BJA FY 21 Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program

PROGRAM NARRATIVE

Category 1c – City of Atlantic City

STATEMENT OF THE PROBLEM

(a) Target Community in the Proposed Initiative

The target community is the City of Atlantic City, NJ, often known by its initials **A.C.,** is a coastal resort city in Atlantic County, New Jersey, United States, known for its casinos, boardwalk, and beaches. In 2019, the city had a population of 37,999. It was incorporated on May1, 1854, from portion of Egg Harbor Township and Galloway Township. It borders Absecon, Brigantine, Pleasantville, Ventnor City, Egg Harbor Township, and the Atlantic Ocean.

Communities included in the program

There are ten (10) communities that will be included in this program: South & North Inlet, Bungalow Park, Back Maryland, Marina District, Downtown, Westside, Ducktown, Venice park, Chelsea, Lower Chelsea, and Chelsea heights. A 2019 American Community Survey (five-year Census) revealed that roughly 37,999 people, at an average reside within the 08401 Zip code (Atlantic City). The survey also showed that there are 15,504 households, and 2.4 persons per household residing in the city. The population density was 3,531.4 per square mile. There were 20,429 housing units at an average density of 1,862.2 per square mile (719.0/km^2). Further, the racial makeup was 16% (6,080) White, 34% (12,920) Black or African American, 16% (6,080) Asian, and 3.0% (1,140) from two or more races. Hispanic or Latino of any race were 31.0% (11,780) of the population. Of the 15,504 households, 24% had children under the age of 18; 33.0% were married couples living together; 32.0% had a female householder with no husband present and 25.0% were non-families. Of all households, 76% were occupied and 24%

were vacant. The average household size was 2.40 and the average family size was 3.34 (AFF, 2012). 24% of the population were under the age of 18, 61% from 18 to 24, and 15% who were 65 years of age or older. The median age was 36.4 years.

The most recent Census Bureau (2019)showed that median household income was $29,232 (with a margin of error of +/- 10%). The per capita income for the city was $20,380 (+/-10%). About 37.1% of the population were below the poverty line, including 54% of those under age 18 and 24% of those age 65 or over (Census Bureau, 2019).

(b) Scope of Opioid Overdose Crisis and Growing Impact-The rising misuse of opioids, including heroin, morphine, and other prescription pain medicines, has resulted in major public health concern that for Atlantic City as well as a national epidemic, with the drug overdose death rate nearly triple that of 1999. A recent CDC report, which analyzed death certificate data for opioid overdoses across 28 states, found that nearly 60% of states demonstrated a significant increase in synthetic opioid death rates between 2014 and 2015.

Nearly 90% of the 2,900 reported drug overdose deaths in New Jersey involved opioids in 2018—a total of 2,583 fatalities (and a rate of 29.7). While most drug overdose deaths in 2018 involved an opioid, overdose deaths involving specific opioids are not included for the state because the data reported did not meet inclusion criteria (Rudd RA, et al., 2016).

The 2020 New Jersey Substance Abuse Monitoring System (NJ-SAMS) report indicated that Heroin is the Primary drug in Atlantic City and Atlantic County. Substance Abuse Admissions by Primary Drug within Municipality report presented that 2,124 residents of the City of Atlantic City have admitted to using primary drug such as alcohol (378), cocaine (126), heroin(1227), other opiates (92), marijuana (243), and other drugs (53). The overdose report in Atlantic County indicated that from 311 victims (54%) of overdose occurred in Atlantic City from illicit drug use

between 2019 and 2020. Research analysis revealed that most overdoses were male (71%), aged 26-35 (23%), and Caucasian (72%), where (16.2%) were African Americans and (10.9%) were Latino/Hispanics (Merydawilda Colon et al.,2019).

In Addition, Atlantic City has other emergencies that supports the emerging need for a comprehensive Opioid, Stimulants, and Substance Abuse, Site-based Program (COSSAP). Foe example, the poverty rate exceeded that of the state of New jersey for decades. Roughly, 37.1% of Atlantic City residents had an income below the poverty level in 2019. In Atlantic City, NJ residents are harmed by the compounding effects of racial discrimination, age, economic instability and environmental vulnerability. Substance abuse affects the individual, the family, and the community in significant, costly and measurable ways; from loss of productivity and unemployability to impairment in physical and mental health; from reduced quality of life to increased crime; increased violence; abuse and neglect of children; from dependence on non-familial support systems for survival; to exposure expensive treatments.

The growing problems of substance use and abuse in the community lead to an aggressive and nuisance behavior of homeless people such as pan handling, defecating and urinating and sleeping around public buildings, disorderly misconduct, open drug use, and shoplifting within the City of Atlantic City and cause an arrest sent to jail. The 2020 Substance Abuse Overview report for Substance Abuse Admissions by Municipality and the2019 NJ Resident Primary drug Admissions Report indicated that out of 7, 567 people admitted for treatment in Atlantic county, 2124 (28%) were residents of the City of Atlantic City (See Table 1)

Table 1: Substance Abuse Treatment Admissions (2018)

Primary Drug	New Jersey		Atlantic County		Atlantic City	
	No.	%	No.	%	No.	%

Alcohol	2,091	25%	1127	18%	229	20%
Heroin	4,435	53%	3751	59%	1110	30%
Other Opiates	600	7%	476	7%	105	22%
Cocaine	336	4%	269	4%	99	37%
Marijuana	550	7%	553	9%	214	39%
Other Drugs	371	4%	219	3%	56	26%

Reference:
New Jersey Drug and Alcohol Treatment (2019). Substance Abuse Overview 2018, Atlantic County. Retrieved on March 17, 2021, from https://www.state.nj.us/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2018/Atl.pdf

Heroin/Opioid use is a critical major public health concern in Atlantic City. In 2018, the city had the highest per capita fatal heroin abuse admission rate and **cannot sustain the financial or human impact of the heroin epidemic on the community, and so we are requesting federal assistance in effecting change.** For decades, heroin has been considered the "choice" drug used by the urban poor. The populations driving the new national spike in addiction are non-Hispanic whites, women, adults ages 18 to 25, those with private insurance and those from higher income brackets, (not drug and alcohol treatment in 2019). In addition, the heroin epidemic in New Jersey has been fueled by a growing population of young adults who get hooked on prescription pain medication and transition to the much cheaper heroin high. South Jersey's key geographical location is only hours from ports of New York, Camden, Newark, Elizabeth, and Philadelphia and major airports where the drugs come in. These locations are the main heroin distribution centers. The overdose rate are strongly correlated with the unemployment rates, access to appropriate treatment, and insurance levels. (Press of Atlantic City, July 2015)

(c) Partner Agencies Committed to the Initiative

This proposal is built upon a firmly established framework of organizations from across the opioid overdose continuum that collaborate, develop, and share best practices through timely dissemination of information to assist individuals and their loved ones fighting the disease of addiction. Moreover, this collaboration is actively undertaking prevention efforts that educate the community on the perils of addiction will lead all aspects of this proposal. This Team is

comprised of the Director of Public Health (Project Director) and representatives from consumer peer groups, including the Jewish Family Services Department, Southern Jersey Family Medical Center, AtlantiCare Regional Medical Center Behavioral Health, Atlantic City Police Department, Atlantic City Municipal Court, and Emergency Medical Services. The Leadership Team will meet monthly during the startup period and quarterly thereafter. The Project Leadership Team will: (a) provide leadership and guidance to achieve the goals of the Outreach Enhancement program; (b) serve as a link between the program and the community; (c) ensure compliance with state and federal laws; (d) develop and implement program sustainability efforts; and (e) review data on program effectiveness and implement continuous quality improvement efforts.

(d) Plans to Overcome Response Gap- The New Jersey Task Force on Drug Abuse Control was created by New Jersey Executive order #219 (2014) charged with studying substance use and addiction and making recommendations to the Governor. This proposal may consult with the New Jersey Task Force and Other Opiate Use strategic plan as established by the by New Jersey's Youth and Young Adults report (2014) to overcome the response gap through problem solving methodology, understanding the circumstances that contribute to the problems and the roles of partners who must contribute to the solutions, to help dissect the problems and devise workable solutions.

(e) Existing Programs & Components Needing Enhancement- Atlantic City's Syringe Access Program (SAP) also known as Harm Reduction Center (HRC) provides a comprehensive approach to harm reduction by integrating behavioral interventions and access to services to prevent and reduce the transmission of HIV, Hepatitis, and other blood-borne diseases. The Atlantic City Syringe Access Program is an anonymous program offering unused syringes and

injection equipment at no cost for individuals who inject substances. No ID is required to get service. Services offered include: Clean syringe, sanitation kits to support injections, Overdose reversal meds such as naloxone (Narcan). Education on safe injection, and Safe disposal, Harm Reduction Education Sessions and referrals to local resources for help such as Medication Assisted Treatment options. Additionally, the current Syringe Access Program provides equipment such as Syringes (various sizes available), Sharps Containers, Tourniquets, Cookers, Cottons, Sterile Water, First Aid Supplies and on-site testing available for HIV, STD, Hepatitis C, Hepatitis B and Pregnancy (NASEN, 2021). Restructuring the existing SAP to provide additional services such as drop-in access to food, telephone, laundry services, restrooms, showers, and computer services is vital.

This proposal will help to improve our collaboration with harm reduction activists and HIV/AIDS researchers. Activists are struggling to implement harm reduction programs. Therefore, our lessons learned will be helping to provide the data needed to justify large-scale expenditure on harm reduction programs to support the residents and visitors of Atlantic City. Without these public expenditures, the harm reduction programs would not have achieved the scope they needed to be successful to stop the HIV epidemic among people who inject drugs (PWID) (Don C., & Des Jarlais, 2017)

(f) Federal Assistance urgently needed for enhancement initiative- With federal assistance, the Atlantic City Department of health and Human Services (ACDHHS) will be able to enhance and expand its response to the current opioid addiction and overdose crisis. Additionally, long-term connections to care need to be initiated through existing peer connectors and treatment programs, particularly immediate linkage to medication-assisted treatment (MAT). If the individuals cannot be connected directly to care, they can be linked to local organizations for support. We must also

do more to support law enforcement's linkage of overdose survivors with existing organizations and care providers rather than having to take them into custody. Current tools include statutes such as *N.J.S.A. 30:4-27.9*.c of the New Jersey Screening Service procedures (2013), which allows police officers to commit a person to observation for 72 hours if they are experiencing suicidal ideation. Federal support will further enable the ACDHHS to employ its multi-disciplinary collaborative approach to: a) enhance and actively engage individuals with opioid misuse; and b) accelerate the systematic analysis of real-time law enforcement and EMS calls for service, including data on naloxone administration, individual response, location by zip code, and the product that caused the overdose

PROJECT DESIGN AND IMPLEMENTATION

(a) Goals and objectives

This project identifies two overarching goals that are consistent with Comprehensive Addiction Recovery Act (CARA): 1) to reduce opioid misuse and the number of overdose fatalities; and 2) to enhance the proactive use of prescription drug monitoring programs to support clinical decision making and prevent the misuse and diversion of controlled substances. This project will achieve these goals by pursuing six interrelated objectives shown in Table 2.

Table 2: Project objectives

Objectives:
Objective 1 Enhance Cross-System Planning & Collaboration.
Objective 2 Enhance Outreach Strategies to OD Survivors & Families
Objective 3 Enhance OD Diversion Programs at Sequential Intercepts.
Objective 4 Enhance Strategies for Targeting "High Frequency Cases.
Objective 5 Leverage I-STOP to Improve Prescribing Patterns.
Objective 6 Evaluate Program Impact (data-driven).

The Table 3 below presents an overview of the anticipated activities associated with each objective:

Table 3: Overview of Project Activities by Objective

Objectives	Activities
Objective 1: Enhance Cross System Planning & Collaboration	Seek technical assistance from BJ A-funded TIA provider Activate & Sustain Involvement of Partner organizations via the Project Leadership Confirm & use data source agreements for planning analysis Complete (update annually) OD Outreach & Prevention Strategy Complete training of project & partner staff as needed Provide OD Prevention & Outreach Services according to strategic plan
Objective 2: Enhance Outreach Strategies to OD Survivors & Families	Identify number of new OD individuals daily Identify new OD individuals surviving daily (eligible to receive services) Daily individuals provided recovery support or connection to peer recovery Track individuals served (referred to support, services received, engaged for 30t days, referred to SUD treatment, family/ friends served, etc.)
Objective 3: Enhance OD Diversion Programs at Sequential Intercepts	Complete (update annually) Intercept Opioid OD Diversion Plan with SAA Identify number taken to REAP (a community based diversion program) Identify number diverted to treatment court programs Cross-system screening for SUD using validated risk/needs assessment Cross-system facilitated enrollment of OD survivors in health care coverage
Objective 4: Enhance Strategies for Targeting "High Frequency Cases	Define "high frequency" utilizer with assistance from BJA-funded TIA provider Complete (update annually) High Frequency OD Intervention Strategy Track high frequency individuals referred to treatment & receiving treatment Track high frequency individuals with comprehensive case management plans
Objective 5: NJ PMP to Improve Prescribing Patterns	NJ PMP training to enhance the medical management of OD survivors in recovery (to reduce prescribing of high-dose painkillers)
Objective 6: Evaluate Program Impact (data-driven)	Activate Research Partnership with guidance from BJA-funded TTA provider Complete Program Evaluation Plan (update annually) with BJA approval Submit quarterly performance metrics via BJA 's online Performance Measurement Tool Local Performance Assessment- formative assessment of effectiveness done annually and 90 days after end of award Attend BJA & National Meetings for shared learning & dissemination

The Atlantic City COSSAP implementation plan will be used to help faster to help to increase cooperation across all community action leaders by assessing gaps and needs; determining the most crucial assignments needed and prioritize them, accordingl; mapping out assumptions and risks; assigning responsibility and outlining activities.

Project Implementation Timeline is presented below and provides an overview of the entire project.

Table 4. Time Line for Key Project Activity

Activities	Year 1/Q				Year 2/Q				Year 3/Q				Responsible staff
	1	2	3	4	1	2	3	4	1	2	3	4	
Objective 1: Enhance Cross-Section Planning & Collaboration													
Seek technical assistance from BJ A-funded TIA provider	√												Project Director
Activate & Sustain Involvement of Partner organizations via the Project Leadership	√	√	√	√	√	√	√	√	√	√	√	√	
Confirm & use data source agreements for planning analysis	√	√											
Complete (update annually) OD Outreach & Prevention Strategy	√	√	√										Lead team
Complete training of project & partner staff as needed			√	√									Project Coordinator
Provide OD Prevention & Outreach Services according to strategic plan			√	√	√	√	√	√	√	√	√	√	
Objective 2: Enhance Outreach Strategies to OD Survivors & Families													
Identify number of new OD individuals daily		√	√	√	√	√	√	√	√	√	√	√	Project Coordinator with Leadership
Identify new OD individuals surviving daily (eligible to receive services)			√	√	√	√	√	√	√	√	√	√	
Daily individuals provided recovery support or connection to peer recovery				√	√	√	√	√	√	√	√	√	

Track individuals served (referred to support, services received, engaged for 30+ days, referred to SUD treatment, family/ friends served, etc.)					√	√	√	√	√	√	√	√	Team Oversight
Objective 3: Enhance OD Diversion Programs at Sequential Intercepts													
Complete (update annually) Intercept Opioid OD Diversion Plan with SAA Identify	√	√	√					√				√	Lead team
Identify number taken to REAP (a community-based diversion program)		√		√	√	√	√	√	√	√	√	√	Project Coordinator
Identify number diverted to treatment court programs			√		√	√	√	√	√	√	√	√	
Cross-system screening for SUD using validated risk/needs assessment				√		√	√	√	√	√	√	√	
Cross-system facilitated enrollment of OD survivors in health care coverage					√	√	√	√	√	√	√	√	
Objective 4: Enhance Strategies for Targeting "High Frequency Cases													
Define "high frequency" utilizer with assistance from BJA-funded TIA provider	√	√											Project Leadership team
Complete (update annually) High Frequency OD Intervention Strategy			√	√				√				√	
Track high frequency individuals referred to treatment & receiving treatment				√	√	√	√	√	√	√	√	√	Project Coordinator
Track high frequency individuals with comprehensive case management plans				√	√	√	√	√	√	√	√	√	
Objective 5: NJ PMP to Improve Prescribing Patterns													
NJ PMP training to enhance the medical management of OD survivors in recovery (to reduce prescribing of high-dose painkillers)			√		√		√		√		√		Project Coordinator
Objective 6: Evaluate Program Impact (data-driven)													
Activate Research Partnership with guidance from BJA-funded TTA provider	√												
Complete Program Evaluation Plan (update annually) with BJA approval Submit	√	√			√				√				Proj.Director
Submit quarterly performance metrics via BJA 's online Performance Measurement Tool	x	x	x	x	x	x	x	x	x	x	x	x	Proj.Director
Local Performance Assessment- formative assessment of effectiveness done annually and 90 days after end of award					√				√				Project. leadership Team
Attend BJA & National Meetings for shared learning & dissemination		√		√		√		√		√		√	

(b) Crosswalks to Allowable Use of Funds- A detailed description of how funds will be utilized is presented in the budget justification. In accordance with the allowable use of funds, the budget will be as follows: (a) Most of the funds will support the Social workers and case managers mandatory position at a 100% FTE; (b) 2% of the funds will used for project management and coordination to provide guidance and supervision skills and assistance in identifying performance measures, tracking measures to assist in the improvement of program implementation and fidelity, providing subject matter expertise and guidance, performing performance evaluations, and/or ensuring effective outcomes evaluation; and (c) the remaining budget funds will be used for the following interwoven purposes: i) cross system change to connect survivors of a non-fatal overdose with treatment providers or a peer recovery coach in an emergency department setting or immediately following the overdose in an effort to engage the

survivor in treatment or support services; ii) enhance access to naloxone and other recovery support services for survivors of non-fatal overdoses and their friends and family; iii) enhance prioritized-ideally immediate-access to detox and treatment services as well as access to medication-assisted treatment; and iv) expand overdose prevention education and community outreach.

(c) Designed to Enhance City's Response to Opioid Crisis- The program's mission is to reduce opioid misuse and the number of overdose fatalities by enhancing the existing overdose outreach infrastructure in a cross-system manner and implementing new policies and procedures to sustain the initiative. Based on its collaborative and systematic approach to an otherwise unmanageable epidemic, this proposal aims to become a statewide recognized model for the prevention of opioid misuse.

(d) Addresses Priority Considerations- The proposal incorporates both Category 1 priority considerations. First, Atlantic County and Atlantic City were disproportionately impacted by the abuse of illicit opioids, stimulants, or other substances as evidenced, in part by a high rate of primary treatment admissions for heroin, opioids and stimulants, high rate of overdoses (2020). Moreover, Atlantic County is further designated as a High Intensity Drug Trafficking Area as part of the NYNJ-HIDTA. (DEA, 2018). As a result, this proposal aims to expand enhanced coordination of prevention and education efforts while simultaneously promoting treatment and recovery, as well as offering alternatives to incarceration programs.

(e) Built Upon Strong Collaborations- this project is built upon locally unique collaborations that makes up the AC COSSAP Team. The Team is comprised of community experts from social service agencies(Jewish family Services), law enforcement Atlantic County Criminal Justice), mental health (ACRMC), addiction treatment providers(John Brook Recovery Service/JBRC),

public health departments (Atlantic City and Atlantic County Division of Public Health) and members of victims' families. The AC COSSAP Committee will meet regularly and report back to the group, including: Medical Provider Education and Policy Reform; Community Education; Families and Consumer Support and Advocacy; Rapid Evaluation and Appropriate Placement Program (police program); Addiction Treatment Providers; Hospitals/ER Partnership; and Naloxone Access.

(f) Data Arrangements- Table 5 below presents a list of data sources (existing, new, and planned). Currently, an in-development data source, using web technology that is available free of-charge from HIDTA (High Intensity Drug Trafficking Areas) program will allow first responders (fire, police, EMS) to use an App on their existing electronic devices to enter real time (two seconds for input) de-identified information on overdose incidents. Currently in practice in ten counties across the nation, this data source will revolutionize our ability to develop best practices to respond to emerging overdose spikes that are occurring across the nation. Our proposal will rely heavily on all data sources reference below, along with future sources to be developed to track cases over time to enhance response and assess effectiveness.

Table 5. Data Sources

Name of Data Sources	Description	Collected by
Naloxone Administrations	Data from police/fire and community opiate overdose reversal forms	ACDHHS
Fatal & Non-Fatal Overdose Data	Data from police/fire and community opiate overdose reversal forms	ACDHHS
Time to Treatment Engagement After Overdose	To be collected for patients after non-fatal overdoses	ACDHHS and Addict-Addict peers
Treatment Retention	Data on duration of contact with the system and duration of treatment	JBRC
Street Surveys	Data from surveys administered by ACDHHS	ACDHHS
Drug Arrests	Data on people arrested for selling heroine/fentanyl	AC Police
OD-MAP: Naloxone Usage App from HIDTA	Real-time program (designed specifically for opiate overdose) to collected time, date, GPS coordinates, doses used	First responders

(g) Project Coordinator Roles and Responsibilities- The Health Officer will work as a project coordinator and will dedicate 10% FTE effort to managing day-to- day operations of the project under the direction of the Project Director and the oversight of the Leadership Team. They will liaison with the Training and Technical Assistance (TTA) provider to: (a) identify the needs of the community, which includes collecting and analyzing administrative and overdose data with the research partner; (b) work with the project staff to design data-driven and evidenced-based outreach and prevention strategies; (c) hold regular stakeholder discussions about project implementation; (d) respond to requests for data reports and information about initiative; (e) ensure continued project implementation and redirection if needed; (f) ensure follow up with the recovering individuals through ongoing communication with the peers and addictions hotline at evaluator-identified key times

CAPABILITIES AND COMPETENCIES

The Atlantic City Department of Health and Human Services is responsible for a day-to-day management of this grant. The core team for the PMP consists of the Director, Program Manager, and program Outreach Director. AC DHHS Director has direct supervisory responsibility for the project, including providing guidance, direction and oversight regarding implementation of the project and proposed enhancements outlined in this application.
This AC COSSAP Team is comprised of the Atlantic City Health Department, Atlantic County Division of Public Health and Jewish Family Services.

In addition, our exiting OFRT members such as Southern Jersey Family Medical Center (SJFMC), John Brooks Recovery Center (JBRC), AtlantiCare Regional Medical Center (ACRMC) Behavioral Health, and the City Atlantic City Municipality Court System will be used to inform this effort.

Key Personnel Highly Qualified- The mission of the AC DHHS is to promote and protect the health, safety, and well-being of Atlantic City residents through active prevention, education, enforcement, advocacy, and partnerships. The Health Department is the natural, neutral leader for this initiative. Atlantic City has a long successful history of providing leadership, technical assistance and guidance to ensure success of projects implemented with community partners. The Director of Health and Human Services will be the Project Director and oversee the grant, staffing selection for the project. The project will be coordinated by the Health Officer, since this is his top public health priority, he will devote 20% of in-kind effort as Project Coordinator.

The Project Leadership Team will guide the search process and will be actively involved in the final interviews and final selection.

Committed to Working Closely with BJA 's TTA Provider(s) and Evaluator: Statement of Assurances, the applicant agrees to work closely with the selected BJA Comprehensive Opioid Abuse Training and Technical Assistance Provider and/or evaluator to complete a program assessment pursuant to guidelines established by OJP, in coordination with the National Institute of Justice.

Strategy for Overcoming Project Challenges- We will be intercepting and following a highly stigmatized, vulnerable, and often street-level population: illicit drug users who have been reversed with naloxone. We will address this challenge by multiple means such as using the ACDHHS freelance Peer Interviewers. This DHHS Peer Interviewer Team has experience conducting surveillance surveys and public health interventions with this population and is known and trusted. We have an existing an Overdose Fatality Review Teams (OFRTs), Track I program and are able to implement evidence-based practices including COSSAP frame of Technical Training Assistance (TTA), and SMAHSA- Medical Assisted Treatment. We have an

established partnership with an existing OFRT member with an existing Confidentiality and Data Sharing Agreements. We will be applying for Track II OFRT program.

Other potential barriers include: lack of trust between individuals with substance use disorder (SUD) and local law enforcement, a broken communication system resulting in late responses to overdosing and connecting these individuals to care in a timely fashion, and insufficient funding to hire staff to create a cohesive and sustainable system. The data-driven strategic planning supported by this project will be essential to developing solutions to overcome these challenges.

DATA COLLECTION PLAN

Roles, Responsibilities, & Procedures for Data Collection and Performance Reporting. The Project Data Coordination Team will consist of Licensed Social/Clinical Worker (LSW/LCSW) Case Manager, and the Data Analyst. The Data Analyst will develop protocols for data collection and data entry for approval by BJA, and Program Director. The Project Coordinator will be responsible for managing all data collection.

The Data Collection Protocol (subject to BJA and IRB approval) will address procedures to:

(a) Collect participant information and eligibility requirements.

(b) Maintain confidentiality of all data.

(c) Prescribe collection of all intake and history data; and

(d) Follow-up with participants receiving services. Select members of the Leadership Team will be involved in:

(a) Maintaining oversight of security and confidentiality of records; and

(b) Reviewing data and reports for continuous quality improvement and informing ongoing program function.

The Data Analyst with the participation of the Project Director, Case Manager, and Project Coordinator, will:

(a) Transmit data to the national evaluation contractor on a quarterly basis.

(b) Receive the national evaluation contractor reports.

(c) Utilize the national evaluation reports to make recommendations for continuous quality improvement; and

(d) Organize and participate in training and technical assistance as required.

All completed participant forms will be kept in a locked file cabinet in a locked office at the Project Coordinator's Offices. The computer database will be secured with password protection.

Performance Metrics to Assess Program Effectiveness- We will assess program effectiveness by following the BJA "Smart Suite" initiative. The anticipated performance metrics are presented in Table 4 that follows. The performance metrics are aligned with the project's six objectives as well as the deliverables that have been previously described.

Table 4- Performance Metrics by Objective

Objectives	Performance Metrics
One: Enhance CrossSystem Planning & Collaboration	Comp let ion of planning activities Multiple data sources used for planning purposes Level of Outreach Partner Activation & Involvement Completion of Staff Training Receipt of technical assistance from a BJ A-funded TT A provider Completion of outreach and prevention strategy Provision of overdose prevention education and community outreach
Two: Enhance Outreach Strategies to OD Survivors & Families	% of individuals that experienced a non-fatal overdose that received recovery support services % of individuals engaged in services for 30 days or more % of individuals in the program that experience a future overdose event % of family members/friends of survivors of non-fatal overdoses that were referred to services
Three: Enhance OD Diversion Programs at Sequential Intercepts	Submission of a coordinated diversion plan with SAA and SSA Implementation of diversion initiatives (by intercept) Level of Diversion Partner Activation & Involvement % of individuals experiencing an opioid overdoes where naloxone was used and survived % of individuals with a history of opioid use diverted from jail or into a diversion program % of participants who successfully completed the court-based diversion program Implementation of screening using a validated risk/needs assessment for SUDs % of participants who received a risk/need screening Provision of assistance in obtaining health care coverage % of target population enrolled in a health care plan
Four: Enhance Targeting "High Frequency Cases	Total number of "high frequency " utilizers served % of" high frequency" utilizers referred for services that received those services (by type) % of "high frequency " utilizers with an individualized comprehensive case management plan

Five: improve Prescribing Patterns	% change in the number of high-dose painkiller prescriptions filled
Six: Evaluate Program Impact (data-driven)	Level of Research Partner Activation & Involvement Reporting program impacts Use of data to inform project activities Utilizing of evidence-based responses Participation in multidisciplinary action group

(c) ***Data Source Strengths*** & ***Weaknesses-*** The nature of our data sources is presented in Table 4 (Section 2-g). We are moving quickly to deploy the real time technology (OD-MAP) that is newly available from HIDTA. That will greatly strengthen the timeliness of overdose trend data that is essential for tracking future incidence of naloxone administrations, redeploying mobile response resources and notifying front line responders. We also have current data sources capable of tracking the times when police dispatchers contact the Addictions Hotline to deploy an Addict-2-Addict peer and to some degree the number of times where the peer meets the individual and connects them to services as well as the ratio of "successful connections" to "unsuccessful connections." Possible data weaknesses in areas related to follow-up that we intend to use the grant to address, such as: (a) the number of individuals that have another non-fatal overdose, and agree to be re-connected to services (i.e. the number of people who experience 1 (one) relapse; number of people who have 2 relapses; and so on); (b) the number of people still linked to system after 1 week; (c) the number of people still linked to treatment system after 1 month; and (c) the number of people still linked to treatment after 3 months.

(d) ***Anticipated Tracking Procedures-*** This will be a priority area of development with the help of the BJA TT A providers. Tracking procedures will be of utmost importance for the program assessment to be successful. As part of the intake to participate in services we plan to ask participants for contact information. We will: (a) have clients complete a 'Contact Form' at intake to services with address & phone; (b) collect information on at least 3 persons that the participant

knows who will know their whereabouts; and (c) keep a tracking database of each participant's address changes, phone numbers, and their friends and family's contact information.

IMPACT/OUTCOMES, EVALUATION, AND SUSTAINMENT

(a) Expected Program Impact- We expect to reduce number of overdose fatalities and to make a major impact on opioid misuse in the City of Atlantic City.

(b) Program Evaluation Plan- Data analysis of performance metrics will be conducted to examine change over time. Data reported the through BJA's online Performance Measurement Tool and other assessments will be analyzed using SPSS to generate frequencies and examine change in each of the performance measures over time at both the individual and group level. Total change in each of the outcome measures over time will be assessed using t-tests. Subgroup analyses (based on demographic characteristics and characteristics of service usage) of change may be conducted based upon the results of bivariate analysis of group differences. Differences in key outcomes based on individual participant factors, including race, gender, age, educational level, and other relevant factors will be conducted as appropriate.

Outcome questions will be explored:

(a) What was the effect of interventions on key outcome goals?

(b) Which program factors were associated with positive or negative outcomes?

This will be informed by process evaluation questions such as:

(a) How closely did implementation match the plan?

(b) Which types of changes were made to the originally proposed plan?

(c) Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

(c) Program Sustainment Plan- The opioid overdose epidemic is rampant and demanding unforeseen resources at all levels of government. Our ability to achieve a significant impact in gaining control of the epidemic should result in dramatic reductions in the demand for expensive urgent response resources. This will eventually allow system savings to be invested in sustaining the system changes that support the prevention and diversion components of the plan.

(d) Local Dissemination Plan- The City of Atlantic City COSSAP Team is geared for frequent local dissemination though community summits, website, and various media outlets.

References:

American community survey (2019). Census data: ACS 2019 5-year Atlantic City, Atlantic County, NJ Census data. Retrieved on June 12, 2021 from Atlantic City city, Atlantic County, NJ - Profile data - Census Reporter

Atlantic County (2020). Substance Abuse Overview. Atl.pdf (state.nj.us)

DEA (2018). Atlantic County Designated as High Intensity Drug Trafficking Area through Federal HIDTA Program. ATLANTIC COUNTY SELECTED AS HIGH INTENSITY DRUG TRAFFICKING AREA THROUGH FEDERAL HIDTA PROGRAM – Office of the Atlantic County Prosecutor (acpo.org)

Don C., & Des Jarlais, (2017). Harm Reduction in the USA: the research perspective and an archive to David Purchase. Harm Reduction Journal., Vol 14, No. 51 https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6

Governor's Council on Alcoholism & Drug Abuse (2014). Confronting New jersey's New Drug problem. https://bjatta.bja.ojp.gov/system/files/naloxone/2014_TaskForce_Report.pdf

HIDTA (2017). National Drug Threat Assessment. Retrieved on June 17, 2021 from https://www.dea.gov/sites/default/files/2018-07/DIR-040-17_2017-NDTA.pdf

Merydawilda Colon et al., 2019). Examining Opioid Overdose Data in Atlantic County: A Description Study. Doi:http://dx.doi.org/10.14713/njs.v5i1.170

New American Fact finder (2012). Atlantic City, Atlantic County, New Jersey

https://archive.today/20200212103750/http://factfinder.census.gov/bkmk/table/1.0/en/DEC/10_DP/DPDP1/0600000US3400102080

New Jersey Drug and Alcohol Abuse Treatment (2020). Substance Abuse Overview 2019, Atlantic County. Atl.pdf (state.nj.us)

N.J.S.A. (2013). Section 30:4-27.9 Screening Service procedures https://law.justia.com/codes/new-jersey/2013/title-30/section-30-4-27.9/

Rudd RA, et al., (2016). Increase in Drug and Opioid-Involved Over Deaths-United States, 2010-2015. Morbidity and Mortality Weekly / December 30, 2016 / 65(50-51);1445–1452

South Jersey AIDS Alliance (2021). Syringe Access Program Atlantic City. Retrieved on June16, 2021 from Syringe Access Program Atlantic City : NASEN Directory

Steve Hughes (2015). **Article.** Why is Atlantic County's fatal heroin overdose rate the highest in New Jersey? Retrieved on June17, 2021 from https://pressofatlanticcity.com/

Sandra Tan (2017). Article. Meet Gale Brunstein, in the general in the war on opioids. Retrieved on June 17, 2021 from https://buffalonews.com/news/local/meet-gale-burstein-the-general-in-the-war-on-opioids/article