Attachment 1

Overview Information from CDC OD2A-S NOFO

Document Intent

The following includes overview information from the OD2A-S NOFO. DOH's intent is for you to be able to quickly access key information related to prevention strategies identified in the grant to inform your LOI. The full NOFO is available online here.

OD2A-S NOFO Prevention Strategies & Activities

The tables below include excerpts related to OD2A-S strategies and activities that partners external to DOH may apply to participate in. Detailed descriptions of these strategies start on page 36 of the NOFO.

In the descriptions below, some categories and activities are listed as 'required'. This means that if DOH receives the grant, the required OD2A activities would be implemented with a combination of DOH staff and partner agencies. As a result, all partner agencies would not need to implement all required activities, instead requirements would be met collectively as a state.

Strategy 6 – Clinician/Health System Engagement and Health IT/PDMP Enhancement
For Category 3, DOH is required to implement at least one activity that supports the use of navigators to link patients to care in emergency departments.

Category	Required Activities
3. Building and implementing health system-wide clinical capacity to screen, diagnose, and support (or connect to) trauma-informed longitudinal care for OUD and StUD and support recovery for adults and adolescents. **[Required]**	Supporting emergency department linkages via multidisciplinary teams including navigators, broadening the scope from only post-overdose scenarios to also include strategies like focused connections during care for conditions that may represent sequelae of substance use (e.g., skin/soft tissue infections) and enhanced universal screening for SUD (e.g., opioids and stimulants) among patients presenting for other reasons to identify new opportunities to engage in and link to care.

Strategy 8 – Harm Reduction
DOH must, at a minimum, implement the required activities within categories one and two.

Category	Required and Recommended Activities

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1. Using navigators to connect people to services **[Required]**	**Required Activity**: Initiating, expanding, and supporting programs and outreach by navigators (e.g., people with lived experience, case managers) to promote access to harm reduction services (such as SSPs) and to link people to care from harm reduction services, as appropriate.
2. Ensuring PWUD have access to overdose prevention and reversal tools, treatment options, and drug checking equipment **[Required]**	**Required Activities**: • Developing and expanding overdose education and naloxone distribution programs that prioritize education and distribution among those who are at the greatest risk of experiencing or witnessing an overdose. • Improving access to low-threshold MOUD and treatment for other substance use disorders (e.g., stimulant use disorder) via co-location with harm reduction services or patient navigation. • Improving availability and access to field drug checking (e.g., mass spectrometry and/or educating PWUD about and disseminating drug checking supplies such as FTS).
3. Improving access to and delivery of harm reduction services to reduce overdose	**Examples of recommended activities** • Partnering with and providing support to existing SSPs and harm reduction organizations to increase access to harm reduction services and support programming to reduce overdose, including support of staff time to increase hours and services. • Increasing awareness of SSPs and harm reduction organizations in communities. • Supporting mobile SSPs. • Supporting other interventions that increase SSP and harm reduction services utilization and reduce overdose.

4. Creating and disseminating education and communication materials to increase awareness of and access to harm reduction resources (such as SSPs) and to combat stigma and change social norms around harm reduction	**Examples of recommended activities** • Producing and distributing risk reduction and overdose prevention educational resources and materials for PWUD. • Developing and implementing trainings and education interventions for those who interact with or provide services to PWUD (e.g., clinicians, community-based organizations, and local leadership) to address stigma experienced by PWUD in their community. • Deploying communication campaigns that focus on harm reduction or stigma reduction messaging, including television, print, radio, outdoor, online, and social media outlets. Campaigns may use CDC-developed resources such as the Stop Overdose campaigns, the Rx Awareness campaign, or other evidence-based resources developed locally and tested with the intended audience.

Strategy 9 – Community-Based Linkage to Care

DOH must include, at a minimum, one linkage to care activity that utilizes navigators.

Category	**Required and Recommended Activities**
1. Initiating linkage to care activities **[Required]**	**Required Activities**: Using navigators to facilitate linking people to care and other services. **Examples of recommended activities** • Developing case management systems to help individuals navigate the processes by which care may be procured. Recipients are encouraged to implement these case management systems within existing SSPs and local harm reduction programs. • Creating post-overdose outreach teams or Assertive Community Outreach programs that connect with the individual within 72 hours of a suspected overdose and provide linkages to care. Team

	composition may include first responders, community health workers, and health care workers. The composition of these teams varies by community.
2. Supporting retention in care **[Required]**	**Required Activity:** Using navigators to facilitate implementing monitoring programs following discharge from acute care to prevent treatment interruption. **Examples of recommended activities** • Creating peer support groups or linkages to community-based self-help groups with an emphasis on peers with lived experience. • Increasing access to and retention in care through the development of telehealth infrastructure and resources.
3. Maintaining recovery	**Examples of recommended activities** • Developing and implementing Recovery Management Checkups protocols that provide support, ongoing assessment, and monitoring after primary treatment for SUD. • Supporting Recovery Community Centers and Mutual-Help Organizations (fostering peer groups that are supportive of recovery and self-acceptance). • Supporting linkage to ancillary services such as job skills trainings, training/employment, cultural community centers, and transportation through partnerships or direct staffing support

Navigator-led activity requirements

Below are CDCs' descriptions of navigator services and requirements. This information is located on page 58 of the NOFO.

Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link People Who Use Drugs (PWUD) to care and harm reduction resources.

Navigators are individuals familiar with the local public health landscape and who work directly with individuals with Opioid Use Disorder (OUD) and/or Stimulant Use Disorder (StUD) to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and their retention (and reengagement if necessary) in Substance Use Disorder (SUD) treatment and care, as well as support access to other services, such as harm reduction and social supports.

CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

Health equity and stigma reduction

The goal of OD2A-S is to improve health equity among groups disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall.

The following definitions are provided by CDC related to health equity.

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

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

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

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality- of-life outcomes and risks.

Additional information related to health equity requirements start on page 86 of the NOFO.

Health equity and stigma reduction are prioritized in each prevention strategy by using a health equity lens. Surveillance and sociodemographic data will inform targeted activities for populations that are underserved and at disproportionate risk for overdose. These populations may include people with a history of SUD and/or overdose, people experiencing incarceration or recent release from incarceration, and people experiencing homelessness.

Evaluation requirements

The following is overview information related to evaluation of prevention activities. Further details are available starting on page 55 of the NOFO.

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DOH is required to evaluate prevention activities and use findings to guide future activities. Standardized performance measures will be used to assess all prevention strategy outcomes.

DOH and organizations partnering on OD2A-S will be required to demonstrate:

- How social determinants of health (SDOH) were considered in activity planning and implementation.
- How the needs of at-risk populations were prioritized.
- How health equity was centered in activity, program, and evaluation development.

DOH will request that partner organizations:

- Collect and share data related to funded prevention activities on a quarterly basis.
- Participate in an in-depth evaluation—called a targeted evaluation project (TEP)—of implemented navigation activities for linkage to care and harm reduction services.

Some examples of required performance measures that recipients may be asked to report to DOH include:

- Number of naloxone doses distributed,
- Number of people utilizing OD2A-funded harm reduction services,
- Number of available evidence-based OUD treatment programs,
- Number of new health equity-focused overdose prevention interventions that address drivers of health disparities,
- Number of partnerships mobilized to address overdose prevention health disparities and inequities, and
- Number of prescribers who use a PDMP before prescribing opioids.