PROGRAM NARRATIVE:

Category 1 - Erie County NY Opioid Overdose Outreach Enhancement Program

1) STATEMENT OF THE PROBLEM (15 %)

1-a) ***Target Community in the Proposed Initiative***- The target community is Erie County, NY, which is the largest metropolitan county in Upstate New York with a population of 921,046 and covers 1,043 square miles.[1] Located in in Western New York, Erie County is bordered to the west by Lake Erie and the Niagara River, and shares an international border with Canada. There are three cities in the County, which includes Buffalo, Tonawanda, and Lackawanna. Buffalo is the second largest city in the state and the largest city in the region with a population of 261,025. Buffalo serves as the County seat. There are 16 villages, 25 towns, and two Native American Indian reservations within the County. Erie County is largely urban with most of the population living within the cities and surrounding communities. A significant rural population resides outside the first and second ring suburban areas whose needs are addressed differently due to geographic distances.

1-b) ***Scope of Opioid Overdose Crisis & Growing Impact***- The rising misuse of opioids, including heroin, morphine, and other prescription pain medicines, has resulted in a national epidemic, with the drug overdose death rate nearly triple that of 1999.[2] 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.[3] Moreover, New York State demonstrated the greatest percent increase in death rates

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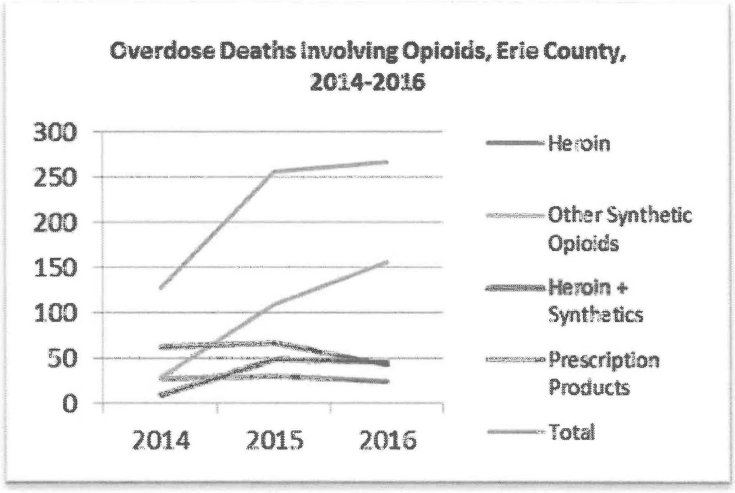
[1] QuickFacts: Erie County, New York. (2016). U.S. Census Bureau. Retrieved from https://www.census.gov/quickfacts/table/RHI105210/36029.

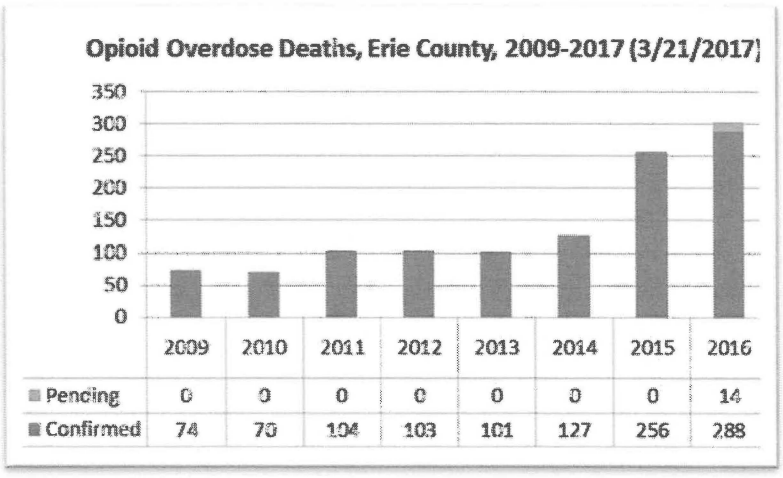
[2] Rudd RA, Seth P, David F, Scholl L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *Morbidity and Mortality Weekly Report, 65*(50-51):1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1

[3] New data show continuing opioid epidemic in the United States. (2016). Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/media/releases/2016/p1216-continuing-opioid-epidemic.html.

overall (136%). Unsurprisingly, Erie County has also experienced a rise in opioid misuse and related deaths. During 2009-2016, the drug overdose death rate in Erie County increased by 297%, with more than 1,000 opioid-related deaths in total.[4] Young people, particularly between the ages of 20-39, have been the most disproportionately impacted.



Since 2014, New York State has seen a significant increase in the number of opioid overdose deaths, which can be attributed, in part, to the initiation of state's prescription drug monitoring program I-STOP (Internet System for Tracking Over-Prescribing). Consistent with national trends, health officials in Erie County indicate that the majority of individuals initiate opioid use via legally-obtained prescription drugs. However, there is a growing subset of individuals, particularly teens, who are exposed to opioids via drug experimentation. As a result, Erie County has experienced a 303% increase in synthetic opioid related deaths during 2014 – 2015, which far exceeds the state average. Moreover, the Erie County Medical Examiners'



	2009	2010	2011	2012	2013	2014	2015	2016
Pending	0	0	0	0	0	0	0	14
Confirmed	74	70	104	103	101	127	256	288

[4] Erie County Medical Examiner's Office

Office has identified numerous synthetic opioids (both legal and illegal, some of them hundreds of times more potent and faster-acting than heroin alone) in the toxicology results of those deceased.

Given the growing demand for synthetic opioids, the people manufacturing and supplying heroin to Western New York (whether local, national, or international) will likely introduce other, stronger fentanyl variants in the months and years ahead. This indicates the need for a more timely and comprehensive response at the time of non-fatal overdose to stop the current exponential increase in opioid overdose deaths in Erie County. While Erie County comprises roughly 8% of the total population of Upstate New York, the area accounted for 16% of all opioid deaths and 10% of heroin overdose deaths throughout Upstate New York in 2015. Even more shocking, the rate of opioid overdoses excluding heroin was 22.3% in Upstate New York. The outpatient emergency department visit rates in Erie County for those three categories (opioid overdoses, heroin overdoses, and opioid overdoses excluding heroin) were near or exceeding double the rates of the other counties that comprise rest of Upstate New York. Furthermore, Erie County accounted for approximately 25% of all Upstate naloxone administrations reported by law enforcement in 2015 and nearly 50% of reports from the Registered Community Opioid Overdose Prevention (COOP) programs in the entire Upstate area.

1-c) ***Partner Agencies Committed to 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. A Project Leadership Team of committed partner agencies (see Memorandum of Agreement in

Attachment 1) will lead all aspects of this proposal. This Team is comprised of the Public Health Commissioner (Project Director) and representatives from consumer peer groups, including the Department of Mental Health, the Crisis Services Hotline, the Rapid Evaluation Appropriate Placement (REAP), the NY 8th Judicial District Treatment Court, Behavioral Health, Emergency Medical Services, and the Research Partner. The Leadership Team has committed to 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.

1-d) ***Alignment with Strategic Plans to Overcome Response Gap***- This proposal is fully aligned with the strategic plan mandated by Erie County Executive Order #14, which created the Erie County Opiate Epidemic Task Force in 2016. This proposal directly relates to the major strategic components: (a) Rapid Evaluation & Appropriate Placement (REAP); (b) Family & Consumer Support Advocacy; (c) Naloxone Access; (d) Provider Education & Policy Reform; (e) Hospital & Emergency Department partners; and (f) Treatment Provider partners. Therefore we have excellent alignment with Erie County strategic planning infrastructure, but the epidemic is running rampant and our response is still inadequate.

1-e) ***Existing Programs & Components Needing Enhancement***- The Erie County Department of Health (ECDOH) is addressing this opioid epidemic through a public health perspective and the implementation of evidence-based harm reduction initiatives, which include the Expanded Syringe Access and Disposal Project (ESAP), the Opioid Overdose Prevention Program/Narcan Administration Project (OOPP) geared at first responders, and Opioid Epidemic Task Force,

which includes community experts from social service agencies, law enforcement, physicians, mental health and addictions providers, the health insurance industry, and members of victims' families. The ECDOH, in conjunction with the Opioid Epidemic Task Force, also provides the following programs and services: (a) in-person trainings and Narcan kit dissemination for police, fire departments, and civilians to recognize and reverse opiate overdoses (to date, over 15,000 individuals have been trained); (b) collection of "reversal forms" from first responders and civilians when naloxone is used to reverse an opiate overdose (these forms are later analyzed for educational and planning purposes, with nearly 1,300 police/fire forms and 380 civilian forms entered to date); (c) development and maintenance of working relationships with health service providers (such as Evergreen Health Services) and community organizations (such as GROUP Ministries) to assess and link treatment facilities, increase opiate awareness and prevention education, and provide counseling and support services; (d) collaborate with Peer Agencies such as Addict-2-Addict[5] for additional support and educational services, including 24 call response and 24/7 peer availability, as well as regularly scheduled support groups and community educational forums; and (e) manage the REAP (Rapid Evaluation and Appropriate Placement) program that is modeled after programs such as PAARI (the Police Assisted Addiction and Recovery Initiative, developed in Gloucester, MA), which connects individuals with substance use disorders (SUDs) directly to treatment programs and resources, instead of arresting them and adding to the jail population (this is a Sequential Intercept 1 program- before arrest occurs and create a diversion path that law enforcement can follow when working with individuals with SUD.

[5]Peer Connection. Addict 2 Addict. Retrieved from http://wnyil.org/addict-2-addict.html.

These initiatives make it clear that no single strategy alone can address this complex, multifaceted issue. Thus, the coordination of the many individual anti-opioid initiatives currently operational throughout Western New York is critically needed.

1-f) ***Federal Assistance urgently needed for enhancement initiative***- With federal assistance, ECDOH will be able to expand and enhance 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 Section 9.41 of the NYS Mental Health law, which allows police officers to commit a person to observation for 72 hours if they are experiencing suicidal ideation, or Section 22.09, which allows police officers to take a person into custody if they are too intoxicated to make rational decisions.

Federal support will further enable the ECDOH 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.

2) PROJECT DESIGN AND IMPLEMENTATION (35 %)

2-a) ***Goals and Objectives Are Aligned with CARA***- This project identifies two overarching goals that are consistent with 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 1. Table 2 below presents an overview of the anticipated activities associated with each objective:

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

Table 2- **Overview of Project Activities by Objective**	
Obj. 1 **Enhance Cross-System Planning & Collaboration**	Seek technical assistance from BJA-funded TTA 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
Obj. 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 30+ days, referred to SUD treatment, family/ friends served, etc.)
Obj. 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
Obj. 4 **Enhance Strategies for Targeting "High Frequency Cases**	Define "high frequency" utilizer with assistance from BJA-funded TTA 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
Obj. 5 **Leverage I-STOP to Improve Prescribing Patterns**	Leverage I-STOP training to enhance the medical management of OD survivors in recovery (to reduce prescribing of high-dose painkillers).
Obj. 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

While the Project Implementation Timeline is presented and explained in-depth in Attachment 2, Table 3 below provides a brief overview:

Table 3- ***Timeline for Key Project Activity***	Pre-Award	Year 1	Year 2	Year 3	Post-Award	Responsible Staff
Pre-award Preparations:						
Activate the Project Leadership Team by Aug '17						Proj Dir. & Assoc Proj Dir.
Enter into Teaming Agreement with HIDTA for OD-Map web technology						
Provide just in time documentation to BJA by end of Sept '17						
Recruit and hire Project Coordinator by Oct '17						Assoc Proj Dir. w/ Research Partner
Obtain BJA approval of Subaward with Research Partner (Univ at Buffalo)						
Submit & obtain IRB & BJA approval of Eval Plan						
Obj. 1 Enhance Cross-System Planning & Collaboration						
Seek technical assistance from BJA-funded TTA provider						Proj Dir. & Assoc Proj Dir.
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						
Obj. 2 Enhance Outreach Strategies to OD Survivors & Families						
Identify number of new OD individuals daily						Project Coordinator with Leadership Team Oversight
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.)						
Obj. 3 Enhance OD Diversion Programs at Sequential Intercepts						
Complete (update annually) Intercept Opioid OD Diversion Plan with SAA						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						
Obj. 4 Enhance Strategies for Targeting "High Frequency Cases						
Define "high frequency" utilizer with assistance from BJA-funded TTA provider						Proj 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						
Obj. 5 Leverage I-STOP to Improve Prescribing Patterns						
Leverage I-STOP training to enhance the medical management of OD survivors in recovery (to reduce prescribing of high-dose painkillers).						Project Coordinator
Obj. 6 Evaluate Program Impact (data-driven)						
Activate Research Partnership with guidance from BJA-funded TTA provider						Proj Dir
Complete Program Evaluation Plan (update annually) with BJA approval						Proj Dir & Research Partner
Submit quarterly performance metrics via BJA's online Performance Measurement Tool		x x x x x x x x x x x x			x	
Local Performance Assessment- formative assessment of effectiveness done annually and 90 days after end of award						Proj Leadership Team
Attend BJA & National Meetings for shared learning & dissemination						

2-b) ***Implements Mandatory Project Components***- In accordance with the mandatory project components, the project will implement evidence-based harm reduction initiatives; use a multi-disciplinary collaborative approach to engage individuals with opioid use; systematically analyze first-responder call data for service and naloxone administration; document, with the expertise of the University at Buffalo Primary Care Research Institute, the impact of the opioid epidemic based on local, regional, or state-level data; employ a project coordinator, who manages the operations during the planning and implementation phase; and work with BJA's TTA provider(s) and evaluators to track quarterly performance measures.

2-c) ***Crosswalks to Allowable Use of Funds***- A detailed description of how funds will be utilized is presented in the budge justification. In accordance with the allowable use of funds, the budget will be as follows: (a) 60% of the funds will support the mandatory project coordinator position at a 90% FTE; (b) 22% of the funds will engage a research partner to conduct action research and provide 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.

2-d) ***Designed to Enhance State & County Response to Opioid Crisis***- As stated in the letter from

, the proposed project definitely addresses a state-identified priority. 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.

2-e) ***Addresses Priority Considerations***- The proposal incorporates both Category 1 priority considerations. First, Erie County is currently experiencing a disproportionately high opioid misuse and fatality epidemic, which by year's end will have claimed more than 1,000 individuals since 2012[6]. Moreover, Erie County NY is a further designated as a High Intensity Drug Trafficking Area as part of the NYNJ-HIDTA.[7] 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. Secondly, this proposal includes the expertise of an action research team from the University at Buffalo Primary Care Research Institute that specializes in program evaluation and addiction services research. The action research team will further increase local capacity and identify research-based strategies that focus on problem identification, solution design, and project evaluation.

2-f) ***Built Upon Strong Collaborations***- As previously described in Section 1-c, this project is built upon nationally unique collaborations that make up the Erie County Opiate Epidemic Task

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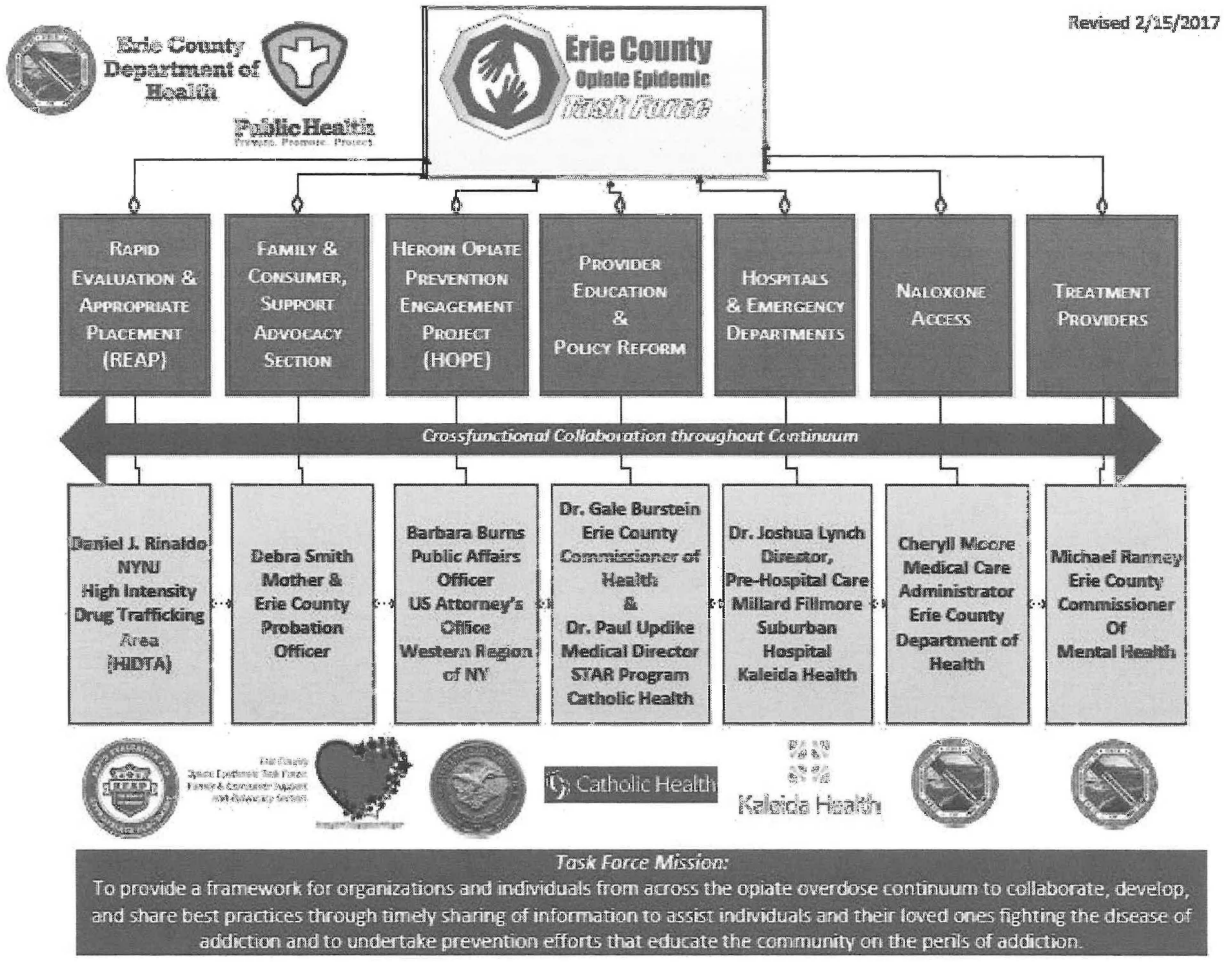
[6] Tan, S. (March 4, 2017). Meet Gale Burstein, the general in the war on opioids. *The Buffalo News*. Retrieved from http://buffalonews.com/2017/03/04/general-war-opioid-overdoses/

[7] High Intensity Drug Trafficking Areas [Char]. (2017). U.S. Drug Enforcement Administration. Retrieved from https://www.dea.gov/ops/HIDTA_2017_map.pdf.

Force. The Task Force is comprised of community experts from social service agencies, law enforcement, physicians, mental health and addictions providers, the health insurance industry, small businesses, and members of victims' families. As shown in the following diagram, the Task Force includes seven committees that 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.



To date, Task Force collaborations have: (a) engaged 13 police departments and one faith-based organization as entry points; (b) recruited and trained 100 "Angels" as support

persons for those that may present at local PDs to access treatment; (c) trained medical providers in buprenorphine and primary care pain management; (d) established local pain management guidelines adopted by the Medical Society of the County of Erie; (e) obtained Tower Foundation funding to support education and trainings; (f) made policy recommendations to NYS Heroin Task Force on prescribing guidelines; and (f) reached out to local, state and federal speaking engagements to educate peers.

2-g) ***Data Arrangements***- Table 4 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 4- Data Sources

Name of Data Source	Description	New / Existing	Collected by	Data sharing arrangement	Frequency of Availability
Naloxone Administrations	Data from police/fire and community opiate overdose reversal forms	Existing	ECDOH	No conflicts identified	At will
Fatal and Non-fatal Overdose Data	Data from police/fire and community opiate overdose reversal forms	Existing	ECDOH	No conflicts identified	At will
Time to Treatment Engagement After Overdose	To be collected for patients after non-fatal overdoses	New	ECDOH and Addict-2- Addict peers	To be determined	To be determined
Treatment Retention	Data on duration of "contact with the system" and duration of treatment	Existing	EC Mental Health Dept.	To be determined	To be determined
Street Surveys	Data from surveys administered by ECDOH workers	Existing	ECDOH	No conflicts identified	Annual, Periodic
Drug Arrests	Data on people arrested for selling heroin/fentanyl	New	Buffalo Police or Erie County Sheriffs	To be determined	To be determined
OD-MAP: Naloxone Usage App from HIDTA	Real-time program (designed specifically for opiate overdoses) to collected time, date, GPS coordinates, doses used	Under development	First responders, program itself	To be determined	Real time

2-h) ***Project Coordinator Roles and Responsibilities***- A project coordinator will be hired under contract to dedicate 90% 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 (see Position Description in Attachment 4). 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.

2-i) ***Research Partner Roles and Responsibilities***- The research partner, (see bio-sketch in), from the University at Buffalo, Primary Care Research Institute will use an "action research" approach to enhance collection and review of data, which in turn will serve as the foundation for outcome evaluations of program interventions will serve on the Leadership Team and will work with the Coordinator to effectively address specific challenges (e.g., increased drug overdose rates, or PDMP utilization). She will also guide the partners in assessing problems, identifying underlying causes of these problems, developing effective strategies to address these problems (e.g., "theory of change"), implementing data-driven strategies/programs, conducting program assessments (e.g., process and outcome evaluations), and providing "real-time" feedback to enhance decision- making.

3) CAPABILITIES AND COMPETENCIES (25 %)

3-a) ***Project Tied to the Erie County Opiate Epidemic Task Force***- As stated previously in section 1-2 and 2-f, this proposal is tied to the Erie County Opiate Epidemic Task Force that provides an exceptionally strong foundation for successful action with its broad, well-established infrastructure of collaborative partnership that spans the continuum of stakeholders needed to address these challenges.

3-b) ***Project Leadership Team Memorandum of Agreement***- As stated in section 1-c, a Project Leadership Team of committed partner agencies (see Memorandum of Agreement in Attachment 1) will lead all aspects of the Project. This Team is comprised of the Public Health Commissioner (Project Director) and representatives from consumer peer groups, the Department of Mental Health, the Crisis Services Hotline, the Rapid Evaluation Appropriate Placement (REAP), the NY 8th Judicial District Treatment Court, Behavioral Health, Emergency Medical Services, and the Research Partner.

3-c) ***Partnered with Nationally Recognized Research Institute (PCRI)***- The PCRI is a unit within the SUNY at Buffalo Department of Family Medicine that specializes in health services research. The Institute includes expertise in family medicine, addiction medicine, psychology, nursing, epidemiology, education, health system organization, program evaluation, quantitative and qualitative research methodologies, and systems management. Nationally recognized as a leader in primary care research, the group's focus includes areas such as community based participatory research (CBPR), addictions research, health disparity research, management of complex chronic conditions, health care practice transformation, comparative effectiveness research, translation of evidence into practice, and health workforce training. A team within the PCRI specializes in the primary care management of opioid addictions. Directed by

a founding member of the American Board of Addiction Medicine (ABAM) in , representing the specialty of Family Medicine. This unit has developed an accredited national network of addiction medicine fellowship programs that was recently recognized by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education. PCRI directs the National Center for Physician Training in Addiction Medicine that is based in the UB Department of Family Medicine. works closely with (the research partner in this project).

3-d) ***Key Personnel Highly Qualified***- The mission of the ECDOH is to promote and protect the health, safety, and well-being of Erie County residents through active prevention, education, enforcement, advocacy and partnerships. The Health Department is the natural, neutral leader for this initiative. Erie County has a long successful history of providing leadership, technical assistance and guidance to ensure success of projects implemented with community partners. The grant will be overseen by Project Director and it will be directly administered by the Associate Project Director , Medical Care Administrator (see bio-sketch). will devote 20% in-kind effort as Project Director, since this issue is her top public health priority. As part of 's existing job description, she will devote 30% in-kind effort to manage the program for the first 90 days (or until a Project Coordinator has been hired) and then will assume the Associate Director role. has extensive grant administration and project management experience with the ECDOH, and she has directly administered and implemented numerous grant projects over the past 20 years. will oversee staffing selection for the project, including the Project Coordinator, management of subcontracts, voucher processing, and other administrative functions as needed.

3-e) ***Plan for Hiring Project Coordinator with Grant Support***- As described in the Timeline in Attachment 2, the Associate Project Director will use the pre-award period to recruit a qualified candidate pool for the Project Coordinator (see Position Description in Attachment 4) by October 2017. The Project Leadership Team will guide the search process and will be actively involved in the final interviews and final selection.

3-f) ***Committed to Working Closely with BJA's TTA Provider(s) and Evaluator***- As attested to in Attachment 7: 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.

3-g) ***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 using the ECDOH freelance Peer Interviewers. This DOH Peer Interviewer Team has experience conducting surveillance surveys and public health interventions with this population and is known and trusted. We have prior experience with the overdose/rescue population in this project and are reasonably assured that the engagement and follow-up tracking will be feasible given our collaborative commitments. 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.

4) DATA COLLECTION PLAN (5 %)

4-a) ***Roles, Responsibilities, & Procedures for Data Collection and Performance Reporting***-

The Project Data Coordination Team will consist of the Associate Project Director, the Project Coordinator, and the Research Partner (the Evaluator). The Evaluator from the University at Buffalo will develop protocols for data collection and data entry for approval by BJA, Director, and Associate 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 Evaluator with the participation of the Project Director, Associate Director, 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.

4-b) ***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 3 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	
Obj. 1 **Enhance Cross-System Planning & Collaboration**	Completion 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 BJA-funded TTA provider
	Completion of outreach and prevention strategy
	Provision of overdose prevention education and community outreach
Obj. 2 **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
Obj. 3 **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
Obj. 4 **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
Obj. 5 **Improve Prescribing Patterns**	% change in the number of high-dose painkiller prescriptions filled
Obj. 6 **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

4-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." We have 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 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.

4-d) ***Anticipated Tracking Procedures***- This will be a priority area of development with the help of the BJA TTA 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.

5) IMPACT/OUTCOMES, EVALUATION, AND SUSTAINMENT (10 %)

5-a) ***Expected Program Impact***- We expect to reduce number of overdose fatalities and to make a major impact on opioid misuse across Erie County New York.

5-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)?

5-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.

5-d) ***Local Dissemination Plan***- The Opiate Epidemic Task Force is geared for frequent local dissemination though community summits, website, and various media outlets.[8]

5-e) ***National Dissemination Plan***- The research partner, is actively involved with the national dissemination in peer reviewed journals and national proceedings related to various addiction initiatives sponsored by Erie County (see bio-sketch in). She will lead the effort for the national dissemination of the project in consultation with the BJA Evaluator.

[8] The Opioid Epidemic Task Force regularly disseminated prevention education and hosts several community events through out the year. For a list of upcoming events, please go to the Erie County Depart of Health website (http://www2.erie.gov/health/) Or connect with Erie County Department of Health via Facebook (https://www.facebook.com/ecdoh), Twitter: (https://twitter.com/ECDOH), Youtube (http://www.youtube.com/playlist?list=PL0DE7E0A3F76269B7), Or LinkedIn (http://www.linkedin.com/company/erie-county-department-of-health?trk=top_nav_home.