logan County April 2019



D2. Examples of Local Promising Practices

Throughout the evolving overdose crisis, a number of evidence-based strategies and interventions have been developed. In addition, several promising practices, which have some data showing positive outcomes, but do not have enough evidence to support generalizable conclusions, have also emerged. The examples provided here include both evidence-based interventions and promising practices that have been implemented by multi-sector teams in local jurisdictions across the United States.

Safe Stations (Annapolis and Anne Arundel County, MD)

At any time, a local resident who is struggling with a substance use disorder can go to any Annapolis or Anne Arundel County Police or Fire Station and request assistance. Upon arrival to a Safe Station, the Public Safety Officer at the station will inquire about any other medical conditions that may require the individual to be transported to the hospital. If transport is needed, the person will be met by the Mobile Crisis Response Team (MCRT) at the hospital. If no additional medical treatment is required, the Public Safety Officer will call the MCRT team and when they arrive at the Safe Station, they will begin their evaluation. The MCRT is solely responsible for evaluating and determining the path of treatment. Individuals seeking assistance will be asked if they are in possession of any weapons or drugs. If so, local law enforcement will be notified and will come to the safe station to take the custody of the items only. The program is a cooperative effort by all levels of government.

Resource: ***https://www.aacounty.org/departments/sao/rehab-programs/safe-stations/***

Peer Support Specialist Warm Hand-off Program (Lancaster and York/Adams Counties, PA)

Peer Support Specialists are people living in recovery with a mental illness and/or a substance use disorder and who provide support to others who can benefit from their lived experiences. RASE, which stands for Recovery, Advocacy, Service, Empowerment, is a Recovery Community Organization, which means that it is comprised entirely of staff and volunteers from the Recovery Community and it exists to serve the Recovery Community, defined by the program as any person in, or seeking recovery, their families, close friends and other loved ones. RASE facilitates Warm Hand Offs for Overdose Survivors (WHOS) programs in hospitals throughout Lancaster and York/Adams Counties. These WHOS programs utilize Certified Recovery Specialists, called WHOS Responders, who respond to Emergency Room calls whenever someone is revived from an overdose with naloxone.

Resource: RASE Warm Hand Off for Overdose Survivors (WHOS) Program | Recovery Community Organization Lancaster PA at ***https://raseproject.org/whos/***

Quick Response Teams (North Carolina)

Post-overdose response teams (PORTs; also called Quick Response Teams, Rapid Response, Community Response Teams, etc.) are an emerging strategy to meaningfully engage with people who have experienced overdose. These teams follow up with patients who have experienced an overdose within 72 hours. Teams seek to link the patient with appropriate care ranging from harm-reduction services to treatment to recovery supports.

Resource: Post-Overdose-Response-Toolkit.pdf at ***https://files.nc.gov/ncdhhs/Post-Overdose-Response-Toolkit.pdf***

Jail Diversion Program (Anne Arundel County, MD)
A Jail Diversion program was established in January 2015 to augment the Anne Arundel County Mental Health Agency's Crisis Response System. The program was initiated at the Jennifer Road Detention Center where pre-trial individuals are detained and serves individuals who are: in pre-trial status, charged with a misdemeanor, and have screened positive for a behavioral health disorder. Individuals who participate in the program must be willing to receive community-based services upon release. Once the individual is referred to the program, the Jail Diversion Specialist screens them. If the individual is accepted in the program, a plan of care is developed and submitted to the judge for review at the 1:00 p.m. docket. If the attorney and the judge approve the plan, the individual is released the same day and the plan of care is implemented. This plan includes strategies to address housing needs, mental health and substance use disorder treatment, physical health, and attainment of benefits. The individuals can receive services for up to 90 days post-release and they are then transitioned into services in the public behavioral health system or other programs if they are privately insured.

Resource: Anne Arundel County Mental Health Agency, Inc. Crisis Response System at ***http://www.aamentalhealth.org/crisisresponsesystem.cfm***

Overdose Education and Naloxone Distribution (OEND) in Criminal Justice Settings (San Francisco, CA)
In recognition of a population that is at high risk for opioid overdose after release from incarceration, San Francisco County Jail OEND Program first began as a pilot program delivered to one pod in 2013 through a collaboration with Jail Health Services (JHS) and the Drug Overdose Prevention and Education (DOPE) Project. It has since expanded to the entire jail.

Jail Health Services determines who is being released within the next 30 days on a monthly basis, and all identified individuals soon to be released are invited to attend the OEND training. Jail Health Services has been trained on OEND by the DOPE Project. After watching the "Staying Alive on the Outside" video and discussing overdose prevention, recognition, and reversal with staff, participants indicate whether they would like naloxone to be placed in their personal property. Upon release, those who received naloxone meet with JHS to review how to administer naloxone.

Resource: A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons at ***https://harmreduction.org/wp-content/uploads/2020/09/A-primer-for-implementation-of-OEND-in-jails-and-prisons-Wenger-2019-RTI.pdf***

MAT in Criminal Justice Settings (Camden County, NJ)
In 2018, the Camden County Jail first announced the Medication Assisted Treatment (MAT) program to help incarcerated individuals with a substance use disorder. The MAT program evaluates every individual upon entry to the facility for a range of mental health and substance use disorders including opioid and alcohol use disorder. Individuals who screen positive for a substance use disorder can then choose to participate in the MAT program, where they begin receiving treatment inside the jail. After leaving the jail, all successful program participants will be connected with Project H.O.P.E. (a nonprofit organization dedicated to improving the health and wellness of those in need) and either the Volunteers of America (VOA) Safe Return Program or the Camden County Co-Occurring Reentry Program, for reentry services and continued medical treatment and counseling.

Resource: Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit at ***https://www.thenationalcouncil.org/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons/***

Innovative Data Use Strategy to Enhance a Crisis Response Unit (Manchester, NH)

New Hampshire ranked third among U.S. states for the most overdoses in 2019. Manchester is at the epicenter of this epidemic, with 13.5% of all overdose fatalities, despite comprising only 8.3% of the State's total population. A PHAST leadership team, represented by the Manchester Police Department and Manchester Health Department, collaboratively applied for, and were awarded, a federal grant from the University of Baltimore's Center for Drug Policy and Prevention to fund their Crisis Response Unit: United in Harm Reduction. This expanded program will be using a combination of spatial mapping through ODMAP and social network analysis from Police Department reports to identify high-risk and high-influence individuals for proactive, targeted intervention in the city. The goal of the approach is to connect with individuals pre-overdose, as well as post-overdose, to prevent or mitigate the risk of a fatal overdose. Outreach to identified individuals is conducted by the Manchester Fire Department with support from the Health Department. Resources will include: linkages to care (access to Safe Station, MAT, physical care, mental health care, food, housing, etc.), Leave Behind Kits (naloxone, overdose prevention materials and training, community resource listings), and fatality prevention resources (e.g., warm weather gear).

Resource: Center for Drug Policy and Prevention Announces Eight Awardees Across Seven States for Community-Based Overdose Reduction Program Grants at ***https://www.ubalt.edu/news/news-releases.cfm?id=3655***

D3. Example of Implementation Plan: Evidence-based Intervention Expansion

This example scenario describes how multiple agencies within a jurisdiction are able to work together to address a key challenge related to a naloxone distribution program implemented by local police departments. An example implementation plan based on this scenario is provided below.

Scenario

In a jurisdiction with multiple police departments, a PHAST law enforcement partner reports during a PHAST meeting that the majority of police departments have implemented a naloxone program. In this program, all officers must carry naloxone and be trained to use the overdose reversing drug in the event of a suspected drug overdose. However, the PHAST law enforcement officer also shared that "Some police departments have not implemented the program because of resistance from their police chiefs."

PHAST partners began to brainstorm possible reasons why police chiefs may appear to be resistant to this program. Members of the PHAST come to learn that the outlier police chiefs believe overdose reversals should be addressed by paramedics and not police officers and are opposed to adding additional training and supply burden. Following this brainstorming session, PHAST partners begin to identify and prioritize recommendations to address this barrier in order to expand the intervention to all area police departments.

Implementation Plan

Here is the PHAST's implementation plan to expand the naloxone distribution program to all police departments in the jurisdiction. The organization/individuals responsible for each step are underlined:

- The **public safety champion** personally reaches out to start a dialogue with police chiefs who have not implemented a naloxone program about naloxone distribution and invites them to attend a PHAST meeting to learn more about law enforcement naloxone distribution programs
- The **PHAST coordinator** schedules a meeting with all police chiefs and PHAST partners at which the following will occur:
    - **Police chiefs and officers** who have experienced firsthand the benefit of naloxone programs speak about their personal experiences.
    - The **organization that managed naloxone distribution** for the county shares data on the number of lives saved with overdose reversals, by geographic region.
    - **First responders** share their lived experience and the emotional toll of witnessing repeat overdoses.
    - **A person who is in recovery** for opioid use disorder speaks about their past overdose reversal experiences and their pathway to recovery.
    - **Public health and behavioral health partners** express appreciation and share compassion-fatigue resources for first responders.
    - **Multi-sector leaders** express their support for the program and a desire to expand to all area PDs.

E1. Resources on Substance Use Disorder and the Overdose Crisis

Disclaimer: 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.

Questions to Consider	Resources
Science of drug use and addiction	Olsen, Y. and Sharfstein, JM. The Opioid Epidemic: What Everyone Needs to Know. Oxford University Press (2019). Drugs, Brains, and Behavior: The Science of Addiction (https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface)
Stigma of addiction	Shatterproof Addiction Stigma Index (https://www.shatterproof.org/our-work/ending-addiction-stigma/shatterproof-addiction-stigma-Index) Words Matter - Terms to avoid or use when talking about addiction (https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)
Harm reduction principles	Drug Policy Alliance: Harm Reduction 101 (https://drugpolicy.org/issues/harm-reduction) National Harm Reduction Coalition: Principles of Harm Reduction (https://harmreduction.org/about-us/principles-of-harm-reduction/) Syringe Services Programs (SSPs) | CDC (https://www.cdc.gov/ssp/index.html)
Compassion fatigue and the need for responder wellness	The Code Green Campaign (https://codegreencampaign.org/) Tips for Emergency Responders (https://emergency.cdc.gov/coping/responders.asp)
Social determinants of health	Addressing the Opioid Crisis through Social Determinants of Health: What Are Communities Doing? (https://opioid-resource-connector.org/sites/default/files/2021-02/Issue%20Brief%20-%20Final.pdf) NACCHO: Health Equity in Response to Drug Overdose (https://www.naccho.org/programs/community-health/injury-and-violence/opioid-epidemic/health-equity-drug-overdose-response#plan-implementation)
Medication for Opioid Use Disorder (MOUD)/Medication Assisted Treatment (MAT)?	SAMHSA: Medication Assisted Treatment (https://www.samhsa.gov/medication-assisted-treatment)

E2. PHAST Toolkit Action Steps

Module 1: Building or Formalizing a PHAST

Action Step: Assess and Establish PHAST-critical Elements

Checklist: Do you have the following?

- ☐ Visible and vocal champions in public health and public safety
- ☐ Diverse partner engagement
- ☐ Consistent participation, or commitment to consistent participation for new teams
- ☐ Designated resources to support a program coordinator and data analyst
- ☐ Data access and analytic capability
- ☐ Plan for meeting schedule, location, and communication protocols

Action Step: Determine Your PHAST Structure

- ☐ Establish joint leadership between a public safety and public health representative
- ☐ Determine if an additional co-lead is needed
- ☐ Determine individual roles and responsibilities for each co-lead
- ☐ Fill position of PHAST program coordinator OR identify individual who will fulfill this role
- ☐ Fill position of PHAST data analyst OR identify analyst(s) who will fulfill this role
- ☐ If applicable, identify your overdose fatality review (OFR) coordinator
- ☐ If applicable, identify your PHAST workgroups

Action Step: Identify and Engage PHAST Partners

- ☐ Determine which sectors/agencies listed in Table 5: PHAST Partners and Agencies are not currently represented in your PHAST
- ☐ Identify potential partners from sectors/agencies/cultures/perspectives not currently represented
- ☐ Develop a standardized process for inviting new partners to join PHAST
- ☐ Reach out to new partners to invite them to join PHAST
- ☐ (For existing teams) Re-engage with organizations previously unable to participate
- ☐ Review list of identified currently engaged partners and new partners who have expressed interest to determine if any key organizations or perspectives are still missing. Re-engage as needed

Action Step: Discuss Roles and Responsibilities

- ☐ Develop a PHAST Orientation plan or standardized 'onboarding' process
- ☐ Establish and communicate expectations to partners

Action Step: Share Experiences

- ☐ Partners share information about their individual role/responsibility and experience related to the overdose crisis, what is working and what challenges they face

Action Step: Discuss SOS, Equity Goals, and Apply PHAST Guiding Principles to your Work

- ☐ Introduce and discuss SOS goals of PHAST with partners
- ☐ Introduce and discuss PHAST Guiding Principles with partners
- ☐ Ensure all partners are in agreement with the Guiding Principles
- ☐ Introduce and discuss concepts of equity, diversity, and inclusion

Action Step: Formalize Inter-agency Partnerships with MOU, DUAs, and DSAs

- ☐ Draft and sign a MOU to establish mutual support and commitment to ongoing collaboration

Module 2: Collaborative Data Sharing and Use

Action Step: Review Aggregate and Case-level Data

- ☐ Review and discuss the uses for aggregate and case-level data

Action Step: Assess Shared Understanding

- ☐ Review the list of question in the Resources on Substance Use Disorder and the Overdose Crisis Table (see Appendix) to assess partners' knowledge
- ☐ Identify learning areas or topics to be discussed in future PHAST meetings
- ☐ For each topic, identify guest speakers or resources to support future learning

Action Step: Assess Data Availability and Data Gaps

- ☐ Review and discuss each key investigation question (see Data Inventory Table in the Appendix)
- ☐ Identify which partners can answer which questions with the data they have
- ☐ For questions that can be answered, determine how to share and present data to partners at upcoming PHAST meetings
- ☐ For questions that cannot be answered, determine if the data gap is critical to your work. If it is critical, brainstorm potential data sources and develop a plan to reach out to entities who have access to and may be willing to share these data with the PHAST. Also consider what questions may be answered through overdose fatality reviews.
- ☐ Update inventory as access to data sources change over time
- ☐ Update inventory as new data investigation questions are identified by the PHAST

Action Step: Improve Data Access and Use

Are you currently using or have you discussed the benefits of using the following approaches to address critical data gaps and/or to improve data access and data use?

- ☐ Data maps/Geographic Information System (GIS) mapping
- ☐ New data analysis methodologies or approaches
- ☐ New data collection
- ☐ Sequential Intercept Mapping

Action Step: Establish Simple Data Sharing Practices

- ☐ Identify what types of data are collected by different partner agencies
- ☐ Determine what data can be shared and presented to increase partners' collective understanding of the local overdose crisis
- ☐ Revisit DSAs as needed
- ☐ Establish frequency for how often data will be shared or updated
- ☐ Identify format for data presentations

Action Step: Organize Topical Presentations by Partners or Expert Guest Speakers

- ☐ Organize and conduct topical presentations by partners or expert guest speakers at PHAST meetings

Action Step: Facilitate Data-Driven Discussions and Collective Interpretation

- ☐ When data are shared, partners engage in data-driven discussions to collectively identify local gaps, needs, and problems

Action Step: Identify Gaps and Needs

- ☐ Following each data presentation or data sharing activity, discuss the suggested questions in this section
- ☐ Identify and record the underlying problem, issue, gap, or need
- ☐ Identify and record implications and actionable insights on the Data Inventory Table (see Appendix) or another tracking tool

Module 3: Collaborative Problem Solving and Coordinated Interventions

Action Step: Review Evidence-based Interventions and Promising Practices

- ☐ Share CDC's Evidenced-Based Strategies for Preventing Opioid Overdose: What's Working in the United States (***https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf***) with partners and ask them to independently review strategies
- ☐ Collectively review the evidence-based strategies with partners
- ☐ Identify partners in your community who are implementing the strategies
- ☐ Invite identified partners to present on their experiences, lessons learned, and outcomes (if available)
- ☐ Discuss opportunities for improving jurisdictional capacity and interventions to prevent overdoses

Action Step: Identify Existing Interventions Related to Overdose Prevention

- ☐ Complete the Inventory of Evidence-based Interventions (***Please see C5 in the Appendix***)

Action Step: Identify Evidence-based Interventions to Address Local Needs, Gaps, and Challenges

- ☐ Discuss how local needs, gaps, and challenges are or are not being effectively addressed through existing evidence-based interventions using the questions list in Module 2 (Action Step: "Identify Gaps and Needs")
- ☐ Determine if there are important gaps not being addressed at all through any existing programs. If there are, select new evidence-based interventions that may address these
- ☐ Develop a list of existing evidence-based interventions that can be expanded or improved upon and new evidence-based interventions that can be implemented (using ***C5 in the Appendix*** this can be tracked using the Inventory of Existing Evidence-based Interventions template)

Action Step: Identify Barriers and Facilitators for Implementing, Expanding, or Improving Evidence-based Overdose Prevention Interventions

- ☐ For the intervention you have selected, determine what challenges and obstacles you need to overcome (policies, programs, perceptions) and who is experiencing them. Then, determine what changes need to be made to implement/expand/improve that intervention that will help you address these challenges
- ☐ Identify barriers to making each proposed change
- ☐ Identify facilitators to making each proposed change
- ☐ Document proposed changes and their barriers and facilitators

Action Step: Prioritize Interventions

- ☐ Develop a set of prioritization criteria
- ☐ Select and conduct a prioritization activity
- ☐ Discuss results with partners

Action Step: Identify Supports and Design Changes

- ☐ Discuss and recommend solutions that specifically address barriers to change and leverage facilitators to change

Action Step: Develop an Implementation Plan

- ☐ Develop a detailed plan that documents recommendations and design changes chosen by the PHAST

Module 4: Monitoring and Maintaining Progress

Action Step: Identify Indicators of Success

- ☐ Determine what interventions you want to monitor
- ☐ Discuss what success looks like for each selected intervention

Action Step: Select Performance Measures

- ☐ Select performance measures that allow you to determine if your intervention is working as intended
- ☐ Select equity measures
- ☐ Set targets for each performance measure
- ☐ Develop a data collection plan
- ☐ Develop a timeline for reporting/sharing measures

Action Step: Monitor and Report on Performance Measurement Results

- ☐ Determine how performance measures will be reported out to partners
- ☐ Assess progress and evidence of success
- ☐ Assess limitations and challenges
- ☐ Update the Inventory of Evidence-based Interventions template with identified successes and limitations

Action Step: Celebrate Wins and Make Improvements

- ☐ Determine if targets have been met
- ☐ Discuss and interpret findings
- ☐ Identify recommendations for program improvements or other needed changes
- ☐ Celebrate and communicate success
- ☐ Resume the process of identifying performance indicators and measures to assess any new improvements introduced; collect and review data; and identify new opportunities for improvement

E3. Glossary of Terms

9-1-1 Good Samaritan Laws	Good Samaritan immunity laws provide protection from arrest and prosecution for witnesses who call 911. Laws vary by jurisdiction in the types of drug offenses that may be exempt and whether immunity takes effect before arrest or before prosecution.[56] Typically, Good Samarian Laws only protects the caller and victim from arrest and prosecution for simple drug possession, possession of paraphernalia, and/or being under the influence. Such legislation does not protect people from arrest for drug sales or other offenses. These laws are viewed as an important solution to encourage overdose witnesses to seek medical help.
Compassion fatigue	The emotional strain of working with those suffering from the consequences of traumatic events. Compassion fatigue can result from exposure to one case or from cumulative exposure to trauma.
CompStat	A widely accepted performance management approach used by law enforcement agencies to help focus attention and resources on crime and the causes of crime.
Drug court	Drug courts are problem-solving courts that take a public health approach using a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities work together to help addicted offenders into long-term recovery.
Pre-arrest diversion	A strategy that interrupts traditional criminal justice pathways in the service of public health and overdose prevention by diverting low-level offenders who have opioid use disorder into treatment or support services.
Epidemic	Rapid spread or increase in the occurrence of a disease.
Harm reduction	Harm reduction is a proactive and evidence-based approach to reduce the negative personal and public health impacts of behavior associated with alcohol and other substance use at both the individual and community levels.
Medication-assisted treatment (MAT)	The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. Currently, there are three drugs approved by the FDA for the treatment of opioid use disorder: buprenorphine, methadone, and naltrexone.
Medications for Opioid Use Disorder (MOUD)	Medications prescribed by a healthcare provider that can help manage and/or treat opioid use disorder. Currently, there are three drugs approved by the FDA for the treatment of opioid use disorder: buprenorphine, methadone, and naltrexone.
Naloxone	Sold under the brand name "Narcan" among others; a medication used to block the effects of opioids, especially decreased breathing in overdose.
Overdose Detection Mapping Application Program (ODMAP)	An overdose mapping tool that allows first responders to log an overdose in real time into a centralized database.

Opioids	Natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others.
Opioid Use Disorder	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.
Overdose fatality review	A process of conducting a confidential review of a selection of overdose death cases in the jurisdiction.
Performance management	An ongoing practice of using information and feedback on the work of an organization or activity to improve its process and outcomes.
Performance measures	Quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator.
Public Health	Public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[57]
Public Safety	Government agencies responsible for ensuring the well-being and safety of the public through law enforcement, criminal justice, and first responder duties.
Rx Stat	RxStat is model for advancing a shared understanding of the patterns and characteristics of problem drug use in a local jurisdiction. It brings together representatives from public health and public safety and uses a multidisciplinary and data-focused approach to generate information which can be used to tailor targeted interventions and policy responses to reduce overdose deaths. RxStat was developed in New York City in 2012 initially in response to increases in overdose deaths involving prescription opioids; it has since shifted to address substance use disorders.
Safe stations	Usually 24-hour safe environments where people seeing recovery support can go to be linked to treatment or recovery support services.
Stigma	A perceived negative attribute that causes someone to devalue or think less of the whole person; discrimination; hate.
Substance Use Disorder	A problematic pattern of use of one or more substances leading to clinically significant impairment or distress.

Endnotes

1 NCHS, National Vital Statistics System. Estimates for 2020 are based on provisional data. *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm*

2 Centers for Disease Control and Prevention (CDC). *Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008.* MMWR MorbMortal Wkly Rep. 2011 Nov 4; 60(43):1487-1492.

3 Rudd RA, Paulozzi LJ, Bauer MJ, Burleson RW, Carlson RE, Dao D, Davis JW, Dudek J, Eichler BA, Fernandes JC, Fondario A. *Increases in heroin overdose deaths—28 states, 2010 to 2012.*MMWR MorbMortal Wkly Rep. 2014 Oct 3; 63(39):849.

4 O'Donnell JK, Gladden RM, Seth P. *Trends in deaths involving heroin and synthetic opioids excluding methadone, and law enforcement drug product reports, by census region—United States, 2006–2015.* MMWR MorbMortal Wkly Rep. 2017; 66:897–903.

5 O'Donnell JK, Halpin J, Mattson CL, Goldberger BA, Gladden RM. *Deaths involving fentanyl, fentanyl analogs, and U-47700—10 states, July–December 2016.* MMWR Morb Mortal Wkly Rep. 2017; 66:1197–202.

6 Gladden M, O'Donnell J, Mattson C, Seth P. *Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine – 25 States, July-December 2017 to January-June 2018.* MMWR Morb Mortal Wkly Rep 2019:68(34);737-744.

7 NCHS, National Vital Statistics System. Estimates for 2020 and 2021 are based on provisional data. Estimates for 2015-2019 are based on final data (available from: *https://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm*).

8 Centers for Disease Control and Prevention. Overdose Data to Action. (2021). Retrieved from *https://www.cdc.gov/drugoverdose/od2a/index.html* on 2021, September 24.

9 Heller D, Bradley O'Brien D, Harocopos A, Hreno J, Lerner J, McCoy EB, Nolan M, Phillips Lum P, Tuazon E, Parker C, Kunins H, Paone D. RxStat: Technical Assistance Manual. 2014. New York City.

10 Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2020. Available at *http://wonder.cdc.gov*.

11 NCHS, National Vital Statistics System. Estimates for 2020 are based on provisional data.

12 Centers for Disease Control and Prevention (CDC). *Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008.* MMWR MorbMortal Wkly Rep. 2011 Nov 4; 60(43):1487-1492.

13 Rudd RA, Paulozzi LJ, Bauer MJ, Burleson RW, Carlson RE, Dao D, Davis JW, Dudek J, Eichler BA, Fernandes JC, Fondario A. *Increases in heroin overdose deaths—28 states, 2010 to 2012.*MMWR MorbMortal Wkly Rep. 2014 Oct 3; 63(39):849.

14 O'Donnell JK, Gladden RM, Seth P. *Trends in deaths involving heroin and synthetic opioids excluding methadone, and law enforcement drug product reports, by census region—United States, 2006–2015.* MMWR MorbMortal Wkly Rep. 2017; 66:897–903.

15 O'Donnell JK, Halpin J, Mattson CL, Goldberger BA, Gladden RM. Deaths involving fentanyl, fentanyl analogs, and U-47700—10 states, July–December 2016. MMWR Morb Mortal Wkly Rep. 2017; 66:1197–202.

16 Gladden M, O'Donnell J, Mattson C, Seth P. Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine – 25 States, July-December 2017 to January-June 2018. MMWR Morb Mortal Wkly Rep 2019:68(34);737-744.

17 Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2018. NCHS Data Brief, no 356. Hyattsville, MD: National Center for Health Statistics. 2020.

18 US Department of Health and Human Services. Press Release: HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. Oct 26, 2017; (Accessed September 24, 2021. *https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html*)

19 Volkow ND, Collins FS. The Role of Science in Addressing the Opioid Crisis. New England Journal of Medicine. 2017;377(4):391-4. *https://doi.org/10.1056/NEJMsr1706626*

20 Winslow, CEA. The untilled field of public health. Mod Med 1920;2:183–91.

21 Police Executive Research Forum. (2013). COMPSTAT: Its Origins, Evolution, and Future in Law Enforcement Agencies. Retrieved from *https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/PERF-Compstat.pdf on 2021*, September 24.

22 American Society of Addiction Medicine. (2011, August 15). Public Policy Statement: Definition of Addiction. Retrieved from *https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf* ?sfvrsn=a8f64512_4 on 2021, September, 24

23 NIDA. (2018, July 20). Drugs, Brains, and Behavior: The Science of Addiction. Retrieved from *https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface* on 2020, February 5

24 Kosten TR, George TP. The neurobiology of opioid dependence: implications for treatment. Sci Pract Perspect. 2002;1(1):13-20. doi:10.1151/spp021113

25 Yale Medicine. (2021). Fact Sheets: Opioid Use Disorder. Retrieved from *https://ym.care/4nk* on 2021, September 24

26 *https://www.cdc.gov/drugoverdose/drug-free-communities/index.html*

27 National Institute on Drug Abuse. Drugs, brains and behavior: the science of addiction. July 2018. *https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction* Accessed June 11, 2019.

28 American Society of Addiction Medicine. Definition of Addiction. *https://www.asam.org/quality-care/definition-of-addiction*. Accessed June 11, 2019.

29 World Health Organization. Social Determinants of Health. Retrieved from *https://www.who.int/health-topics/social-determinants-of-health*

30 National Institute on Drug Abuse. 2021, March 11. Opioid Overdose Crisis. Retrieved from *https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis* on 2021, September 24.

31 NIDA. 2018, July 20. Drugs, Brains, and Behavior: The Science of Addiction. Retrieved from *https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface* on 2020, February 5

32 NIDA. 2018, August 1. Comorbidity: Substance Use Disorders and Other Mental Illnesses Drug Facts. Retrieved from *https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses* on 2021, September 24

33 Centers for Disease Control and Prevention. 2021, September 2. Recovery is Possible: Treatment for Opioid Addiction. Retrieved from *Recovery is Possible: Treatment for Opioid Addiction | Drug Overdose | CDC Injury Center* on 2021, September 24.

34 Jeff Beeson, Deputy Director, Washington/Baltimore HIDTA, "ODMAP: A Digital Tool to Track and Analyze Overdoses," May 14, 2018, nij.ojp.gov: *https://nij.ojp.gov/topics/articles/odmap-digital-tool-track-and-analyze-overdoses*

35 Munetz MR, Griffin PA. Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. Psychiatr Serv. 2006 Apr;57(4):544-9. doi: 10.1176/ps.2006.57.4.544. PMID: 16603751.

36 Brinkley-Rubinstein, L., Zaller, N., Martino, S., Cloud, D.H., McCauley, E., Heise, A., & Seal, D. (2018). Criminal justice continuum of opioid users at risk of overdose. Addictive-Behaviors, 86, 104-110

37 Centers for Disease Control and Prevention. Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018. Accessed 2021, September 24 from *http://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf*

38 Chan B, Gean E, Arkhipova-Jenkins I, Gilbert J, Hilgart J, Fiordalisi C, Hubbard K, Brandt I, Stoeger E, Paynter R, Korthuis PT, Guise J-M. Retention Strategies for Medications for Addiction Treatment in Adults With Opioid Use Disorder: A Rapid Evidence Review. (Prepared by the Scientific Resource Center under Contract No. HHSA 290-2017- 00003C). AHRQ Publication No. 20-EHC012. Rockville, MD: Agency for Healthcare Research and Quality. July 2020. Errata August 2020. Posted final reports are located on the Effective Health Care Program search page. DOI: *https://doi.org/10.23970/AHRQEPCRAPIDMAT*

39 Collins, S.E., Lonczak, H. S., & Clifasefi, S. L. (2015). LEAD program evaluation: Recidivism report. Seattle, WA: University of Washington LEAD Evaluation Team, Harm Reduction Research and Treatment Lab.

40 Sharon Reif, Ph.D., Lisa Braude, Ph.D., D. Russell Lyman, Ph.D., Richard H. Dougherty, Ph.D., Allen S. Daniels, Ed.D., Sushmita Shoma Ghose, Ph.D., Onaje Salim, Ed.D., L.P.C., and Miriam E. Delphin-Rittmon, Ph.D. (2014) Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. Psychiatric Services 65(7) pp. 853-861. Published Online: 1 Jul 2014; *https://doi.org/10.1176/appi.ps.201400047*

41 Bassuk, E.L., et al., Peer-delivered recovery support services for addictions in the United States: a systematic review. J Subst Abuse Treat, 2016. 63: p. 1-9.

42 PUBLIC SAFETY-LED LINKAGE TO CARE PROGRAMS IN 23 STATES: The 2018 Overdose Response Strategy Cornerstone Project. High Intensity Drug Trafficking Area Program. Accessed at: *https://www.hidtaprogram.org/pdf/2018%20Cornerstone%20Linkage%20to%20Care%20Report%20FINAL.pdf*.

43 "Definition of strategy." Oxford University Press. Accessed 2022, September 29 from *https://www.oxfordlearnersdictionaries.com/definition/english/strategy.*

44 U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. Introduction to program evaluation for public health programs: A self-study guide. Atlanta, GA: Centers for Disease Control and Prevention, 2011.

45 Brownson RC, Fielding JE, Maylahn CM. Evidence-based public health: a fundamental concept for public health practice. Annu Rev Public Health. 2009;30:175-201. doi: 10.1146/annurev.publhealth.031308.100134. PMID: 19296775.

46 Spencer LM, Schooley MW, Anderson LA, Kochtitzky CS, DeGroff AS, Devlin HM, et al. Seeking Best Practices: A Conceptual Framework for Planning and Improving Evidence-based Practices. Prev Chronic Dis 2013;10:130186. DOI: *http://dx.doi.org/10.5888/pcd10.130186*

47 The Public Health System & the 10 Essential Public Health Services, accessed on February 7, 2020 at *https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html*

48 The public health system: *https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html*

49 Shabbar I. Ranapurwala et al. "Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015", American Journal of Public Health 108, no. 9 (September 1, 2018):pp. 1207-1213.

50 Collins SE, Lonczak HS, Clifasefi SL. LEAD Program Evaluation: Recidivism Report (March 27, 2015). Harm Reduction Research and Treatment Lab, University of Washington – Harborview Medical Center.

51 Collins SE, Lonczak HS, Clifasefi SL. LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs (June 2, 2015). Harm Reduction Research and Treatment Lab, University of Washington – Harborview Medical Center. *https://cops.usdoj.gov/pdf/vets-to-cops/e030917193-CP-Defined.pdf*

52 COMPSTAT: ITS ORIGINS, EVOLUTION, AND FUTURE IN LAW ENFORCEMENT AGENCIES, Bureau of Justice Assistance (*https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/PERF-Compstat.pdf*)

53 Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: improving public health and safety. *JAMA*, *301*(2), 183–190. *https://doi.org/10.1001/jama.2008.976*

54 A data sharing agreement (DSA) - or data use agreement (DUA) - is a legal contract between partner agencies that documents the terms in which data will be shared and how they will be used. These agreements can protect the entity providing the data as well as serve as a channel for communicating data needs and expectations between agencies. For more information on DSAs and DUAs, please refer to **Module 1 in the PHAST Toolkit.**

55 This Sample Memorandum of Understanding was developed by John Volpe, Health Management Associates. Previously John served as special advisor on criminal justice for the New York City (NYC) Department of Health and Mental Hygiene, founding the Office of Criminal Justice. The office was designed to lead in the areas of policy, system design, cross-sector collaboration and developing and improving service delivery where health and social services intersect with crisis systems, law enforcement, the courts, probation and parole, as well as jails and prisons.

56 Drug Misuse: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. GAO-21-248. Washington, D.C.: March, 2021. Accessed *https://www.gao.gov/assets/gao-21-248.pdf* on 7 October, 2021

57 Winslow, CEA. The untilled field of public health. Mod Med 1920;2:183–91.