Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

MEMORANDUM

Date: March 17, 2022

To: Subrecipient agencies

From: Jolene Defiore-Hyrmer, MPH
Bureau of Health Improvement and Wellness
Ohio Department of Health

Subject: Emergency Department Comprehensive Care Continuation Solicitation EC23 9/1/2022 – 8/31/2023

The Ohio Department of Health (ODH), Bureau of Health Improvement and Wellness announces the availability of grant funds.

All electronic applications and attachments are due by 4:00 p.m., Monday, May 2, 2022. Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete the GMIS training offered by ODH.

Any award made through this program is contingent upon the availability of funds for this purpose. The subrecipient agency must be prepared to support the costs of operating the program until receipt of grant payments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) Manual rules, policy and procedure updates posted on the GMIS Bulletin Board, and any other program-specific requirements as outlined in the competitive Solicitation. Reference the competitive Solicitation for more information. The competitive Solicitation for this grant program can be found on the ODH website https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/. Allotments will be established in GMIS by ODH. Please refer to the GMIS bulletin board for current allotment percentage.

If you have questions, please contact Temple Ellis at 614-728-3614 or e-mail at Temple.Ellis@odh.ohio.gov.

I. TABLE OF CONTENTS

I. CONTINUATION FUNDING APPLICATION GUIDANCE

100% Deliverable Funding

A. Policy and Procedures: The Continuation Funding Application consists of three parts: Program Updates (if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH OGAPP manual rules, and any other program-specific requirements as outlined in the competitive Solicitation. This Solicitation pertains to budget period: September 1, 2022, to August 31, 2023, of the total project period, March 1, 2021, to August 31, 2023. Reference the competitive Solicitation for more information.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Number of Grants and Funds Available: This program is funded through the Centers for Disease Control and Prevention (CDC) Overdose Data to Action funding, CDC-RFA-CE19-1904. Subrecipients previously funded for the Emergency Department Comprehensive Care (EC21) Grant are eligible to apply. Three grants are available for funding. Each grant has a funding range of $300,000 - $400,000. ODH reserves the right to modify the amount of funding based on funds available.

No grant award will be issued for less than $30,000. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.

C. Formatting Requirements for Attachments:

- Properly label each item of the application packet (ex. budget narrative, program narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and budget narratives must be submitted in portrait orientation and fit on 8 ½ x 11 paper when printed.
- Number all pages (print on one side only). Place agency name and GMIS number on each page.
- Use a 12-point font.
- Forms must be completed and submitted in the format provided by ODH.

D. Qualified Applicants:

The following criteria must be met for grant applications to be eligible for review:

1. Applicant does not owe funds in excess of $1,000 to the ODH.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, May 2, 2022.**

II. PROGRAM UPDATES:

Program should review the Evidence of Health Equity Strategies Checklist in Appendix C when drafting the program narrative, objectives, and work plan.

A. Program Progress Report: Subrecipient is to submit their EC21 program reports in GMIS by the dates identified in the EC21 competitive solicitation.

B. Program Narrative: Complete and submit a narrative statement (do not exceed 15 pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding.

Program Narrative Outline:

1. Program Updates
   a) Personnel – List all employees, percentage of time, and short description of job responsibilities/duties.
   b) Partnerships – Provide an update on established partnerships that you will be utilizing in the following grant year.
2. Work Plan Updates
   a) Provide a narrative description of each objective, indicating any updates/progress and changes proposed for the following grant year.
      i. Successes – Describe successes for each objective and plans for expansion.
      ii. Challenges – Describe challenges for each objective and strategies that have been implemented to overcome challenges.
      iii. Opportunities – Describe opportunities for progress for each objective in the following grant year.
      iv. Health Equity – Describe plans for identifying and addressing priority populations for each objective.

C. Objectives and Work Plan: Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART) objectives and submit an updated work plan using the template provided for you in Appendix F. Reference the competitive Solicitation for information. This should be based on a review of the Progress Plans submitted to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing or unmet); major findings; and how barriers were addressed.

D. Documentation and Progress on Health Equity and Disparity Reduction Activities:

Please provide detailed updates on the goals, objectives, and deliverables specified in the Competitive Solicitation relating to health equity. This information must be supported by data. Continuation Solicitations should prepare a summary of activities completed, during the previous funding period, to outreach to the priority populations and/or neighborhoods specified in their plan.

E. Program Budget: Prior to completion of the budget section, reference the competitive Solicitation for unallowable costs and review criteria.

1. Budget Narrative: Provide a budget justification narrative outlining how the deliverable will be met. (A budget justification example can be found on GMIS).

Match or Applicant Share is not required by this program. Do not include match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.

2. 2023 Budget via GMIS: Complete requested budget information as follows:

a) **Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period September 1, 2022, to August 31, 2023.

The applicant shall retain all original fully executed contracts on file.

b) **Compliance:** Answer each question on this form. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

3. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees — unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;

16. Purchases of the following: Naloxone/Narcan, syringes, fentanyl test strips, harm reduction kits, furniture or equipment;
17. HIV/HCV/other STD/STI testing;
18. Drug disposal, including implementation or expansion of drug disposal programs or drug take back programs, drug drop box, drug disposal bags;
19. The provision of medical/clinical care;
20. Research
21. Development of educational materials on safe injection;
22. The prevention of Adverse Childhood Experiences (ACEs) as a stand-alone activity; and
23. Public safety activities that do not include clear overlap/collaboration with public health partner and objectives.
24. All costs related to out-of-state travel, unless prior approved by ODH
25. Training longer than one week in duration, unless prior approved by ODH
26. Contracts, for compensation, with advisory board members
27. Incentives to employees
28. Any goods or services for personal use regardless if reported as taxable income to employee
29. Grant-related equipment costs greater than $1,000, unless justified and approved by ODH

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to subrecipients for purposes later discovered to be prohibited. Please refer to the OGAPP manual for additional information.

F. Other Application Requirements:

Program Specific Attachments: Complete and submit the following attachments.

a) Program Narrative
b) Work Plan
c) Budget Justification

a. Other Required Documentation:

- Subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

  This information is maintained on the following website: http://supplier.ohio.gov/.

  Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

- **Audit:** Subrecipient agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via audits@odh.ohio.gov. Reference the GMIS Bulletin Board for more information.

- **Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the application section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each applicant via the Internet.

- **Assurances Certification:** Each subrecipient must acknowledge the Assurances (Federal and State Assurances for Sub-grantees) form in GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive, and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subrecipient agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

- **Federal Funding Accountability and Transparency Act (FFATA):** All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload into the federal system.

  All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to www.dnb.com. For information about System for Award Management (SAM) go to https://beta.sam.gov/.

  Information on Federal Spending Transparency can be located at www.usaspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at https://www. whitehouse.gov/.

  1. (Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed in order to submit the application.)

- **For Non-Profit Organizations Only:**

  1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. Attach the current Certificate of Insurance Liability in GMIS.

  2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS the Internal Revenue Services (IRS) letter approving non-tax-exempt status.

G. Human Trafficking:

Human trafficking is defined by the use of force, fraud, or coercion to compel victims into performing labor or commercial sex acts. Populations at increased risk include but are not limited to lesbian-gay-bisexual-transgender-questioning individuals, individuals with disabilities, undocumented immigrants, runaway and homeless youth, temporary guest-workers and low-income individuals.

The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

a. Victims of human trafficking are included in your agency's priority population that may include, but are not limited to the following:
   1. Populations at increased risk
   2. Mental health population
   3. Homeless population

b. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

__X__ Applicable to the Emergency Department Comprehensive Care (EC23) grant.

H. Post Submission Requirements: Continuation applicants are required to submit subrecipient program and expenditure reports.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

a. Program Reports: Subrecipient Program Reports must be completed and submitted via GMIS by the following dates. Program may require additional reporting through the Ohio Department of Health REDCap system. **Program reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

__X__ Program Reports Required _____ No Program Reports Required

Period	Report Due Date
September 1, 2022 – November 30, 2022	December 15, 2022
December 1, 2022 – February 28, 2023	March 15, 2023
March 1, 2023 – May 31, 2023	June 15, 2023
June 1, 2023 – August 31, 2023	September 15, 2023

b. **Subrecipient Reimbursement Expenditure Reports:** Subrecipient Monthly Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
September 1 – 30, 2022	October 10, 2022
October 1 – 31, 2022	November 10, 2022
November 1 – 30, 2022	December 10, 2022
December 1 – 31, 2022	January 10, 2023
January 1 – 31, 2023	February 10, 2023
February 1 – 28, 2023	March 10, 2023
March 1 – 31, 2023	April 10, 2023
April 1 – 30, 2023	May 10, 2023
May 1 – 31, 2023	June 10, 2023
June 1 – 30, 2023	July 10, 2023
July 1 – 31, 2023	August 10, 2023
August 1 – 31, 2023	September 10, 2023

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
September 1 – November 30, 2022	December 10, 2022
December 1, 2022 – February 28, 2023	March 10, 2023
March 1 – May 31, 2023	June 10, 2023
June 1 – August 31, 2023	September 10, 2023

Note: Obligations not reported on the final monthly or fourth quarter expenditure report will not be considered for payment with the final expenditure report.

c. **Final Expenditure Reports:** A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4:00 p.m. on or before October 5, 2023. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of ALL Subrecipient Program and Expenditure Reports via the ODH's GMIS system indicates acceptance of OGAPP. Clicking the "Submit" or "Approve" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of OGAPP rules and regulations.

B. APPENDICES

- **A.** Continuation Solicitation Reimbursement Type Form
- **B.** B1. Deliverable Descriptions
  B2. Deliverable Allocations
- **C.** ODH Evidence of Health Equity Strategies Checklist
- **D.** Annual Guidance
- **E.** Application Instructions
- **F.** Annual Work Plan Template
- **G.** Overdose Rate per County
- **H.** Overdose Report per Race/Ethnicity
- **I.** Emergency Department Visits for Suspected Overdose by County
- **J.** Budget Justification Template
- **K.** Sample Program Reporting

Submission Required

See due date below

CONTINUATION SOLICITATION
REIMBURSEMENT TYPE FORM

Ohio Department of Health Office of Health Improvement and Wellness
Violence and Injury Prevention Section

ODH Program Title:
Emergency Department Comprehensive Care (EC23)

Reimbursement Type (check one) Monthly ☐ **OR** Quarterly ☐
(Please note that no changes to the reimbursement type can be made after the project number is created in GMIS. No waivers/appeals will be accepted.)

Please print:
Current Project Number _____

Applicant Agency/Organization _____

Applicant Agency Address _____

_____

Agency Contact Person Name and Title _____

Telephone Number _____

E-mail Address _____

_____ _____
Agency Head (Print Name) Agency Head (Signature)

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS.

Due to ODH by March 30, 2022.
Please email completed form to Karen Tinsley (karen.tinsley@odh.ohio.gov).

Deliverable Descriptions

Name of Subgrant Program: Emergency Department Comprehensive Care (EC23)
Budget Period: 09/01/2022 – 8/31/2023
# of Deliverables: 7
Use Budget Justification Scenario#: 3

_X__ Deliverables Only

REQUIRED DELIVERABLES: Deliverables 1 through 5 are required. Required deliverables include program reporting, a site visit, statewide collaboration, program expansion, and evaluation.

Deliverable 1 – Program Reporting
In conjunction with identified health system partners, subrecipients will utilize adequate resources, planning, and mechanisms to facilitate efficient data collection and reporting. Data collection will occur in incremental timeframes that support long-term objectives of evaluation and reporting. Data collection and reporting will provide sufficient evidence and offer insight to project progress, outcomes, and impact.

Objective 1A. By August 31, 2023, subrecipient will submit quarterly narrative and quantitative program reports for all emergency department sites to ODH.

Required Benchmarks:

- Narrative and quantitative program reports due December 15, 2022; March 15, 2023; June 15, 2023; and September 15, 2023.

Deliverable 2 – Site Visit
The subrecipient will facilitate a program site visit inclusive of relevant tours, meetings with key stakeholders, and program staff in conjunction with identified health systems/emergency department partners.

Objective 2A. By August 31, 2023, subrecipient will facilitate a program site visit in conjunction with identified health systems/emergency department partners.

Required Benchmarks:

- Site visit plan due February 28, 2023
- Site visit documentation due May 31, 2023

Deliverable 3 – Statewide Collaboration
The subrecipient will be an active member of the designated state drug overdose prevention action group and participate in bi-monthly Emergency Department Comprehensive Care (EDCC) Statewide Workgroup calls. Subrecipients will be required to facilitate one workgroup call in coordination with ODH VIPS.

Objective 3A. By August 31, 2023, subrecipient will actively participate in bi-monthly EDCC Statewide Workgroup calls. Subrecipient will plan and facilitate one workgroup call in coordination with ODH VIPS.

Required Benchmarks:

- Documentation of participation in bi-monthly calls due quarterly: November 30, 2022, February 28, 2023, May 31, 2023, and August 31, 2023.
- Documentation of facilitation due by August 31, 2023.

Deliverable 4 – Program Expansion
In conjunction with ODH VIPS, subrecipient will implement a plan for expansion of the EDCC Program in current and/or new emergency department sites.

Objective 4A. By August 31, 2023, subrecipient will expand the EDCC program in two current and/or new emergency department sites. Subrecipients should also consider social vulnerability of the hospital catchment area when selecting new sites and consider proximity to Ohio Health Improvement Zones referenced in Appendix C, Evidence of Health Equity.

Required Benchmarks:

- Submission of a signed formal agreement with a minimum of two health systems/emergency departments due November 30, 2022
- Draft protocols, guidelines, framework and/or workflows due November 30, 2022
- Finalized protocols, guidelines, framework and/or workflows due February 28, 2023
- Documentation of implementation due May 31, 2023
- Documentation of sustainability of program expansion due August 31, 2023

Deliverable 5 – Evaluation

Subrecipient will complete a comprehensive evaluation of the impact of the Emergency EDCC program and share findings and lessons learned with community stakeholders. The evaluation must address program impact on reducing health disparities.

Objective 5A. By August 31, 2023, subrecipient will submit a completed comprehensive evaluation.

Required Benchmarks:

- Evaluation plan due November 30, 2022
- Evaluation report due May 31, 2023
- Evidence of evaluation report and lessons learned were shared with key stakeholders due August 31, 2023

OPTIONAL DELIVERABLES – Deliverables 6 and 7 are optional. Optional deliverables include sustainability supports and the development of resources to assist in the expansion of the EDCC program in Ohio.

Deliverable 6 – Sustainability Supports

Subrecipient will plan and implement strategies supporting the sustainability of EDCC program. Subrecipient will draft and submit a proposal that identifies sustainability options, assesses viability and impact, and elaborates on the plan to facilitate implementation of overall project sustainability efforts and supports. Sustainability supports may include EHR/EMR enhancements, staff engagement, real-time treatment finder system enhancements, improved transitions to care or other identified sustainability measures.

Objective 6A. By August 31, 2023, subrecipient will implement strategies supporting the sustainability of the EDCC program.

Required Benchmarks:

- Proposal due November 30, 2022
- Evidence of implementation due August 31, 2023

Deliverable 7 – Resource Development

In conjunction with ODH VIPS, subrecipient will develop and disseminate resources to support the uptake of the EDCC Program in Ohio. Resources may include guidance documents, recommendations for implementing quality improvement processes, recorded trainings, additions to the online emergency department toolkit and/or other sustainable resources.

Objective 7A. By August 31, 2023, subrecipient will

Required Benchmarks:

- Proposal due November 30, 2022
- Drafted resources due May 31, 2023
- Evidence of implementation due August 31, 2023

Deliverable Allocations		
Appendix B2		
Name of Subgrant Program: Emergency Department Comprehensive Care (EC23)		
Budget Period: 9/1/22 - 8/31/23		
# of Deliverables: 7		
Use Budget Justification Scenario #: 3		
X Deliverables Only		
	Required/Optional	
Deliverable 1 - Objective 1A - Program Reporting	Required	Provided by Applicant
Deliverable 2 - Objective 2A- Site Visit	Required	Provided by Applicant
Deliverable 3 - Objective 3A - Statewide Collaboration	Required	Provided by Applicant
Deliverable 4 - Objective 4A - Program Expansion	Required	Provided by Applicant
Deliverable 5 - Objective 5A - Evaluation	Required	Provided by Applicant
Total for deliverables 1 - 5		$300,000.00
Deliverable 6 - Objective 6A - Sustainability Supports	Optional	Provided by Applicant
Deliverable 7 - Objective 7A - Resource Development	Optional	Provided by Applicant
Total for deliverables 6 and 7		$100,000.00
Grand Total		$400,000.00

Appendix C

ODH Evidence of Health Equity Strategies Checklist

This checklist should be used to support planning, implementation, and evaluation of equitable strategies to reduce disparities and overcome social determinants of health. This checklist is a guide to establish a baseline criterion that all projects funded by ODH to support alignment with established priorities to achieve optimal health for all Ohioans.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

Racial and ethnic minorities, those living in rural communities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, learn, work, play, and age. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods and freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH).** SDOH are a root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation. See Ohio's State Health Assessment Ohio's health data. https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment

2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused.

Ohio Health Improvement Zones (OHIZ) refer to any community with a US Centers for Disease Control, Agency for Toxic Substance and Disease Registry (CDC/ADSTR) Social Vulnerability Index (SVI) Score of .75 or higher. The SVI measures the socioeconomic and demographic factors that affect the resilience of individuals and communities – the ability to prevent human suffering and financial loss in a disaster. The SVI uses the most current data available from the US Census Bureau American Community Survey 5-year estimates (2014-2018) to assign each census tract in the nation a score ranging from 0 – 1, detailing areas of high and areas of low SVI. The SVI is comprised of 15 indicators grouped into 4 themes: socioeconomic status, household composition and disability, minority and language, and housing and transportation. Census tracts with scores of .75 and greater are designated as Ohio's Health Improvement Zones. For more information on Ohio's Health Improvement Zones visit: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-improvement-zones.

3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.

4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review 2030 Target Setting Methodologies for Objectives in Healthy People 2030.

5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

The following are best practices toward eliminating disparities and achieving health equity and are not required, but highly encouraged.

1) Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in Healthy People 2030, the State Health Improvement Plan (SHIP) and local Community Health Assessments .
   - State Health Improvement Plan - https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship
   - Healthy People 2030 - https://health.gov/healthypeople

2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.

3) Identify up- and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.

4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, local industries, businesses, universities, businesses, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program.

Appendix D

Annual Guidance

Overview

This project is being funded by federal funds through the Centers for Disease Control and Prevention (CDC), Overdose Data to Action (OD2A) funding. The purpose of this funding is to provide the necessary support for hospital systems/emergency departments to sustain and expand on existing comprehensive care services and programs for patients who present in emergency departments with substance use disorder. This application is for the program period 9/1/2022 – 8/31/2023. The budget justification needs to cover the budget period of 9/1/2022 – 8/31/2023. Total available funds per applicant are up to $400,000 for the project year for deliverables 1-7.

Deliverables are listed in Appendix B1. Deliverables 1 – 5 are required. Deliverables 6 and 7 are optional. Deliverable interventions should intend to reach priority populations and be implemented in heavily burdened counties and populations (please reference Appendices G, H, and I). All deliverable documentation will be subject to ODH approval.

Funding

The total funding for required deliverables 1 – 5 is $300,000. The total funding for optional deliverables 6 and 7 is up to $100,000. The total funding for all required and optional deliverables is $400,000. Subrecipient may set the individual amount per each deliverable. Allocated amounts for deliverables will be subject to ODH approval.

Program Reporting

Quarterly program reporting is a required activity. The program report will consist of narrative and quantitative sections. The narrative portion of the program reports should convey the subrecipient's dedication to evidence-based practices, engagement with community partners and the statewide collaborative, and methods being employed to address health disparities as it pertains to their priority populations. Please see Appendix K for metrics required for the quantitative portion of the program report.

- There will be a total of four program reports submitted on December 15, 2022, March 15, 2023, June 15, 2023, and September 15, 2023.

Site Visit

Site visitation is a required activity. One site visit will occur during the program period. If possible, the site visit will be conducted in person. In-person site visits may be replaced by a virtual site visit if circumstances necessitate such action. The length of the site visit shall be no less than two hours. Amounts allocated to the site visit should be indicative of the length of time planning and hosting the visit.

- Subrecipient will submit a site visit plan by February 28, 2023. The plan shall include a list of activities and objectives that will be completed during the site visit.
- Subrecipient will submit site visit documentation by May 31, 2023. Documentation must include but is not limited to presentation slides, agenda, and list of attendees.

Statewide Collaboration

Active participation in the Ohio Overdose Prevention Network (Ohio OPN) is a required activity for this continuation year. Ohio OPN is a subgroup of the Ohio Injury Prevention Partnership (OIPP). It was created to focus specifically on the epidemic of drug overdose deaths. Ohio OPN has four subcommittees: Data and Evaluation, Harm Reduction, Primary Prevention, and Linkages to Care. The Linkages to Care Subcommittee will be forming a workgroup for emergency departments. Subrecipient will become a member of Ohio OPN's Emergency Department Statewide workgroup. Workgroup calls will occur bi-monthly. The workgroup calls will be open to anyone interested in emergency department initiatives, beyond the ED and EC grant program. A workgroup call schedule will be provided by ODH.

- Documentation of participation by the subrecipient's core members in the bimonthly workgroup calls must be submitted before November 30, 2022, February 28, 2023, May 31, 2023, and August 31, 2023. Documentation includes workgroup call minutes and documents created for the workgroup.

Subrecipients are required to facilitate one of the bi-monthly workgroup calls. Subrecipient will work in collaboration with ODH to plan and prepare an agenda for the call. Call topics should focus on needs as identified by the workgroup. Speakers may be invited to the call from the subrecipient agency, other agencies, or other states to speak on topics related to implementing a comprehensive system of care in the emergency department.

- Documentation of facilitation of one workgroup call will be submitted at the end of the quarter when the call was completed. Documentation of call facilitation includes a planned agenda, presentation slides, and/or minutes.

Program Expansion

Program expansion is a required activity. Subrecipient is responsible for implementing the EDCC program in a minimum of two additional emergency department sites. Chosen emergency department sites do not have to be a part of the subrecipient's health system. Chosen emergency department sites must be in heavily burdened counties and are subject to ODH approval. A complete implementation plan of the expansion must be submitted with the application and should include specific strategies that will be employed to address health inequities.

- Signed formal agreements with each emergency department site are due November 30, 2022 and should include a statement of commitment from members of leadership, assignment of responsibilities, resource allocation, financial arrangement, risk-sharing, and sustainability.
- Draft protocols, guidelines, frameworks, and/or workflows are due November 30, 2022.
- Finalized protocols, guidelines, frameworks, and/or workflows are due February 28, 2023. Documentation of implementation is due May 31, 2023.
- Documentation of program sustainability for the additional emergency department sites is due August 31, 2023.

Evaluation

Completion of a comprehensive program evaluation is a required activity. The evaluation should demonstrate the impact and outcomes of the entire grant program, beginning March 1, 2021. The evaluation must address all strategies implemented, including how the subrecipient addressed health inequities. Subrecipient should utilize guidance documents that provide instruction on effective ways to assess health equity such as but not limited to the Culturally Responsive and Equitable Evaluation (CREE) Approach and the Addressing Health Equity in Evaluation section of the CDC's *A Practitioner's Guide for Advancing Health Equity*.

- The evaluation plan is due by November 30, 2022.
- The evaluation report is due May 31, 2023 and must convey the entire impact of the program and lessons learned.
- Dissemination of findings and lessons learned with community stakeholders is due August 31, 2023.

Sustainability Supports

Implementation of sustainability supports is an optional deliverable. The proposal should clearly convey the effectiveness of proposed activities and how they will impact sustainability. A clear outline of action steps required for implementation must be included in the proposal. Examples of sustainability proposals may include EHR/EMR enhancements, staff engagement activities that promote buy-in and reduce stigma, real-time treatment finder system enhancements, improved transitions to care, or other identified sustainability measures.

- The sustainability proposal is due by November 30, 2022.
- Documentation of implementation of identified sustainability supports is due August 31, 2023.

Resource Development

Development and dissemination of resources to support the adoption of comprehensive emergency department programs in Ohio is an optional deliverable. Subrecipient can develop materials such as guidance documents that contain sample policies and protocols, recommendations for implementing quality improvement processes, recorded training, additions to the online emergency department toolkit, evaluation practices, real-time treatment finder best practices, and other identified resources.

- Subrecipient will submit a resource development proposal by November 30, 2022.
- Resource development drafts are due May 31, 2023.
- Subrecipient will disseminate resources to the identified population. Documentation of dissemination of developed resources is due August 31, 2023.

Appendix E

Application Instructions

To complete the continuation application for ODH, complete each of the required application components listed below. Attachments should be named as indicated below and attached in GMIS 2.0 per system instructions.

Please Note: Proposed strategies should not be duplicative of activities already funded through the Ohio Department of Health (ODH), Violence and Injury Prevention Section (VIPS). If similar activities or activities within the same health system/emergency department are proposed, the applicant should differentiate between current work and fully explain how the proposed strategies will be additive and not duplicative.

The following components are required:

A. **Program Narrative: 15-page limit –** named "*Agency Name_Narrative_2023*"
The program narrative should explain any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding. An outline for the Program Narrative is included below:

1. Program Updates
    a) Personnel – List all employees, percentage of time, and short description of job responsibilities/duties.
    b) Partnerships – Provide an update on established partnerships that you will utilize in the following grant year.
2. Work Plan Updates
    a) Provide a description of each objective, indicating any updates/progress and changes proposed for the following grant year.
        i. Successes – Describe successes for each objective and plans for expansion.
        ii. Challenges – Describe challenges for each objective and strategies that have been implemented to overcome challenges.
        iii. Opportunities – Describe opportunities for progress for each objective in the following grant year.
        iv. Health Equity – Describe plans for identifying and addressing priority populations for each objective.

B. **Work Plan (Appendix F): no page limit -** named *"Agency Name_ Work plan_2023"*

C. **Budget Justification (Appendix J): no page limit** – named *"Agency name_Budget Justification_2023"*
This funding is deliverable-based, and the required budget narrative should follow the template provided. However, for the purposes of the application please summarize how the requested funds will be allocated within the project including the following:

1. Salary for personnel to implement identified strategies along with names of staff, if known.
2. Implementation funds and known strategies those funds will be directed to.
3. Key implementation partners with proposed compensation and contracts to be initiated.

Appendix F

Annual Work Plan Template

2022 Emergency Department Comprehensive Care Project ANNUAL WORK PLAN TEMPLATE					
Organization Name:					
Objective 1A: Program Reporting					
Activity	**Partners Identified**	**Steps Proposed**	**Timeline (Month/Year)**		**Performance Measures/Outcomes**
			Start	**End**	
Objective 2A: Site Visit					
Activity	**Partners Identified**	**Steps Proposed**	**Timeline (Month/Year)**		**Performance Measures/Outcomes**
			Start	**End**	

Objective 3A: Statewide Collaborative					
Activity	Partners Identified	Steps Proposed	Timeline (Month/Year)		Performance Measures/Outcomes
			Start	End	

Objective 4A: Program Expansion					
Activity	Partners Identified	Steps Proposed	Timeline (Month/Year)		Performance Measures/Outcomes
			Start	End	

Objective 5A: Evaluation					
Activity	Partners Identified	Steps Proposed	Timeline (Month/Year)		Performance Measures/Outcomes
			Start	End	

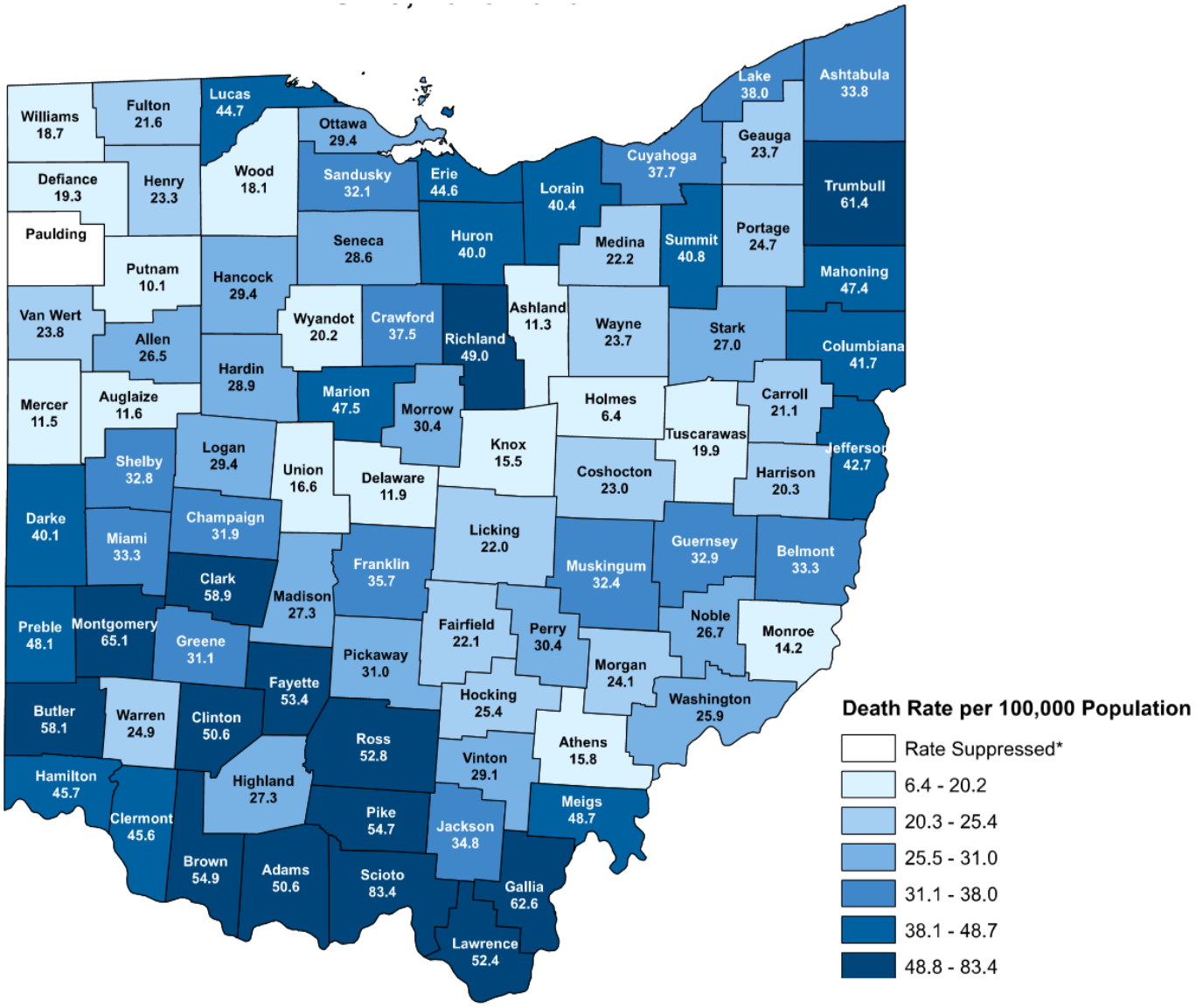
Objective 6A: Sustainability Supports					
Activity	Partners Identified	Steps Proposed	Timeline (Month/Year)		Performance Measures/Outcomes
			Start	End	

Objective 7A: Resource Development					
Activity	Partners Identified	Steps Proposed	Timeline (Month/Year)		Performance Measures/Outcomes
			Start	End	

Appendix G

Overdose Rate per County

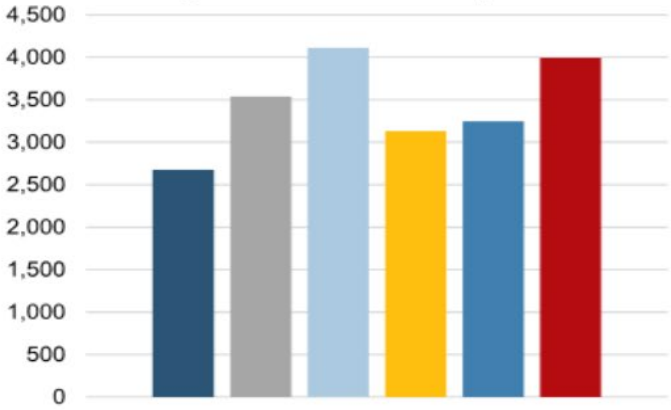
Average Age-Adjusted Rate of Unintentional Drug Overdose Deaths by County, Ohio, 2015-2020



Overdose Report per Race/Ethnicity

Figure 11. Number of Unintentional Drug Overdose Deaths by Race/Ethnicity, Ohio, 2015-2020*

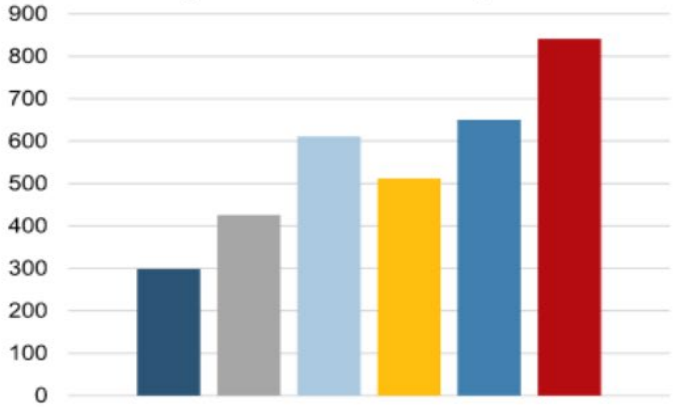
Figure 11a. White Non-Hispanic



White Non-Hispanic:

- Unintentional drug overdose deaths among the white non-Hispanic population were highest in 2017 (4,109 deaths) and made up 85% of all Ohio drug overdose deaths in that year.
- In 2020, there were 3,992 deaths among white non-Hispanic Ohioans, which was a 23% increase over 2019 (3,247 deaths). White non-Hispanic individuals made up 80% of Ohio drug overdose deaths in 2020, compared with 79% of the total Ohio population.

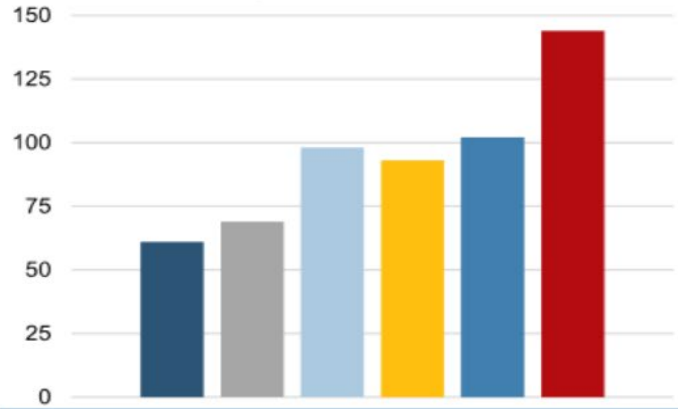
Figure 11b. Black Non-Hispanic



Black Non-Hispanic:

- Unintentional drug overdose deaths among the Black non-Hispanic population were highest in 2020 (841 deaths). Black non-Hispanic individuals made up 17% of Ohio drug overdose deaths in 2020, compared with 14% of the total Ohio population.
- From 2019 to 2020, unintentional drug overdose deaths among Black non-Hispanic Ohioans increased 29%.

Figure 11c. Hispanic



Hispanic:

- Unintentional drug overdose deaths among the Hispanic population were highest in 2020 (144 deaths). Hispanic individuals made up 3% of Ohio drug overdose deaths in 2020, compared with 4% of the total Ohio population.
- The number of unintentional drug overdose deaths among Hispanic Ohioans remained relatively stable from 2017 to 2019. However, from 2019 to 2020, deaths increased 41%.

Appendix I

Emergency Department Visits for Suspected Drug Overdose by County

	2017	2018	2019	2020
Adams	72.1	70.1	68.3	67.1
Allen	99.8	60.3	56.7	76.3
Ashland	53.4	37.9	29.8	51.3
Ashtabula	98.1	68.7	78.6	93.1
Athens	61.8	53.3	52.5	69.3
Auglaize	84.2	72.3	48.1	55.1
Belmont	76.0	70.7	66.3	97.4
Brown	118.9	78.4	75.2	92.3
Butler	171.3	111.5	110.0	109.7
Carroll	53.8	48.2	37.4	47.1
Champaign	110.8	62.9	53.6	76.0
Clark	168.4	95.7	85.2	101.8
Clermont	134.5	98.2	89.5	93.4
Clinton	96.4	75.4	77.5	71.8
Columbiana	78.3	63.7	75.0	89.5
Coshocton	44.9	48.6	53.9	56.5
Crawford	74.2	51.3	57.7	72.3
Cuyahoga	90.1	62.9	61.6	66.9
Darke	65.2	55.1	56.4	66.4
Defiance	52.8	46.0	50.6	53.8
Delaware	59.7	57.4	58.0	72.1
Erie	89.1	61.4	70.3	97.5
Fairfield	74.3	59.1	50.9	61.9
Fayette	220.8	93.5	86.3	102.3
Franklin	81.1	70.8	80.9	95.2
Fulton	56.7	74.0	62.5	79.2
Gallia	142.3	97.1	76.3	101.8
Geauga	78.7	55.1	60.9	62.2

	2017	2018	2019	2020
Greene	116.7	70.2	73.9	70.9
Guernsey	119.2	132.0	102.3	119.9
Hamilton	99.7	82.4	81.9	87.7
Hancock	68.7	68.1	60.7	81.6
Hardin	67.9	42.7	60.1	70.6
Harrison	37.0	29.7	41.4	42.2
Henry	39.2	37.9	47.2	53.6
Highland	129.8	67.7	68.7	72.4
Hocking	44.0	35.6	45.5	62.9
Holmes	32.6	27.6	30.1	40.8
Huron	128.3	74.8	82.8	87.6
Jackson	87.7	70.5	68.0	105.4
Jefferson	56.6	62.9	49.1	72.3
Knox	83.4	56.4	44.3	67.8
Lake	112.8	88.9	91.0	91.2
Lawrence	126.3			
Licking	58.6	50.7	42.9	62.9
Logan	72.7	44.4	44.6	40.8
Lorain	85.0	66.9	61.7	88.2
Lucas	78.7	73.8	74.2	86.6
Madison	88.9	61.9	81.1	91.1
Mahoning	97.5	72.2	72.4	99.4
Marion	99.9	105.1	105.3	119.3
Medina	80.8	53.9	53.6	58.4
Meigs	88.6	71.3	66.0	71.3
Mercer	89.4	48.5	50.5	40.4
Miami	112.9	69.8	71.8	64.8
Monroe		47.5	32.3	76.1

	2017	2018	2019	2020
Montgomery	149.9	79.1	81.5	94.4
Morgan	45.1	45.3	46.4	54.0
Morrow	57.7	44.7	50.8	54.7
Muskingum	70.2	56.3	51.8	71.1
Noble	75.7	66.7	65.2	77.4
Ottawa	64.5	61.2	62.7	58.3
Paulding	41.3	47.3	31.1	38.7
Perry	57.7	44.2	33.2	50.1
Pickaway	65.1	59.7	63.7	105.7
Pike	110.0	71.9	87.0	147.2
Portage	84.2	60.3	68.2	66.7
Preble	161.7	76.1	81.5	95.4
Putnam	55.2	30.5	41.1	50.0
Richland	124.0	66.2	75.1	94.3
Ross	134.1	102.4	128.6	128.5
Sandusky	76.1	59.4	56.4	71.8
Scioto	147.1	103.5	93.0	100.3
Seneca	79.6	60.1	56.6	87.3
Shelby	104.6	68.0	56.3	70.4
Stark	71.0	55.3	49.2	57.0
Summit	96.7	67.9	74.7	65.3
Trumbull	139.3	82.8	98.1	133.8
Tuscarawas	57.8	49.8	53.5	72.9
Union	75.3	69.3	54.1	58.2
Van Wert	91.0	63.3	48.9	62.1
Vinton	58.8	43.8	59.0	95.7
Warren	142.9	85.1	74.5	90.6
Washington	35.3	45.4	34.3	56.0
Wayne	92.8	54.4	71.4	74.8
Williams	50.9	71.8	59.5	76.6
Wood	61.2	55.4	49.6	69.1
Wyandot	61.4	49.0	48.8	54.7

Appendix J

BUDGET JUSTIFICATION EXAMPLE (Deliverables Only)

NOTES:

1. **Budget justification line items MUST be in the same order as in the GMIS budget.**

OTHER DIRECT COSTS

Deliverable – Objectives

(PLEASE REFER TO SUBGRANT SOLICITATION FOR THE REQUIRED SCENARIO) (Note: Budget leverage cannot be used to move funding into or out of any Deliverables – Objective line item. Also, indirect cannot be charged against this line item.)

Scenario 1 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1 $10,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2 $45,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3 $60,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Scenario 2 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1

  Franklin County $40,000

  Union County $11,000

  Madison County $20,000

  Licking County $15,000

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2

Franklin County	$52,500
Union County	$9,500
Madison County	$12,500
Licking County	$16,500

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3

Franklin County	$78,750
Union County	$16,750
Madison County	$8,750
Licking County	$38,750

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Scenario 3 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1

Objective A	$10,000
Objective B	$20,000
Objective C	$30,000
Objective D	$40,000

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2

Objective A	$12,500
Objective B	$2,500
Objective C	$1,500
Objective D	$16,500

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3

Objective A	$28,750
Objective B	$8,750
Objective C	$1,750
Objective D	$38,050

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Total Other Direct Costs **$Total**

Notes:

1. **The budget justification must be signed by the agency head listed in GMIS.**
2. **Budget revisions that do not include a signed budget justification by the agency head listed in GMIS will be disapproved.**
3. **Authorized representative certification language must also be included with agency head signature.**

Subrecipient's authorized representative certifies the foregoing:

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Sub-recipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.

- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

_____

[Signature]

_____

[Print Name & Title]

_____

[Date]

Appendix K

Sample Program Reporting
Data Component

General Baseline Data
Total number of emergency department visits
Number of emergency department visits for overdose[1] as primary or secondary diagnosis
Of which: Number of visits indicated as *Treat & Release (T&R)*
Of which: Number of visits in which patients left *Against Medical Advice (AMA)*
Of which: Number of visits in which patients ELOPED
Of which: Number of visits in which patients were *observed*/visit was indicated as *observation*
Of which: Number of visits in which patients were *admitted*/visit was indicated as *admission* to the hospital directly from the emergency department
Number of non-overdose[1] emergency department visits for patients with primary or secondary diagnoses of opioid abuse, use, or dependence[2]
Number of prescribers[3] in the emergency department
Of which: Number of prescribers[3] DATA 2000/x-waiver trained in the emergency department
Of which: Number of prescribers[3] prescribing MAT[4] in the emergency department[(*)]
Of which: Number of prescribers[3] who encountered patients admitted for overdose[1] or with opioid abuse, use, or dependence[2]
Training
Number of prescribers[3] trained on any component of the comprehensive model/approach for this EDCC project and OUD. This includes trainings such as: Data 2000/x-waiver, SBIRT, motivational interviews, other screening protocols, PRS collaboration, stigma and addiction medicine etc. Please elaborate and indicate trainings in notes section.
Number of staff members[5] trained on any component of the comprehensive model/approach for this EDCC project and/or OUD. This includes trainings pertaining to: SBIRT, motivational interviewing, other screening protocols, PRS collaboration, stigma, addiction medicine, emergency department etiquette etc. Please elaborate and indicate trainings in notes section.
Screening
Number of patients screened for Opioid Use Disorder (OUD) in the emergency department
Number of patients identified with Opioid Use Disorder (OUD) through screening process
Treatment
Number of *referrals*[6] to treatment[7]
Number of *patients warmly handed-off*[8] to treatment[7]
Of which: Number of *post-overdose*[1] *patients warmly handed-off*[8] to treatment[7]
Number of patients warmly handed-off[8] to treatment[7] using telehealth technology
Number of *post-overdose*[1] *patients* warmly handed-off[8] treatment[7] using telehealth technology
Number of treatment referrals facilitated using a real-time treatment finder platform
Number of *patients referred*[6] specifically to MAT[4]
Of which: Number of *post-overdose*[1] *patients referred*[6] specifically to MAT[4]
Number of emergency department patients discharged with a prescription for home initiation of buprenorphine

Linkages
Number of Peer Recovery Support (PRS) coaches operating in the emergency department
Number of *referrals*[6] to risk reduction or wrap-around services[9]
Number of *patients warmly handed-off*[8] to risk reduction or wrap-around services[9]
Of which: Number of *post-overdose*[1] *patients warmly handed-off*[8] to risk reduction or wrap-around services[9]
Number of patients warmly handed-off[8] to risk reduction or wrap-around services[9] using telehealth technology[9]
Number of *post-overdose*[1] *patients* warmly handed-off[8] to risk reduction or wrap-around services[9] using telehealth technology[9]
Number of linkages facilitated using a real-time treatment finder platform
Naloxone
Number of patients who received a naloxone kit[10]
Of which: Number of post-overdose[1] patients who received a naloxone kit[10]
Number of patients who received a prescription for naloxone
Of which: Number of post-overdose[1] patients who received a prescription for naloxone
Number of family members/friend who received a naloxone kit[10]
Of which: Number of family member/friend of a *post-overdose*[1] who received a naloxone kit[10]
Number of naloxone prescriptions filled[11]
Number of naloxone kits and prescriptions refused[12]
Tracking
Number of patients contacted 6 weeks or more post emergency department discharge
Of which: Number of patients contacted 6 weeks post emergency department discharge who report treatment retention

Footnotes
[1] *Overdose includes diagnoses for which only poisoning codes are used (please do not report adverse effect), additionally please only report initial encounters for poisoning (do not report subsequent encounters or sequela). Thus, for the ICD10 codes themselves only include those with a 7th character of "A" for initial encounter and only 6th characters of "1" for unintentional and "4" for undetermined. Please see the following tabs that specify which T40 ICD10 codes should be included. This metric includes patients with a T40 eligible primary diagnosis with an eligible F11 (or opioid-related neonatal/newborn P coded) secondary diagnosis, or vice versa. It is also noted that though the coding conventions for overdoses/poisoning/adverse effects should almost always be that the overdose be coded sequentially first followed by manifestations, I do realize that discrepancies and inconsistency in coding behavior across emergency department sites and systems may result in underreporting if, for example, diagnoses such as respiratory failure and aspiration pneumonia are coded sequentially first and second rather than the overdose.*
[2] *The OUD-Related CPT/ICD10 codes for opioid use, abuse or dependence include the F11 & neonatal/newborn subsets (included on the next tab of this document). This metric should not include individuals that had a primary or secondary T40 diagnosis code for overdose/poisoning/adverse effects.*
[3] *Prescribers includes providers with prescribing privileges in the emergency department and may include MD & DO Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), Advanced Practice Providers (APPs). Please seek prior approval from ODH before including providers that are not mentioned here.*

[4] *MAT includes methadone, buprenorphine, suboxone, and naltrexone but does not include naloxone.*

[5] *Staff members include ancillary personnel such as case managers, medical assistants, nurses, peer recovery support coaches, patient navigators, other care coordinators, paramedics, occupational therapists, security, pastoral care, admin staff. Please seek prior approval from ODH before including staff members that are not mentioned here.*

[6] *Although we recognize that well-done referrals can be sometimes thought of as possibly being warm handoffs, referrals are operationalized to include: making formal referrals within the EMR system (including the providing of information to next level of care via CarePath or fax), scheduling an appointment for or with the patient, assisting with or facilitating the patient to make their own appointment, as well as providing patient with information on where and how to access services that do not receive formal referrals via EMR web/portal-based appointment scheduling or referrals, and/or are not available/reachable by phone. Please also note that this metric is the number of referrals, whereas the following metrics are for number of patients. This is how they are requested by the CDC. Thus, during any given quarter, a patient may be "referred" to treatment or wraparound services multiple times during different emergency department visits or may be referred to multiple treatment or wraparound services. Again, please report the number of referrals here.*

[7] *Imperfect as it may be, treatment is operationalized here to only include referrals and warm handoffs to treatment at/with entities/providers/agencies for substance use or addiction medicine (e.g., detox, inpatient rehabilitation, intensive outpatient, medicated assisted treatment etc.). This does not include referrals for treatment of conditions associated with OUD or referrals strictly for mental/medical/dental/primary health care treatment not in conjunction with substance use or addiction medicine. Additionally, in scenarios in which MAT providers are also primary care providers a chart review may be necessary to ascertain the nature of the referral to determine whether the referral was for MAT or solely for other primary care needs. Please count patients admitted to the hospital for inpatient detox as "warm handoffs" to treatment.*

[8] *According to the US Department of Health & Human Services: Agency for Healthcare Research and Quality, "A warm handoff is a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present)." More information and guidelines for clinicians can be found on the website url linked below. When patients are linked with a PRS coach in the emergency department this does constitute a warm handoff to wrap-around services. However, in scenarios where the PRS coaches don't get the opportunity to meet the patient in the emergency department and end up calling the patient after discharge, after reviewing a log (as described to sometimes happen at Mercy Fairfield), this does not count as a warm handoff. It does, however, count as a referral to wraparound services. Please count patients admitted to the hospital for inpatient detox as "warm handoffs" to treatment. Scheduling an appointment and/or providing information to next level of care is not a warm handoff. These would be considered referrals in this context. PRS is a significant component of warm handoffs, and when PRS coaches physically take the person to treatment, this is considered a warm handoff to treatment.*

https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html

[9] *Risk reduction and wrap-around services are not technically one in the same, but for the sake of this reporting are combined and will be used interchangeably. Risk reduction and wrap-around services include utilizing PRS coaches, testing (HIV/HCV/STI), Syringe Service Programs (SSPs), fentanyl test strips, primary medical, dental and mental health care, childcare, educational, vocational, family housing, transportation, food security, health insurance, financial and legal assistance and services. Please seek prior approval from ODH before including risk reduction and wrap-around services that are mentioned here. Though naloxone is clearly considered risk-reduction, please do not count naloxone kits distributed or prescriptions provided here. That naloxone kit and prescription data will be combined with the risk reduction data reported here, as appropriate, when reporting to the CDC. You can, however, count referrals and warm handoffs to naloxone access points and programs such as Project DAWN in this metric.*
[10] *This does not include kits given to family and friends. If you would like to report on such please do so in the comments section.*
[11] *Naturally, reporting on this metric will only be possible for the internal health system pharmacies, and may underreport actual number of scripts filled if/when patients fill scripts elsewhere. This is an acknowledged limitation.*
[12] *We recognize that this may not be easily extractable from the EMR, however, given trends seen across projects, this is important data for us to collect and track. We understand this may require chart reviews by indicating which patients were eligible (those with primary or secondary diagnoses for overdose or opioid use/abuse/dependence), and subtracting those that received a kit or prescription, and then reviewing notes to determine whether staff offered naloxone (kit or script) and if the patient was indicated to have refused such or eloped etc.*
[*] *This metric will include those prescribers that are and are not waiver trained, to account for the non-waivered prescribers that are prescribing vivitrol.*