



# Local Health Department Approaches to Opioid Use Prevention and Response: An Environmental Scan

July 2019



**Public Health**  
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# NACCHO

National Association of County & City Health Officials

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## Introduction

In December 2018, the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* released a report of opioid-involved overdose deaths<sup>1</sup> finding that 47,600 Americans died because of opioid-related overdoses in 2017— 68% of all fatal overdoses and six times the number recorded in 1999.<sup>2</sup> Despite these statistics, strides have been made across the county to slow the epidemic's progression. Inevitably, much of this important day-to-day work falls to communities and their local health departments (LHDs), which play an invaluable role in designing, coordinating, and implementing the response.

## Background

Despite these efforts, there is a lack of information about how LHDs are conducting opioid prevention and response activities and a lack of access to case studies and evidence-based best practices to guide LHDs seeking examples of experienced programs. In an initial attempt to learn more, the National Association of County and City Health Officials (NACCHO) included questions about opioids in their biannual 2018 [Forces of Change Study](#) and found that about two-thirds of LHDs actively addressed the opioid crisis in 2017.<sup>3</sup> While a few other data points on the subject were collected, NACCHO identified a further need to dive deeper and document the range of activities LHDs conduct by administering an environmental scan. The goal of the scan was to create a foundational understanding of LHD opioid overdose prevention and response efforts to inform priorities at the local, state, and national levels.

# Methods

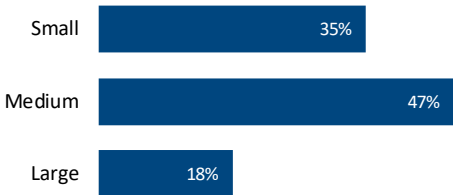
NACCHO distributed the environmental scan survey in January 2019 to 388 LHDs identified from the 2018 Forces of Change survey<sup>4</sup> as respondents who reported conducting activities to address “opioid use and abuse” in 2017. This sample is not intended to be nationally representative. Of the 388 LHDs surveyed, 198 completed the survey for a response rate of 51%.

Questions were compiled using the CDC’s [Evidence-Based Strategies for Preventing Opioid Overdose](#) and NACCHO’s programmatic expertise. The scan was distributed online via Qualtrics Survey Software™ to collect both quantitative and qualitative data. All data were self-reported; NACCHO did not independently verify the data provided by LHDs. Some detail may be lost in the figures due to rounding.

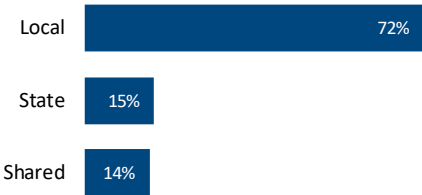
Throughout this report, statistics are compared across three categories of population size. Small LHDs serve populations of less than 50,000 people. Medium LHDs serve populations of 50,000 to 499,999 people. Large LHDs serve populations of 500,000 people or more.

Data are also presented by type of governance, which is the LHD’s relationship to their state agency. Locally governed LHDs are agencies of local government. State-governed LHDs are local or regional units of the state health agency. LHDs that are governed by both state and local authorities are referred to as having shared governance.

**Figure 1. Respondents by Size of Population Served**  
Percent of respondents, n=198



**Figure 2. Respondents by Type of Governance**  
Percent of respondents, n=198



## Local Opioid Overdose Prevention and Response Activities

Of 198 total respondents, 81% reported conducting opioid overdose prevention and response activities. Another 17% reported that they did not conduct activities, and 3% did not know.

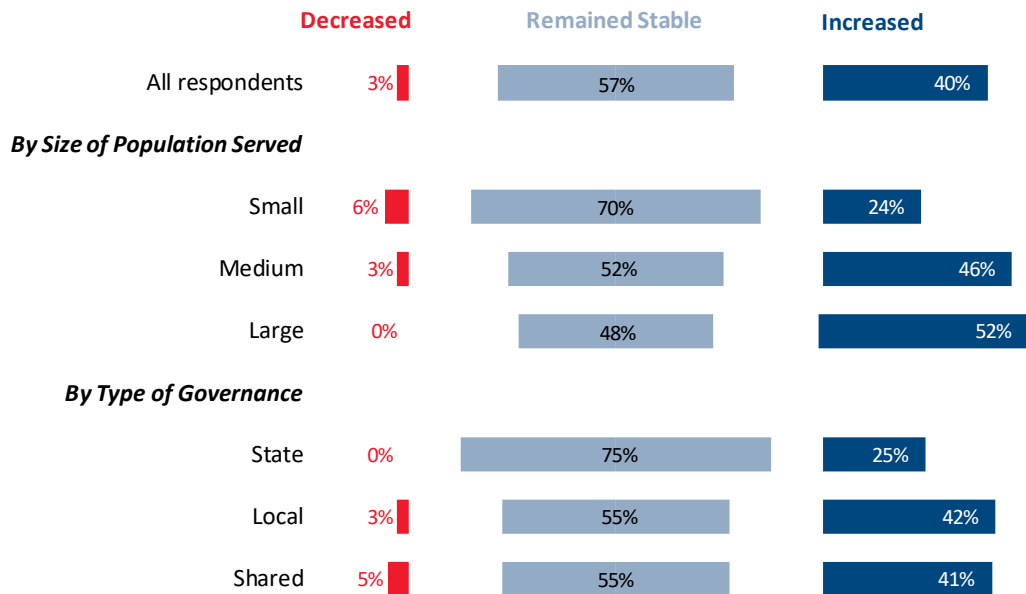
By subgroup, survey respondents reported conducting opioid overdose prevention and response activities at the following rates: 71% of small LHDs, 85% of medium LHDs, and 89% of large LHDs. Responses across LHD governance structures showed that higher proportions of LHDs with local and shared governance conducted activities, 88% and 81% respectively, compared to state-governed LHDs, where 55% reported conducting activities. Respondents were asked about the following topic areas covered throughout the remainder of this report:

- Workforce
- Programmatic Services
- Clinical Services
- Policy
- Communications
- Partnerships
- Data Collection
- Evaluation

## Workforce

Examining LHD activities requires considering LHD workforce capacity. Across the 155 environmental scan respondents, an estimated total of 1,048 employees were working on opioid-related activities in 2018. The chart below shows reported workforce fluctuations overall and by subgroup compared to the previous year.

**Figure 3. Opioid-Related Workforce Changes Compared to Previous Year, 2018**  
Percent of respondents, n=160



**97% of respondents reported that their LHD workforce capacity either remained stable or increased compared to the previous year.**

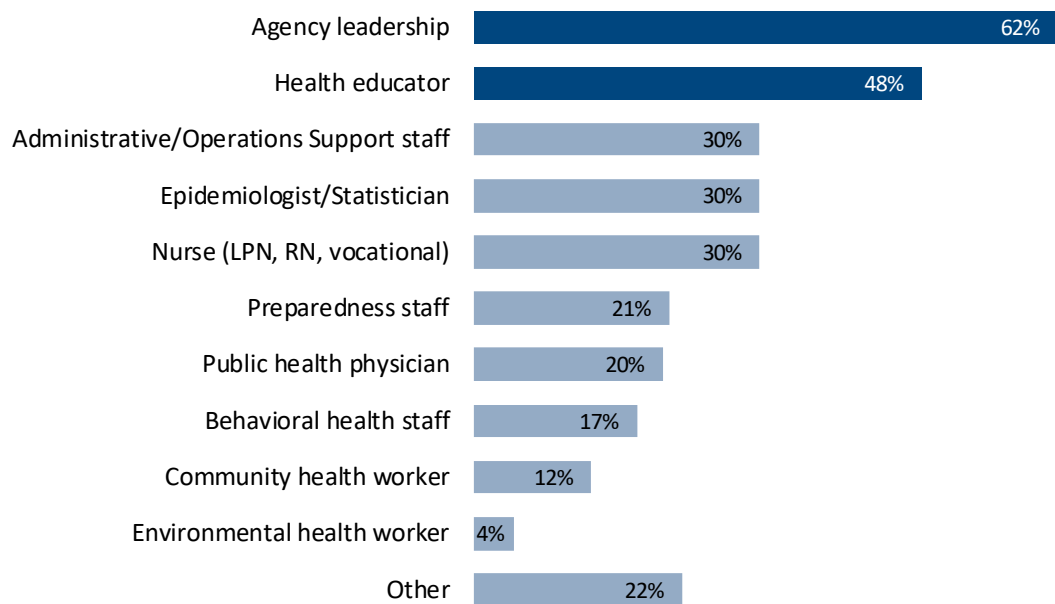
Most respondents reported a close divide between either maintaining or increasing their workforce, an expected response to increasing state and federal funding for the issue.

Across subgroups, responses were similar, except for small and state-governed LHD respondents, which largely maintained workforce capacity, rather than increased workforce capacity. For small LHDs, this could be due to the limitations of short-term grant funding.

Respondents were asked to identify the primary position(s) held by their opioid-focused workforce. The prominence of agency leadership and health educators is evident across all health department sizes and governance structures. Some of the “other” roles reported include planners, medical examiners, outreach and recovery coaches, HIV case managers, communications staff, and prevention specialists.

**Figure 4. Primary Positions of Staff Conducting Opioid Activities**

*Percent of respondents, n=145*



**The most commonly reported LHD staff positions conducting opioid-related activities are agency leadership and health educators.**

Agency leadership and health educators play pivotal roles, but it is important to note the relative lack of diversity of the staff involved. Agency leadership are integral players in engaging their communities around public health concerns, aligning LHD programming with local health priorities, and implementing programming. However, centralizing response activities to fewer staff roles may discourage program sustainability, for example, in the event of staff turnover. Likewise, health educators play a key role in educating the public and reducing misinformation, however the nature of the opioid crisis requires a number of clinical and social service treatment options for individual with opioid use disorder (OUD). It is important that LHDs and their advocates reflect on workforce diversity and support efforts to, when possible, expand the scope and capabilities of staff conducting prevention and response activities.

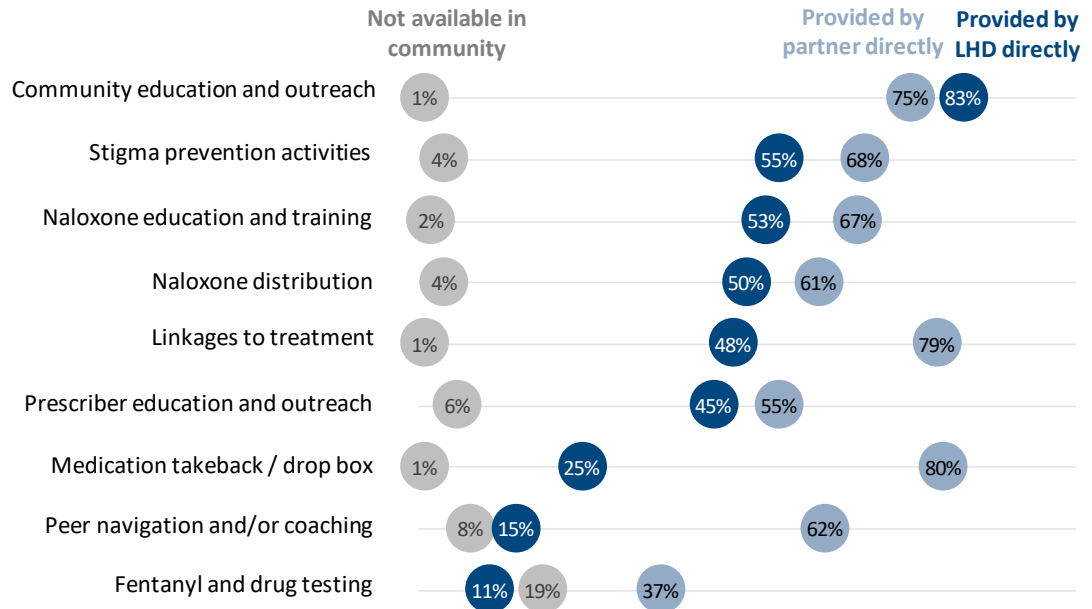
Finally, workforce availability is ultimately based on funding. The 2018 Forces of Change survey reported that many LHDs do not dedicate general funds to conduct opioid-related activities. Notably, state-governed LHDs more commonly reported being unsure of the dedication of general funds compared to agencies with local and shared governance. This could indicate that health departments within state-controlled structures face communication or institutional barriers.

## Programmatic Services

Opioid-related services encompass a wide range of activities, necessitating a combination of LHD and partner-provided services. Respondents were asked to identify whether the following programmatic services are available in their jurisdiction and, if so, who provides them. The most common programmatic service provided by respondents is community education and outreach. Fentanyl and other drug testing was least likely to be available.

**Figure 5. Programmatic Services**

Percent of respondents, n=151–159



### Over 80% of respondents reported directly providing community education and outreach.

While some partners conduct activities that fill gaps not addressed by LHDs, over 50% of respondents noted that partners provide services that are also provided directly by LHDs, namely: stigma prevention activities, naloxone education and training, and naloxone distribution. Looking into activities provided by multiple sources could help LHDs determine whether these services are complementary or duplicative in nature, and if necessary, consider consolidating or diversifying available programmatic services.



We developed a filterable, web-based, publicly available service locator to help community members connect with specialty substance use disorder treatment services known as the Service and Bed Availability Tool (SBAT), available here: <https://sapccis.ph.lacounty.gov/sbat/>. — Los Angeles County Department of Public Health, California

### Over 75% of respondents reported working with partner organizations to provide community education and outreach and linkages to treatment.

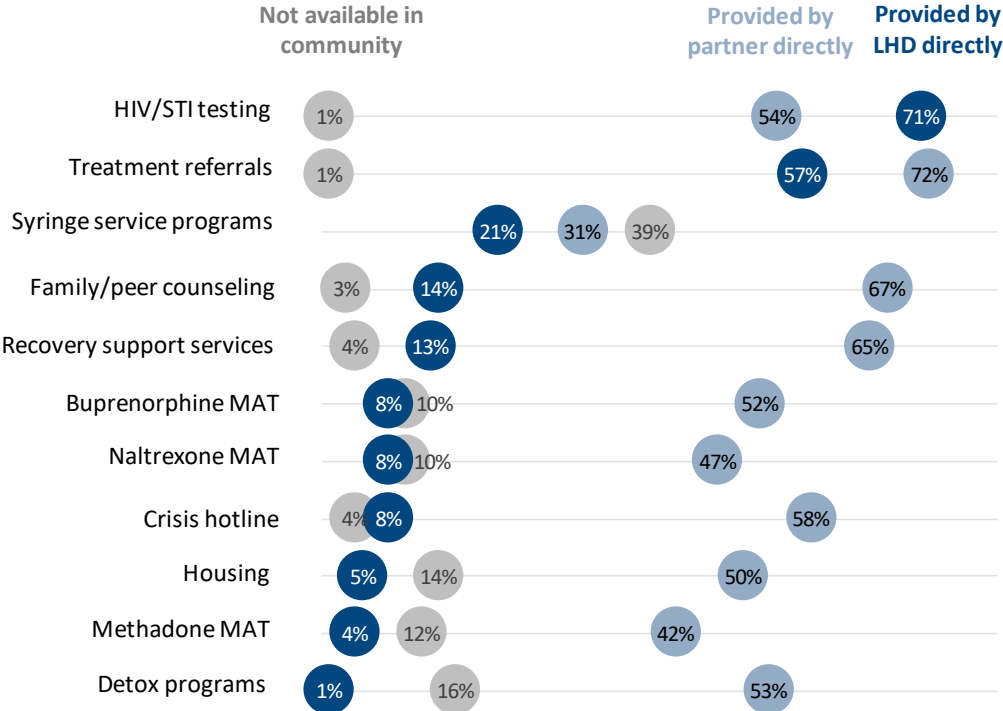


# Clinical Services

Respondents were also asked whether the following clinical services are available in their jurisdiction and who performed them. Although many LHDs do not regularly provide clinical services, they do often act as a conduit for partnering with other community agencies to provide these services. In alignment with this concept, 57% of respondents reported providing referral services as the second most reported clinical service provided directly by LHDs—the most reported being HIV/STI testing.

“We have developed an alliance action plan which community stakeholders have identified gaps in service. The action plan has dates of expected completion and also activities of which have been completed. This information is available at [www.healthypima.com](http://www.healthypima.com).” — Pima County Health Department, Arizona

**Figure 6. Clinical Services**  
Percent of respondents, n=153–158



Except for HIV/STI testing, clinical opioid-related services are more likely to be provided by a partner organization than an LHD.

## Example of Clinical Services

LHD respondents reported that SSPs were the least available among clinical services in their communities. Although some states prohibit SSPs, this is concerning, since SSPs are a CDC-recommended community-based prevention program backed by 30 years of research that are shown to be safe, effective, and cost-saving.<sup>5</sup> Similarly, LHDs that are unaware of MAT services in their community would not be able to provide local treatment referrals.

**40% of respondents indicated that syringe service programs (SSP) are not available in their communities and 12%–20% of respondents indicated being unsure about whether a medication-assisted treatment (MAT) service was available in their community.**



“The Health District and Trac-B, in collaboration with Nevada AIDS Research and Education Society (NARES), launched southern Nevada’s first comprehensive needle exchange program in April 2017, including a delivery component involving vending machines... The Health District helped pave the way for this intervention to take root due to a Health District staff community assessment on people who inject drugs. Health District staff are also the ones conducting stakeholder meetings in rural Nevada to see if the community is receptive to receiving a syringe vending machine.” — Southern Nevada Health District, Nevada

Lastly, the 2018 Forces of Change findings highlight some barriers to LHD provision of programmatic and clinical services, including lack of workforce expertise/training and not having enough data to determine the problem/solution.<sup>6</sup> The most commonly selected barrier among LHDs, however, was a lack of dedicated funding for opioid overdose prevention and response.

## Policy

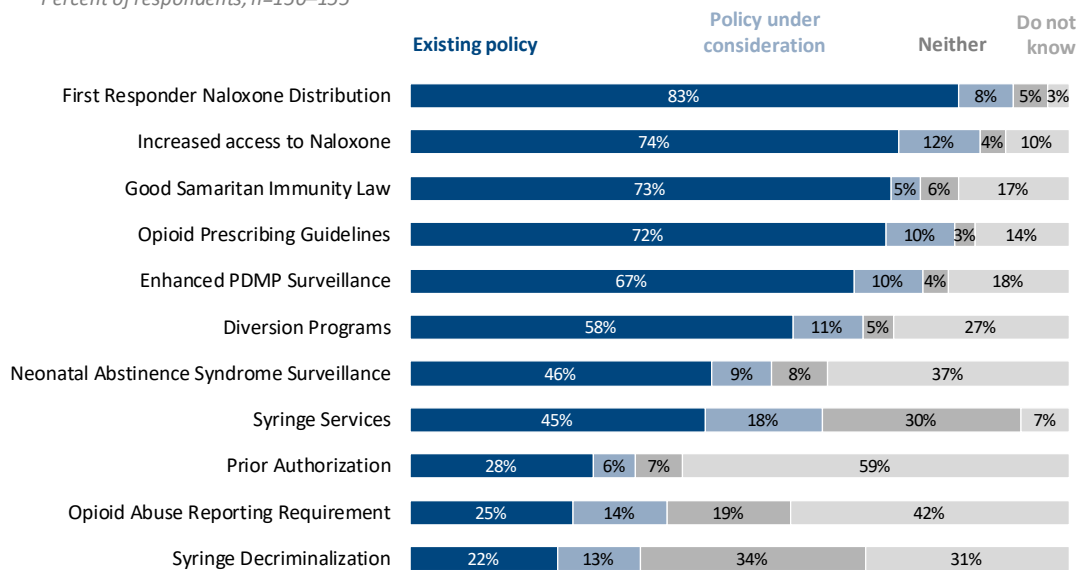
Policy changes play a pivotal role in mitigating the impacts of opioid use in a community and can even determine the types of interventions available. In 2018, a Stanford University study aimed to estimate the effect of policies on opioid-related health outcomes through modeling. The study found that “over five years, increasing naloxone availability, promoting needle exchange, expanding [MAT], and increasing psychosocial treatment increased life years and quality-adjusted life years and reduced deaths.”<sup>7</sup>

Respondents were asked to review a list of opioid-related policies and indicate whether they currently existed or were under consideration in their jurisdiction. Understanding the importance of policy, results from this question are encouraging.

**More than 70% of respondents reported having the following policies in their jurisdictions: first responder naloxone distribution, increased access to naloxone, Good Samaritan immunity policies, or opioid prescribing guidelines.**

**Figure 7. Opioid-Related Policy Status within LHD Jurisdiction**

*Percent of respondents, n=150–155*



Syringe services was also the policy most reported as “under consideration,” followed by opioid abuse reporting requirements and syringe decriminalization. While over two-thirds of respondents reported involvement in developing or advocating for syringe services policies, under one-third reported that syringe services and syringe decriminalization policies neither existed nor were under consideration. These results affirm the difficulty LHDs experience in both advocating and gaining approval for these policies.



“[We] worked to have [Neonatal Abstinence Syndrome] (NAS) as a reportable disease, so appropriate follow-up and connection to services would be done.” — Prince William Health District, Virginia

Among subgroups, one result stood out: small LHDs have the highest rate of involvement in syringe services policies compared to large and medium LHDs. It is important to note that some states, like Missouri, have state-level restrictions around SSP implementation, which could explain these results.



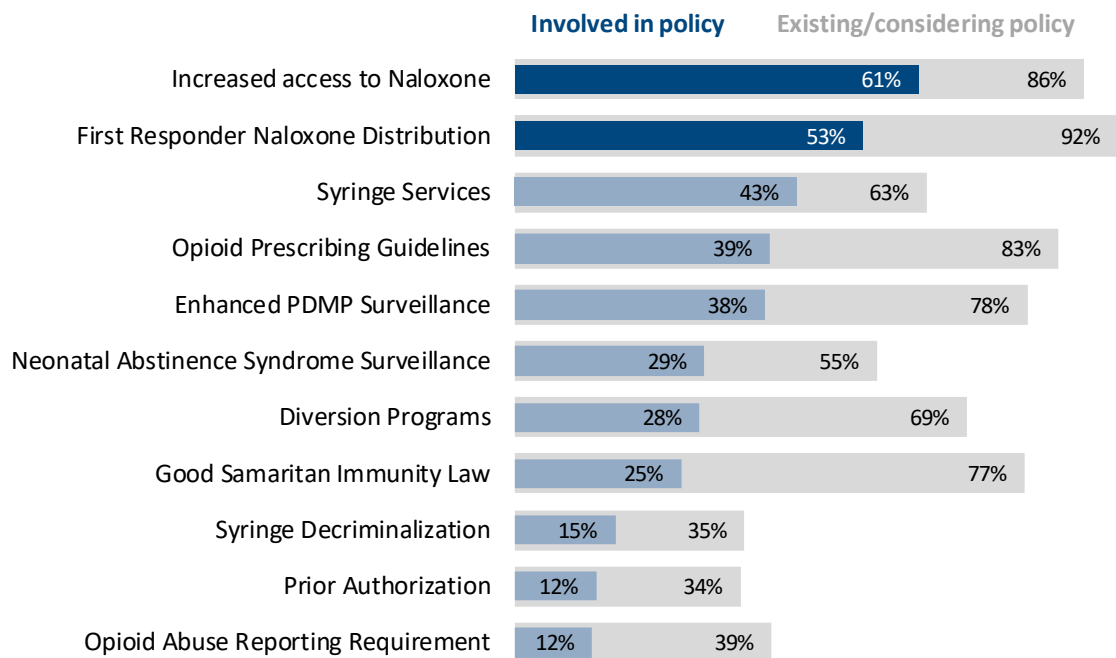
“[The] DC Health Department has convened an inter-agency working group of public health, behavioral health, and public safety agencies, with the DC Department of Behavioral Health...[and] have provided input (and testified) to the City Council on opioid legislation, particularly on availability of naloxone. The health department has also set up standing orders with community pharmacies to access naloxone.”  
 — District of Columbia Department of Health, Washington DC

To gauge LHD involvement in policy formation, respondents were asked whether their LHD has been actively involved in opioid-related policy development or advocacy activities in the past five years.

**More than half of respondents reported being involved in policies about access to or distribution of naloxone.**

**Figure 8. LHD Involvement in Opioid-Related Policy in the Past Five Years**

*Percent of respondents, n=150–155*



Health departments reported involvement in the development and advocacy of all highlighted opioid-related policies. This involvement can be as simple as sharing public health data with those advocating for the policy or as involved as providing formal testimony to elected officials. However, there is no clear relationship between their involvement and the likelihood of policy adoption. For example, 77% of respondents work in jurisdictions that either currently have or are considering a Good Samaritan Immunity Law; however, only one-fourth of respondents have been involved in the development or implementation of the policy within the past five years.

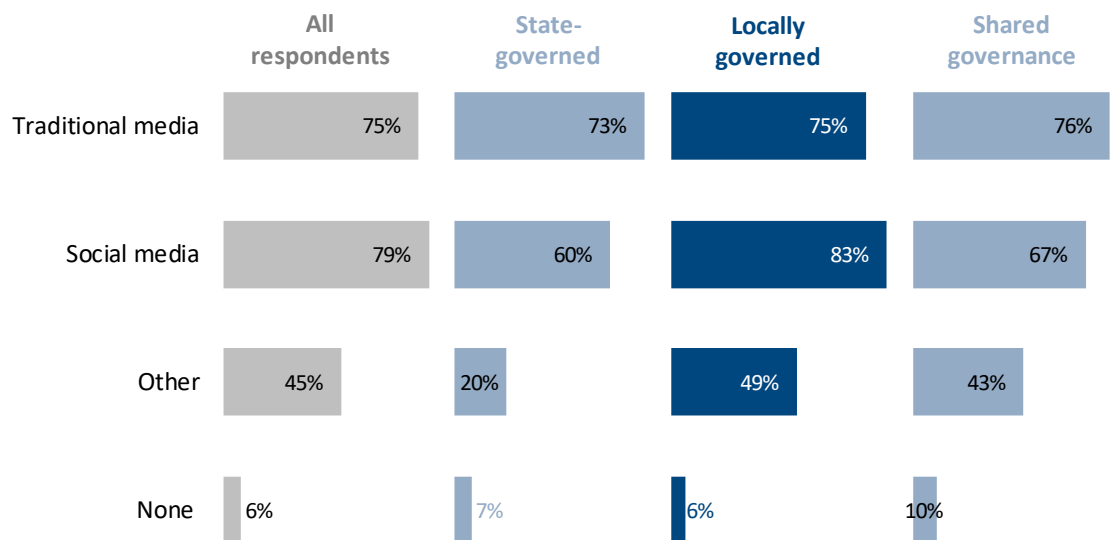
LHD leaders are trusted health leaders and are often called upon to engage in policy-related activities. NACCHO has many resources to help build these skills and identify policy solutions to public health problems. Additional resources, including NACCHO’s Board-approved policy statements, can be found under Injury and Violence Prevention, here: <https://www.naccho.org/advocacy/activities>.

## Communications

Communications efforts help LHDs raise awareness of local public health concerns and available services. Respondents were asked about the types of communications platforms they used to spread awareness about opioid prevention and response activities.

**Figure 9. Channels Used to Communicate about Opioid-Related Activities**

*Percent of respondents, n=157*



**Compared to LHDs with state or shared governance, locally governed respondents are more likely to use social media to communicate about opioid prevention and response activities.**

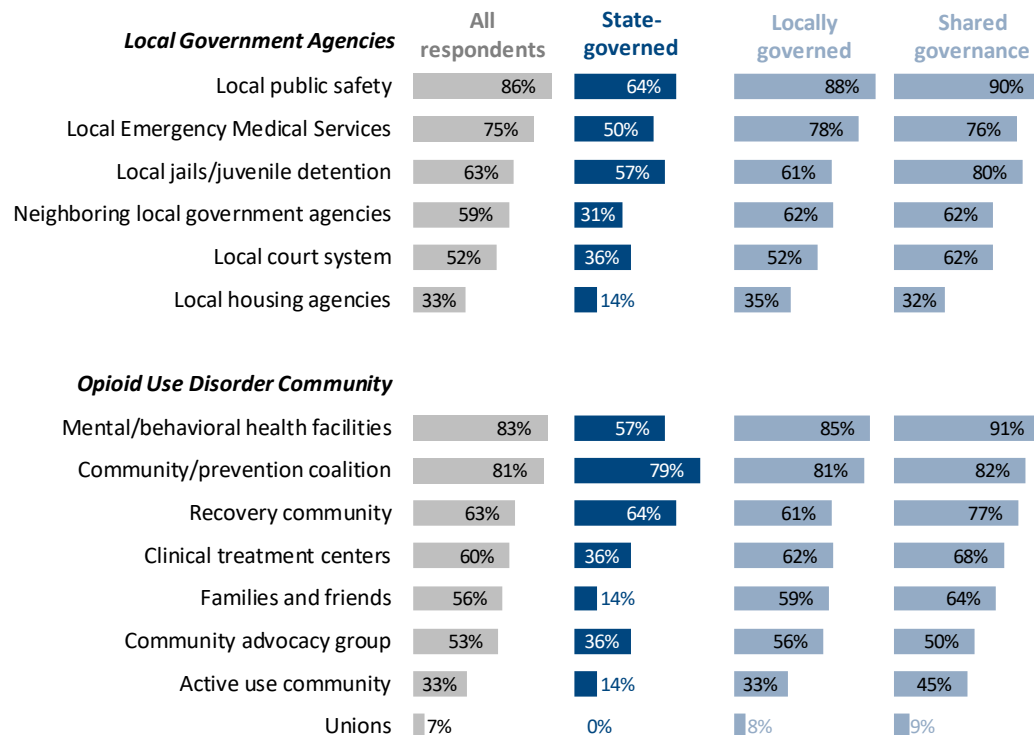
As expected, both traditional (e.g., news media, radio, billboards) and social media (e.g., Facebook, Twitter, Instagram) usage was prevalent across LHDs of all sizes and governance structures. Over 75% of responding LHDs reported using both traditional media and social media platforms. Other reported methods of communications include word of mouth, email newsletters/listservs, community events, taskforces and coalitions, schools, churches, and partner networks.

“...the negative stigma around addiction is very strong in the community. We always counter with positive messages and that everyone deserves another chance to make a quit attempt, similar to tobacco cessation messaging.” — Erie County Department of Health, Pennsylvania

## Partnerships

The 2018 Forces of Change identified the types of organizations that LHDs generally partner with in conducting opioid-related activities, with the most common partners being local or state agencies (84%), healthcare (73%), schools (64%), and secular nonprofits (60%)<sup>8</sup> While Forces of Change showed that collaboration with local and state agencies was high (84%), collaboration with federal agencies was troublingly low (23%), particularly among small LHDs.<sup>9</sup> Based on these findings, respondents were asked about their partnerships with specific government agencies and partners within the OUD community.

**Figure 10. Organizations Partnering with LHDs to Conduct Opioid-Related Activities**  
Percent of respondents, n=151–156



The top-reported partner agencies were divided across both local government agencies and OUD community organizations. Over 75% of responding LHDs collaborate with local public safety, local EMS, mental/behavioral health facilities, and community/prevention coalitions. The only local government agency with under 50% of respondents reporting collaboration was local housing agencies. Housing as a recovery or upstream public health intervention is gaining momentum. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends recovery housing as an intervention to support individuals in early recovery<sup>10</sup> and encourages housing agencies to play a role in harm reduction activities by making naloxone available and training staff to use it.<sup>11</sup>

Additionally, subgroup analysis shows significant variation in responses from state-governed LHDs when compared to local and shared-governance LHDs. With one exception, state-governed LHDs less frequently reported partnering with agencies across both the local government agencies and the opioid use disorder communities. State-governed LHDs least often reported partnering with local housing agencies, families and friends, and the active use community. On the other hand, differences in LHD size did not result in significant variations in response.

### **Over 80% of respondents reported partnering with both mental/behavioral health facilities and community/prevention coalitions.**

While partnering with local EMS and public safety was predictably high, it is encouraging to note that LHDs work closely with mental/behavioral health specialists as the public understanding of addiction has evolved. Given the prevalence of stigma around OUD, collaboration with the recovery and active use communities is especially important. Concentrating opioid overdose prevention and response efforts on these at-risk communities and those in local jails/juvenile detention centers may improve the uptake and outcomes of clinical and programmatic services.



“With so many, it is challenging to choose one as each partnership is critical in our interventions: public schools, local hospitals, crisis response, police, fire, HIDTA [DOJ’s High Intensity Drug Trafficking Areas Program], treatment centers, and the judiciary.” — Anne Arundel County Department of Health, Maryland

Respondents were also asked about whether they work with healthcare coalitions and their role as either a convener, leader, or participant in another role. Generally, healthcare coalitions are groups of individual healthcare and response organizations in a defined location that play a critical role in developing preparedness and response capabilities.<sup>12</sup>

**74% of respondents reported serving as conveners or leaders of healthcare coalitions, and an additional 20% reported participating in another role.**

Across subgroups, large LHDs were more likely to convene or lead (52%) than their counterparts at small LHDs (39%) and medium LHDs (28%). Likewise, shared governance LHDs were more likely to lead or convene (48%) than their counterparts at state-governed LHDs (29%) and locally run LHDs (35%).



“Initially the coalition was led by volunteers and as it grew, the coalition was able to hire staff through state and federal grants along with some minimal local funding. The coalition is currently under direction of a Board of Directors, full time Executive Director and three paid staff. The Coalition provides comprehensive community education about substance use/abuse. The coalition has been instrumental in bringing together anti-drug stakeholders in a way that has strengthened individual and community assets.” — Johnson County Health Department, Tennessee

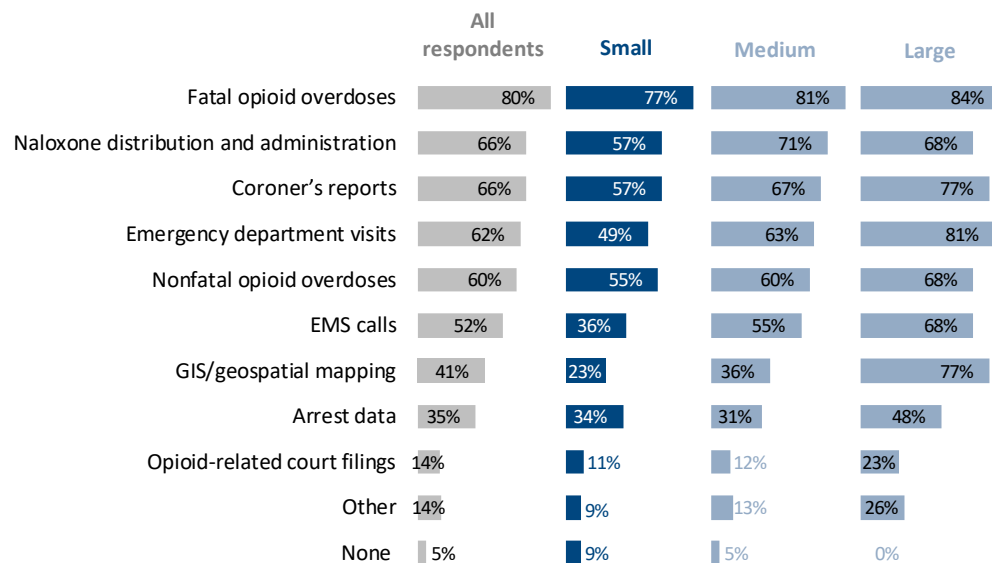
## Data Collection

Data is an integral component of understanding the parameters of a public health issue and having accurate and sufficient information to drive decisions is particularly important. Respondents were asked whether they collect data on a variety of opioid use and overdose-related indicators.

As might be expected, chief among these sources are fatal and non-fatal opioid overdose reports, followed by naloxone distribution reports and coroner’s reports. Only 5% of respondents reported having no data collection efforts.

**Figure 12. Opioid-Related Data Collected by LHDs**

*Percent of respondents, n=153*





**95% of respondents reported conducting some form of data collection. The proportion of large LHDs collecting EMS call data and GIS/geospatial mapping data is nearly twice the proportion of small LHDs.**

Respondents most often reported using an online database and/or teaming with community partners. Among databases, LHDs most often reported using ODMAP and ESSENCE, especially for collection of fatal opioid overdoses, coroner's reports (cause of overdose or death), and naloxone distribution and administration data. The least-common data sources selected by respondents were opioid-related court filings, arrest data, and GIS/geospatial mapping. Large LHDs were notably more likely to have used these underselected data sources than their peers, likely due to funding, workforce, and/or resource availability.

**Opioid Databases Referenced by LHDs:**

- **ODMAP:** Overdose Detection Mapping Application Program. ODMAP is HIDTA's mobile tool designed to provide near real-time suspected overdose surveillance data across jurisdictions to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events.<sup>13</sup>
- **ESSENCE:** Electronic Surveillance System for the Early Notification of Community-based Epidemics. ESSENCE is a surveillance system developed by the Department of Defense that allows users to monitor and facilitate response to early indications of an outbreak.<sup>14</sup>
- **PDMP:** Prescription Drug Monitoring Program. The PDMP is a database that monitors the dispensing of controlled substances. As PDMPs have been adopted in 49 states and operate under a number of localized names, it is possible that they have been utilized by LHDs at a higher rate than the qualitative data indicates.
- **311:** The 311 line is a non-emergency phone number for residents to ask information about services and report complaints or community issues.



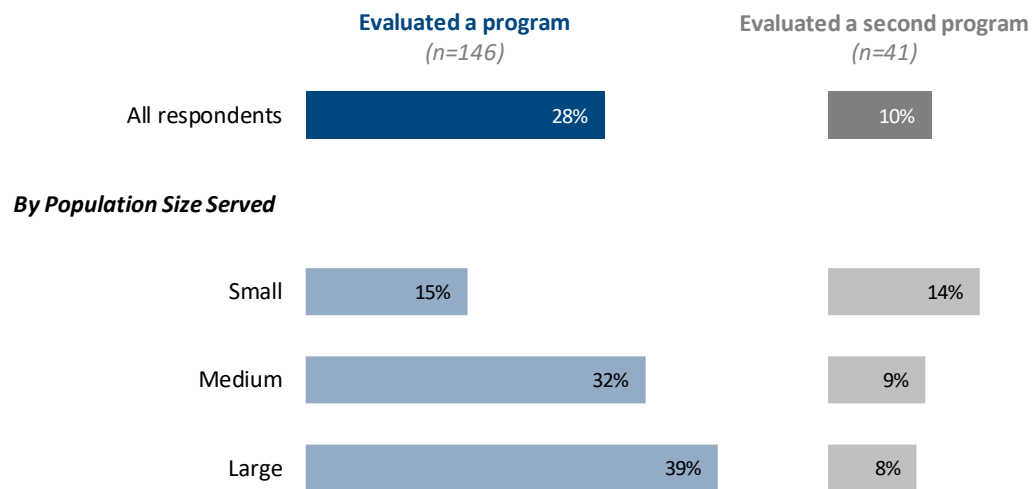
“It is very difficult to collect accurate data on [overdoses]. We process burial permits and have access to death certificates for the city. We get reports from community navigators and service-providing agencies regarding services rendered and number of active cases.” — Chelsea Department of Health and Human Services, Massachusetts

## Evaluation

Evaluation allows LHDs to monitor, improve, and determine the impacts of a program. It also builds the evidence base for effective programming and identifies lessons learned for improving future initiatives. Respondents were asked about whether they have evaluated an opioid-related program and were asked to share information about their evaluation methods and outcomes.

**Figure 13. LHDs Conducting Evaluation on Opioid-Related Programs**

*Percent of respondents*



### Large LHDs were most likely to have conducted an evaluation of an opioid-related program.

Over two-thirds of respondents indicated that they had not started formal evaluations (68%) or were unsure if they had (5%). Evaluation can sometimes require specialized knowledge or expertise, so it is unsurprising that so many respondents have not conducted formal evaluations. In alignment with that, among subgroups, large LHDs, with potentially more resources, were more likely to have conducted an evaluation than medium LHDs or small LHDs.



“[We] collected and identified service data: # overdose, # referred, # contacted, # engaged. Outcome: Peers able to make contact in the ED were significantly more likely to engage the individual and get the individual engaged in treatment. This was presented in 2017 at the National Prescription Drug Abuse and Heroin Summit in Atlanta, GA in 2017.” — Anne Arundel County Department of Health, Maryland

Respondents shared the following methods used for program evaluation: data collection, formal evaluation, gap analysis, mapping, process/ outcome evaluation, observations, participant surveys and pre/post intervention surveys, and university partnerships. Once evaluation has been completed, respondents reported using the following information-sharing methods to disseminate results: annual reports, conference presentations, online dashboards, and published articles.



“For the first evaluation, we used participant feedback, data analysis of harm reduction-syringe exchange program (HRSEP) activity, staff observation, and shadowing other sites as evaluation methods. It was determined that data capture and analysis needed to be improved, [and identified] a need for increased infection disease screenings on site, and increased HRSEP availability through the expansion of operating hours.” — Cumberland Valley District Health Department, Kentucky

While evaluation can seem daunting, many examples of evaluations shared by LHDs included simple tracking of client interactions and resources. Even a simple evaluation process can be valuable to LHDs hoping to maintain, expand, or advocate for important programs and services.

## Local Health Department Stories from the Field

Throughout the survey, respondents were given the opportunity to elaborate on their responses through open-ended questions and by uploading relevant program materials. Respondents were encouraged to share examples of opioid prevention and response practices shared in this section from a diverse range of LHDs representing different geographic locations, jurisdiction sizes, and governance structures.



### Tri County Health Department, Colorado Comprehensive Data Collection Plan

The Tri-County Health Department shares its data collection methods from a variety of sources online at <http://opioid-tchdgis.opendata.arcgis.com/> and <http://substanceabuse-tchdgis.opendata.arcgis.com/>

for partners to access. Data collected and shared includes:

- Vital Records – The LHD uses death and address data to understand the neighborhood level impact of substance misuse related deaths. The data is specific to the type of substance.
- Syndromic Surveillance – The LHD reports weekly trends in ED visits over a period of 12 months. This assesses opioid related ED visits as well as visits related to the use of Narcan/naloxone.
- [Lost Loved Ones](#) – Mapping tool that incorporates data and stories about families who have lost loved ones to opioid overdoses.
- Mental Health and Substance Abuse Treatment Centers – The substance abuse websites incorporate mapping tools that detail mental health and/or substance abuse treatment facilities. Includes information such as locations, services offered, and other information.
- Work in coordination with New America Foundation's opioid mapping workgroup to develop innovative methods to acquire and evaluate opioid-related data and improve the LHD's mapping and data visualization techniques.



### **Cumberland Valley District Health Department, Kentucky Discarded Needle Program**

The Cumberland Valley District Health Department (CVDHD) reported that, “during local election campaigning for the primary in May 2018, an issue arose about an increase of discarded needles in public spaces, which led to calls of closing the syringe exchange program. CVDHD provided data on collected and dispensed syringes in a clear format, arranged for individuals in recovery to tell their experiences with syringe exchange to the fiscal court, and held meetings with the mayor, fiscal court judge, and coroner to address this issue. CVDHD is now collecting data to clarify the issue of discarded needles in public spaces through the creation of a discarded needle program. The elected officials now have a better understanding of the processes and calls for an end to the exchange have abated.”



### **Portland Health Department, Maine Successful Inter-agency Partnerships**

The Portland Health Department in Maine developed strong inter-agency partnerships within the City of Portland government structure. Funding required is minimal, since staff are already in place. By working with the Portland Police and Fire Departments, the health department was able to provide training and other technical assistance around the subjects of harm reduction. This partnership prompted police to hire a community liaison to assist those navigating the health system after an overdose. Additionally, this partnership allowed the syringe exchange to begin distributing naloxone to clients, as the health department was restricted from doing so directly.

The collaboration has positively benefited the community, in that at-risk community members have increased access to naloxone. Officers are carrying [naloxone] and there has been a culture shift in addressing substance use disorder as a treatable condition and not a moral failing.



### **Dorchester County Health Department, Maryland Opioid Coordinator and Peer Navigator Program**

The Dorchester County Health Department has appointed an overdose coordinator to monitor overdose events and responses. The coordinator can ensure that individuals who experience an overdose are connected to treatment and recovery support services. Peer navigators in Dorchester county are contacted at by EMS, law enforcement, or hospital staff after the overdose and arrive within one hour to provide the patient support, information, and make referrals. Peers have responded to 22 [individuals], providing support to all and making treatment referrals for 20 [individuals].



### **Hennepin County Health Department, Minnesota Advocating for MAT Services in Jails and Correctional Facilities**

The Hennepin County Public Health Department in Minnesota partnered with a county data scientist and county safety-net hospital physicians, Hennepin Healthcare, to develop policy recommendations to provide incarcerated individuals with medication-assisted treatment (MAT). The LHD advocated for the services by sharing data about high overdose morbidity and mortality rates of adults upon release from the local jail and correctional facilities. Data and policy recommendations were published in a report, *Criminal Justice System as a Point of Intervention to Prevent Opioid-related Deaths*. The LHD is in the process of developing their MAT services program.



### **Medford Health Department, Massachusetts Comprehensive Stigma Prevention Campaigns**

The Medford Health Department in Massachusetts is part of the Mystic Valley Public Health Coalition, which has run several comprehensive traditional media campaigns. In 2015, the coalition created the [#StigmaPreventsChange](#) campaign, consisting of two audio/video PSAs and two print posters. The [PSA videos](#) were played before movies in local theaters for several weeks over two years; [PSA audio](#) was played on Pandora radio and local radio for six weeks. Print posters were displayed on local buses and commuter rail train platforms in the region. The campaign was also featured on the local news channel. The campaign reached thousands of residents.

Additionally, after death record data identified disproportionate death rates among trades and construction workers, the coalition developed a second targeted campaign for this audience by creating two radio PSAs for two local sports radio stations that aired for five weeks, reaching over 857,000 people.



### **Ste. Genevieve County Health Department, Missouri Innovative Communications Methods: Local Pastoral Alliance**

The Ste. Genevieve County Health Department in Missouri has developed a local pastoral alliance to work with their faith communities on reducing the stigma associated with addiction. Pastors speak and pray with their congregations for persons struggling with addiction, promote community events in their bulletins, and offer programs open to the community addressing addiction issues such as parental education programs, recovery program celebrations, and programs for families facing addiction, all open to the public. The alliance also works with partner organizations such as a women's health fair hosted by a local hospital. The fair included panel presentations each hour from professionals working on opioids in the community, including a discussion by the health department on Narcan. Members of the alliance promote each other's programming, strengthening the alliance.



### **Southern Nevada Health District, Nevada Syringe Vending Machines**

"The Health District and Trac-B, in collaboration with Nevada AIDS Research and Education Society (NARES), launched southern Nevada's first comprehensive needle exchange program in April 2017, including a delivery component involving vending machines. Trac-B Exchange is the first needle exchange program in Las Vegas with a consistent schedule of available times, a physical location for accessibility, a variety of harm reduction materials and supplies, along with testing and education. The syringe vending machine is also the first of its kind in the continental U.S. As of January 2019, there is one storefront and three syringe vending machines, and there are plans to put syringe vending machines in rural parts of Nevada. The Health District helped pave the way for this intervention to take root, due to a Health District staff community assessment on people who inject drugs. Health District staff are also conducting stakeholder meetings in rural Nevada to assess if the community is receptive to receive a syringe vending machine. District staff are also on site once a week to do HIV/HCV testing. The majority of this work is funded by Nevada's 1802 HIV prevention funds (the vending machines and supplies except for syringes and cookers)."



**Nashua Division of Public Health and Community Services,  
New Hampshire**  
**Safe Stations and Syringe Service Program Evaluation**

The Nashua Division of Public Health and Community Services reported evaluating their Syringe Service Alliance of the Nashua Area (SSANA) for effectiveness in delivery and access by tracking services provided and client contacts. 67% of those who accessed syringe services were less likely to have a second overdose. The program distributed 37,300 syringes from February 1, 2018 – January 30, 2019 with 16,243 syringes returned for appropriate disposal. There were a cumulative of 552 outreach encounters and 290 naloxone packages distributed. Approximately 33 individuals were referred to treatment services and 32 received HIV and HCV testing. There were no increases in syringe sightings reported by police.



**Franklin County Health Department, Ohio**  
**Improving Naloxone Access and Linkages to Care in Jails**

The Franklin County Health Department in Ohio developed jail-based programming in partnership with the Franklin County Office of Justice Policy and Programs. Funded by the Ohio Department of Health, the program aims to create linkages to care and increase access to naloxone for individuals in jail by funding four peer supporters to work both in and out of the jails with the participants of the Pathways to Women's Healthy Living Program. The peer supporters provide both navigation and coaching services by leading weekly group counseling sessions in the jails and for women who have exited the jail. They also transport women to get necessary resources, such as identification or groceries, and connect them with care aimed at establishing a safe and stable life outside jail.





### **Montgomery County Health Department, Ohio Partnering to Learn from Experienced Coalitions**

The Montgomery County Health Department sent members of their local opioid coalition to meet with Hamilton County's coalition. The goal was to assess what worked well for them, what barriers they overcame, and what their remaining challenges were. The members returned with takeaways for Montgomery County's coalition after attending two different meetings: one with the steering committee and one with the coalition. The attendees reported value in listening, questioning, and collecting information from a group that had several years' more experience conducting opioid programming.



### **Allegheny County Health Department, Pennsylvania Developing a Cadre of Diverse Opioid Policies**

The Allegheny County Health Department was able to shepherd through numerous opioid prevention and response-related policies including:

- Developing and issuing a Naloxone standing order
- Releasing a statement supporting MAT in collaboration with the Department of Human Services
- Advocating for access to PDMP data
- Distributing naloxone to local police and fire
- Advocating to exclude needles from laws regulating paraphernalia
- Approving the expansion of needle exchange programming
- Active in design and implementation of EMS naloxone leave-behind programming



### **Metro Public Health Department, Tennessee Tracking Overdose Activity with ODMAP**

The Metro Public Health Department is exploring the use of the ODMAP system from HIDTA for close to live tracking of OD activity and for triggering emergency response for any mass OD event. The Department is also looking at the SUD cascade of care model (as used by HIV) as a way of taking siloed data and making it useable for community health planning.



### **Public Health Madison and Dane County, Wisconsin Real-time Public and Private Overdose Mapping**

Public Health Madison and Dane County has found success in mapping overdoses by both public and private locations. Although a small distinction, this effort has helped the LHD focus on the local private businesses for overdose prevention education and Narcan distribution.



### **Wauwatosa Health Department, Wisconsin Comprehensive Social Media Campaign**

The Wauwatosa Health Department in Wisconsin has a comprehensive network of online social media platforms used to engage their residents regarding substance use. The [Wauwatosa Health Department Substance Use Website](#) serves as an online resource for residents regarding substance use and to share highlights about upcoming events, new information, etc.

Wauwatosa also has multiple social media links where they synchronize regular information sharing:

[Community Substance Use Facebook Page](#) | [General Facebook Page](#) | [Instagram Page](#) | [Twitter Page](#)

The health department has additionally created a [Substance Use Information Guide](#) and a [Community Resource Guide](#) for Wauwatosa residents that have been shared via their social media sites.

## Next Steps

NACCHO also asked LHDs which opportunities or resources they would be most interested in receiving information on from NACCHO or partner organizations. Grant opportunities was the most selected, but LHDs were also interested in local case studies/examples, factsheets or issue briefs, Internet-based training, outreach/communications, technical assistance, and in-person training.

In addition to this report, NACCHO plans to share information gathered from the environmental scan via factsheets or issue briefs and stories from the field.

NACCHO also plans to continue working with select LHD respondents to gather more information through key informant interviews and with the 17% of respondents who reported no longer conducting opioid prevention and response activities to gather additional insight.

## Limitations

Findings from the environmental scan provide insight into the opioid prevention and response activities being conducted by LHDs and help to identify local practices. However, the survey sample was not a statistically representative random sample of LHDs, and these findings are not intended to be nationally representative. Several known differences exist between environmental scan respondents and the national LHD population. For example, large and medium-sized LHDs are overrepresented in the results and the respondent pool is not geographically representative. Survey participants were initially selected due to participation in a previous NACCHO survey. Additionally, data was self-reported; NACCHO did not verify responses. Differences in the interpretation of survey questions may exist among respondents. Finally, responses may have been impacted by the position within the LHD of each respondent.

## NACCHO Opioid Epidemic Toolkit

NACCHO has developed a free, online toolkit of opioid epidemic resources categorized as either local, state, or federal resources within five topic areas: monitoring and surveillance, prevention, harm reduction and response, linkage to care, and stakeholder engagement and community partnerships.

Additionally, resources have been collected from local health departments through this Environmental Scan. Those resources are available in the toolkit, available here: <https://www.naccho.org/programs/community-health/injury-and-violence/opioid-epidemic/local-health-departments-and-the-opioid-epidemic-a-toolkit>.

## Footnotes

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# NACCHO

National Association of County & City Health Officials

*The National Connection for Local Public Health*

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