COMMONWEALTH of VIRGINIA

Department of Health

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April 21, 2025

MEMORANDUM

TO: The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: Opioid Impact Registry

This report is submitted in compliance with Chapter 631 of the 2023 Virginia Acts of the Assembly which amended and reenacted § 54.1-3408 and states:

> *3. That the Department of Health (the Department) shall begin development of a Commonwealth opioid impact reduction registry. The registry shall include a list of nonprofit organizations that work to reduce the impact of opioids in the Commonwealth and shall list the services provided by each such organization and contact information for each such organization to be published on the Department's website. The Department shall develop a process to determine which organizations that work to reduce the impact of opioids in the Commonwealth to include in such registry and what criteria and metrics should be utilized to determine their inclusion in such registry. The Department shall examine administrative burdens on local governments in procuring the services of nonprofit organizations on the registry in a timely manner. The Department, within existing resources, may publish an initial list of known nonprofit organizations that work to reduce the impact of opioids on the Department's website that is searchable by zip code. The Department shall report on the process, criteria, and metrics for the registry, including the*

verification process to ensure an organization meets the criteria to be listed on the registry, and recommendations on reducing administrative burdens on local governments to contract with organizations on the registry to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023.

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/KB
Enclosure

Pc: The Honorable Janet Vestal Kelly, Secretary of Health and Human Resources

OPIOID IMPACT REGISTRY

REPORT TO THE GENERAL ASSEMBLY

2023

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The Code of Virginia § 54.1-3408 instructs the Virginia Department of Health (Department) to begin development of a Commonwealth opioid impact reduction registry, including a list of nonprofit organizations that work to reduce the impact of opioids in the Commonwealth. The registry development shall include a process to determine which organizations working to reduce the impact of opioids in the Commonwealth should be included, identifying criteria and metrics to be utilized in determining inclusion, and an examination of the administrative burdens on local governments in procuring in a timely manner the services of the organizations included in the registry. The Code of Virginia requires the Department to report on the progress of this registry plan to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023.

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EXECUTIVE SUMMARY

SUMMARY OF ACTIVITIES AND FINDINGS

During the 2023 Virginia General Assembly session, SB 1415 was passed to amend and reenact § 54.1-3408 of the Code of Virginia. The amendments instructed the Virginia Department of Health (The Department, otherwise known as VDH) to accomplish several directives. During this reporting period, VDH made the following progress towards accomplishing the outlined directives:

1. *Directive 1: Begin development of a Commonwealth opioid impact reduction registry. The registry shall include a list of nonprofit organizations that work to reduce the impact of opioids in the Commonwealth and shall list the services provided by each such organization and contact information for each such organization to be published on the Department's website.*

   As outlined in this report, as a first step in developing the opioid impact reduction registry, VDH undertook an assessment of existing tools and resources that could potentially meet the goals of an opioid impact reduction registry. VDH collected both quantitative and qualitative data to assess options and outline recommendations for registry development next steps. As a result of this multipronged research effort, VDH concluded that the best use of resources would be to enhance and expand an existing program – 2-1-1 Virginia – to serve as the opioid impact reduction registry and meet the Code requirements of this registry, rather than developing an entirely new program. 2-1-1 Virginia is a program run by the Virginia Department of Social Services (DSS) that provides referrals to Virginians for various social services and opportunities.

   2-1-1 already includes resources for Virginians for substance use disorder prevention and treatment. VDH concluded that DSS could expand the list of existing resources to ensure the list more robust and DSS could enhance the 2-1-1 taxonomy so that substance use and mental health services are well organized within the database and easily searchable, leading to improved connections between users and community resources. Given that 2-1-1 is well known, easily accessible, and has expertise in identifying and validating community resources, 2-1-1 is well positioned to facilitate community and local government access to organizations aiming to reduce the impact of opioid use disorder in their community. As noted in the recommendations, 2-1-1 would need additional funding to augment its staffing and technology to serve as the opioid impact reduction registry.

   VDH discussed the proposal to expand Virginia 2-1-1 to serve as the registry with DSS. They agree with this proposal and provided information to inform this report.

2. *Directive 2: The Department is required to develop a process to determine which organizations that work to reduce the impact of opioids in the Commonwealth to include in such registry and what criteria and metrics should be utilized to determine their inclusion in such registry.*

VDH conducted a literature review, assessed national outcomes measures, and compiled a state-to-state comparison of registry models in order to determine the best approach to identifying community-based organizations for inclusion in an opioid impact reduction registry. Based on the information gathered, VDH recognized that 2-1-1 already has comprehensive existing processes for identifying and validating organizations for inclusion in their resource directory. VDH concluded that 2-1-1's existing process could be enhanced specifically for opioid use prevention.

3. *Directive 3: The Department is required to examine administrative burdens on local governments in procuring the services of nonprofit organizations on the registry in a timely manner. The Department, within existing resources, may publish an initial list of known nonprofit organizations that work to reduce the impact of opioids on the Department's website that is searchable by zip code.*

   VDH's expertise in local government procurement processes is limited. As such, VDH conducted a brief survey of members of the VDH Substance Use Prevention Workgroup, who are experts in substance use disorder prevention and treatment, to solicit feedback on the ease of procuring substance use disorder prevention and treatment services at the local government level. VDH also researched publicly available information regarding facilitators and barriers to procuring such services at the local government level. Based on this qualitative assessment, VDH outlined several barriers, included in this report. With the augmentation of 2-1-1 to serve as the opioid impact reduction registry, local governments should have improved access to a list of community-based organizations that work to reduce the impact of opioids. VDH intends to link to 2-1-1 on its substance use prevention webpages to further facilitate access and awareness.

4. *Directive 4: The Department is required to report on the process, criteria, and metrics for the registry, including the verification process to ensure an organization meets the criteria to be listed on the registry, and recommendations on reducing administrative burdens on local governments to contract with organizations on the registry to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023.*

   In this report, VDH details a process, criteria, and metrics for an opioid impact reduction registry, based on the multipronged research conducted, including quantitative and qualitative assessment existing resources and community needs. VDH details several recommendations regarding registry implementation and additional investigations into administrative burdens for local governments regarding accessing substance use prevention and treatment resources.

This plan does not 1) outline a process for listing or credentialing clinical practice or nonprofit organization support for treatment and recovery based on federal and state statutes, regulations, and guidelines governing such treatment and medications for opioid addiction; 2) constitute a product endorsement; 3) include systems integration, defined as the ability to seamlessly move from the referral platform to the electronic health record (EHR) and vice versa, and to automatically transfer data between the two systems; 4) require VDH data governance, as

there will be no personal protected health information included or collected by VDH; and 5) include independent product testing.

This plan also does not outline registry elements to track referrals and close the loop to know the referral outcomes. The public will not need to sign into the system with a password, only access the information hub for resources. If an individual level treatment plan is created, the chosen registry partner will implement its data governance policies.

It should be considered that the requirement to limit entries to non-profits may eliminate programs of value to Virginians in need, particularly for-profit treatment programs that accept Medicaid reimbursement. Since this limitation was stipulated in the legislation, it will not be discussed further in this report.

RECOMMENDATIONS

VDH developed the following recommendations after extensive research, detailed in the report below. These recommendations which aim to leverage existing resources to establish the opioid impact reduction registry and follow best practices in the field.

Overarching Recommendations

1. VDH recommends that the Commonwealth use the existing 2-1-1 Virginia program, run by the Virginia Department of Social Services (DSS), as the framework for the opioid impact registry. DSS would be responsible for making updates to the existing 2-1-1 Virginia program to ensure it meets Code requirements for an opioid impact registry, including developing an organizational structure for listing opioid use prevention resources (i.e., the taxonomy of, and pathways to, these resources) and assessing the cost for expanding and enhancing 2-1-1 Virginia accordingly. VDH discussed the proposal to expand Virginia 2-1-1 to serve as the registry with DSS. They agree with this proposal and provided information to inform this report.

2. The Virginia Department of Health (VDH) recommends that DSS/Virginia 2-1-1 create a Registry Governance Team responsible for guiding opioid impact registry activities, including major financial, administrative, legal, and scientific decisions that determine the direction of the registry.

Recommendations for Optimizing 2-1-1 Virginia

The following recommendations outline strategies for DSS to optimize 2-1-1 so that its current capabilities are enhanced to meet the expectations of an opioid impact reduction registry. These recommendations address operational processes, including data strategy plans, workflows, and case ascertainment, necessary to implement a high-quality, user-friendly registry.

3. 2-1-1 Virginia should consult with VDH to create a data strategy plan and implement the 2-1-1 Alliance of Information Referral Systems opioid misuse prevention taxonomy that aligns with national initiatives prioritizing the social drivers of health (e.g., Institute of Medicine's recommendations, Healthy People 2030 goals), measures proposed under the

next stage of Meaningful Use, clinical coding under ICD-I0 Z codes, and agency current reporting requirements.
4. 2-1-1 Virginia should develop workflows, initial focus outcomes, related pathways, and the final product registry based on geographical VDH health district regions, high-burden populations and geographical areas, and resource prioritization models.
5. 2-1-1 Virginia should utilize a combination of active and passive (hybrid) case ascertainment versus requiring a mandate registry reporting.
6. 2-1-1 Virginia should vet a master list of community-based services (e.g., non-clinical nonprofits, with or without an IRS Tax Designation) with a service area of the Commonwealth of Virginia to ensure compliance with inclusion criteria.

Recommendations for 2-1-1 Virginia Continuous Improvement Efforts

The following recommendations address intentional, continuous improvement of the registry so that it best meets the needs of Virginians and generates evidence to support its long-term sustainability. These recommendations outline a framework for piloting, scaling, and evaluating efforts.

7. 2-1-1 Virginia should execute a soft launch of the registry in high-burden areas first and then market the registry more broadly.
8. 2-1-1 Virginia should conduct rigorous programmatic and economic evaluation to demonstrate effectiveness and utilization of an opioid impact registry; develop systems to track and evaluate performance; analyze outcomes to demonstrate effectiveness; and utilize the Plan Do Study Act process, a systematic series of steps that can be applied to understand needed improvements to optimize implementation for quality improvement. DSS will assess funding and staffing resources needed for this process and submit budget amendments as appropriate.
9. 2-1-1 Virginia should conduct ongoing outreach to recruit new organizations onto the registry.
10. 2-1-1 Virginia should provide ongoing staff training and technical assistance for registry organizations and the public.
11. DSS should develop a registry sustainability plan.

Recommendations to Assess and Reduce Administrative Burdens on Local Governments

This recommendation outlines a plan to assess and reduce administrative burdens on local governments to contract with organizations on the registry. As the VDH is not a subject matter expert on local government procurement procedures, VDH will partner with other state agencies who have deep expertise in local government procurement to understand barriers and facilitators and make appropriate recommendations.

12. VDH will solicit technical assistance from the Virginia Department of General Services (DGS) and the Opioid Abatement Authority on how to best analyze the administrative burden to local government contracting.

INTRODUCTION

MANDATE

Per § 54.1-3408 of the Code of Virginia, VDH is required to report on the process, criteria, and metrics for the registry, including the verification process to ensure an organization meets the criteria to be listed on the registry, and recommendations on reducing administrative burdens on local governments to contract with organizations on the registry to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023 (0).

ACTIVITIES

The Virginia Department of Health implemented a four-phase approach to create a process for the development of a Commonwealth opioid impact reduction registry pursuant to § 54.1-3408 of the Code of Virginia.

- Phase One: Research
- Phase Two: Qualitative data collection
- Phase Three: Quantitative data collection
- Phase Four: Qualitative data collection specific to examining the administrative burdens of local governments

REPORT OUTLINE

This report details the activities, methodology, principles and approaches, and recommendations resulting from the work of VDH pursuant to § 54.1-3408 of the Code of Virginia.

OPIOID IMPACT REGISTRY

INFORMATION GATHERING: ACTIVITIES AND ANALYSIS

To address the requirements of § 54.1-3408 of the Code of Virginia, VDH implemented a multipronged information gathering effort, including research on existing registries; key informant interviews with registry vendors; quantitative data analysis to identify higher need communities; and surveillance of substance use prevention experts regarding registry implementation. Details of this work and the resulting findings are included below.

PHASE ONE: RESEARCH

In mid-2023, VDH began to create a process for the development of such a registry as defined in § 54.1-3408 of the Code of Virginia with review of gray literature,[1] national outcomes measurements (Healthy People), and registry models. A state-by-state comparison was also conducted to identify and understand similar registry models through a web-based public domain search. However, there were no other opioid registry model guides available in the public domain.

PHASE TWO: QUALITATIVE KEY INFORMANTS/VENDOR COMPARISON

The goal of this phase was for VDH to better understand what systems currently exist that provide resources/referrals aligned with the purpose of the registry, what elements would be beneficial to include in the registry, and lessons learned from existing systems. This phase was critical to ensure that public dollars do not fund duplicative efforts and to ensure that an inventory of registries is documented during the development phase.

Scan preparing for key informant interviews

VDH conducted a scan of the platforms on the market from 2018-2023 and of VDH collaborative partners currently or in the process of standing up public-facing prevention and social determinants of health community resource referral (SDOH CRR) systems.

To identify platforms to include in this review, VDH conducted web searches and identified 39 products that fit the following criteria: 1) platforms being used or soon to be used by the public to find and connect patients with social and recovery organizations, 2) platforms available in any location in the Commonwealth, and 3) platforms not focusing on only one intervention model.

Key informant interviews

To better understand existing systems that might serve the same purpose as the registry, VDH used the information the agency gained in the aforementioned scan to conduct key informant interviews. In mid-2023, VDH conducted key informant interviews through informal conversation with three outside vendors to understand current state-level information hub resource system model functionalities and to identify needed essential functions and pathways.

[1] Gray literature refers to publicly available reports, working papers, white papers, conference abstracts and presentations, unpublished trial data, or user guides developed by government, academics, business, or non-governmental entities. Gray literature can provide balanced evidence through inclusion of negative studies not commercially published; clinical trial details; and more timely access to relevant conference proceedings.

Interviews were 30-60 minutes long and conducted virtually. Detailed notes were taken. A side-by-side comparison table and detailed profiles of the features of these platforms was analyzed, along with implementation lessons learned and recommendations from user organizations. For the purposes of protecting vendor identify, organizations are identified as Vendor A, B, C, etc. and were retained as a separate document. The vendor questionnaire can be found in Appendix B.

The vendor identified as a viable partner to serve as the main operator of the registry was 2-1-1 Virginia. 2-1-1 Virginia is a contracted public/private partnership between the Virginia Department of Social Services (DSS) and the Council of Community Services, in collaboration with the United Way of Central Virginia. 2-1-1 Virginia is a free, 24-hour information and resource referral program which connects users with community-based health and human services. Calls to 2-1-1 Virginia are routed by the local telephone company to a local or regional calling center. The center's referral specialists receive requests from callers, access databases of resources available from private and public health and human service agencies, match the callers' needs to available resources, and link or refer them directly to an agency or organization that can help. Currently, the system has linkage of care resources for substance use and mental health services through an indexed taxonomy. 2-1-1 provides 10 major resource categories and over 300 service types with pathways and has a ready-to-use substance use prevention taxonomy, which ensures resources are well organized, appropriately linked, and foster connection to community resources for 2-1-1 callers. Based on VDH's research, 2-1-1 could be augmented to meet the requirements of § 54.1-3408 of the Code of Virginia.

PHASE THREE: QUANTITATIVE DATA COLLECTION

The goals of this phase were to (1) Clarify the population of focus for the registry (who would access the registry/what population should be served through the registry) to ensure that resources in the registry are appropriately targeted towards those most in need; and (2) Identify critical registry components and elements of registry design that align with best practices and reflect the guidance of stakeholders interviewed and surveyed as part of the information gathering process.

Population of focus

While § 54.1-3408 of the Code of Virginia does not call for a population of focus, it is assumed the priority populations for this initiative are people with a history of overdose, people who use drugs, and people who are at risk for using drugs. The 2-1-1 taxonomy contains population terms that indicate the people for whom services are designed. Virtually any type of service can focus on any particular high-priority group, making it impractical to try to have a separate service/high-priority population term for every possible combination. The high-priority population section also includes topical identifiers/issues, i.e., very general terms such as Aging Issues, Child Abuse Issues, Drug Abuse Issues, and Legal Issues that allow users to modify broad service concepts that might otherwise be vague.

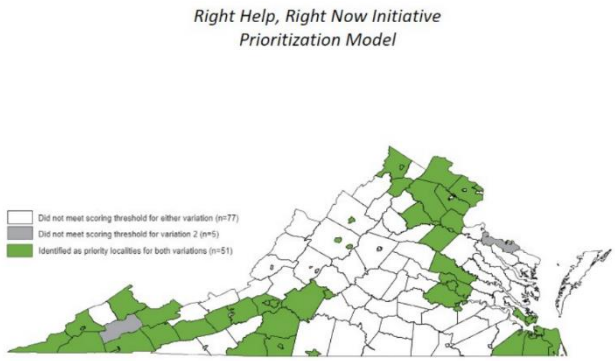
Indicator Tool

VDH intends to use its Overdose Prevention Needs Assessment Tool to determine high-burden areas that should be emphasized in getting immediate resources to by way of the Opioid Impact Registry during a first launch. The prioritization model is under review and includes multiple indicators to identify Virginia localities at higher need for drug overdose-related

surveillance, prevention, and intervention strategies, such as comprehensive harm reduction program expansion, naloxone distribution, and fentanyl wastewater surveillance piloting through the *Right Help, Right Now* initiative. Indicators are used to assess whether a locality may be at a higher burden for drug overdose and misuse and other infectious disease outcomes associated with drug use (e.g., hepatitis C and HIV) in their communities. Note that this model does not assess a locality's staff or resource capacity, readiness, or ability to reach the most highly impacted populations to develop and implement drug overdose prevention and intervention strategies. These factors should also be considered when establishing, expanding, and sustaining drug overdose and substance use-related prevention initiatives.

Prioritization Model

Using its methodology, VDH has identified 56 Virginia localities as priority regions due to overdose burden; this methodology is under review. Once finalized, identified high-priority localities will be considered as pilot regions. An assessment of current capacity to handle increased requests for resources will be conducted prior to piloting, as these factors should also be considered when establishing, expanding, and sustaining drug overdose and substance use-related prevention initiatives. Therefore, it will be important to conduct a readiness assessment prior to launch.



Survey

In January 2023, VDH established an overdose prevention workgroup that includes LHD representatives from high-burden regions and at least one representative from the following VDH Offices: Offices of Family Health Services, Epidemiology, Chief Medical Examiner, Information Management, and Emergency Medical Services (Appendix D). This workgroup is charged with agency strategic planning to ensure alignment of prevention efforts and standardization of data processes, and to ensure agency strategic approaches as funding opportunities arise. To obtain feedback on § 54.1-3408 of the Code of Virginia requirements, a survey was created using the VDH web-based REDCap tool and disseminated to the VDH overdose prevention workgroup members through a link via electronic mail.

The VDH Overdose Prevention Workgroup survey resulted in a 34% response rate. This group provided design input, including the following: 1) construction of a registry team and relevant stakeholders, 2) establishment of a governance and oversight plan, 3) defining the scope and rigor needed, 4) defining the datasets and end user needs, 5) developing a protocol, 6) developing and evaluating a project plan, and 6) adverse event detection and reporting. Feedback provided was analyzed and used to inform the writing of recommendations. Thirty-four percent of workgroup members reported they were aware other community information exchange (CIE) platforms exist in the Commonwealth; however, they are not currently sufficient in quantity or quality. Fifty percent of members responded with a recommendation to stand up the registry statewide as opposed to regionally based on burden. However, workgroup members shared that

implementing a phased in approach with a narrow initial target (e.g., nonprofits focused on overdose prevention, or places where the public can access overdose prevention tools in high-risk areas) is an appropriate strategic base to build and improve upon.

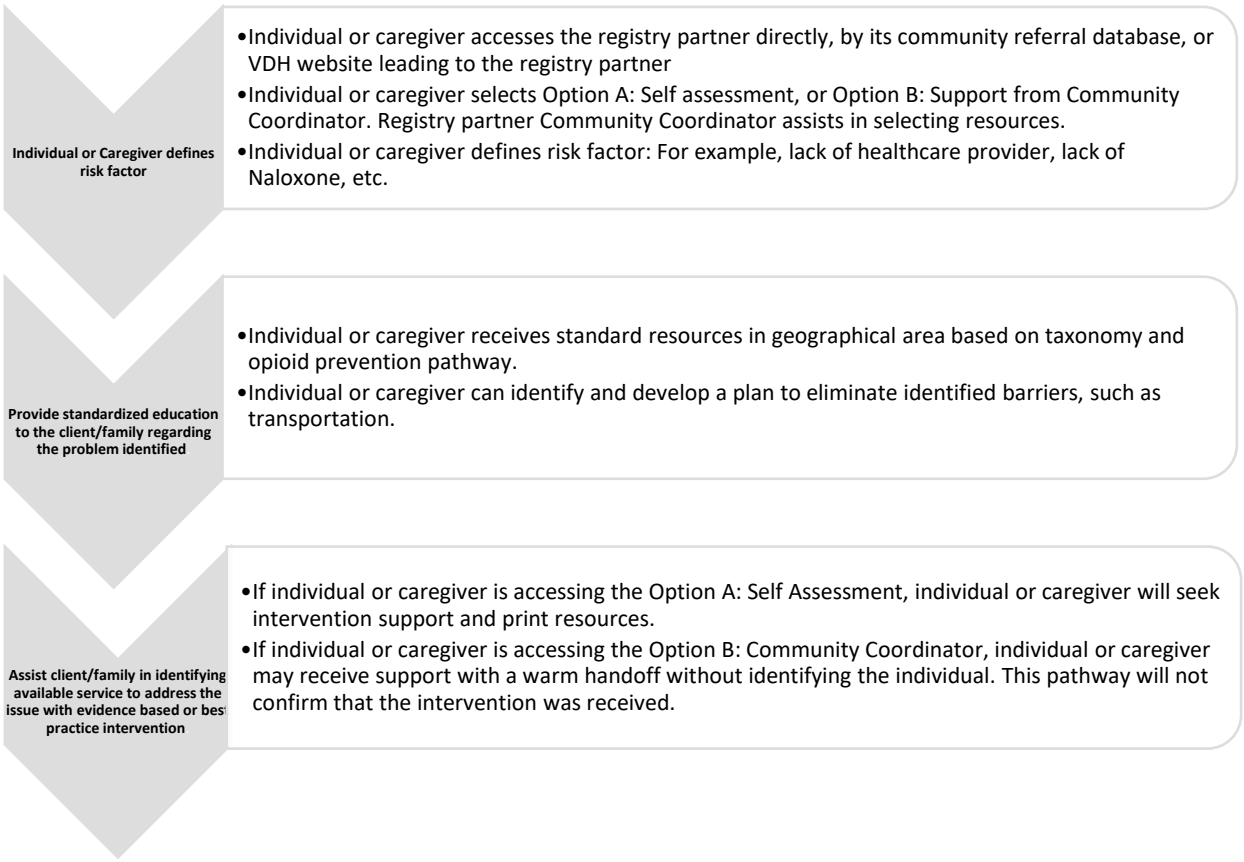
The "Key Functionalities and Vendor Characteristics" table below defines important terms related to the registry and outlines critical registry components that align with best practices and reflect the guidance of stakeholders interviewed and surveyed as part of the information gathering process.

Key Functionalities and Vendor Characteristics

Features	Description
Resource directory	A searchable by zip code, health opportunity/language translation, existing, public-facing directory of community-based organizations and agencies providing services that can help address needs with a current taxonomy and inclusion/exclusion criteria
Services coordination/case management	Ability to define care goals for the end user and allow the view of referrals, services and other activities
Reporting and analytics	The capacity to produce reports on needs screening and referral activities and outcomes
Needs screening	The capacity to record public responses, public questionnaires, and identify social needs
Auto-suggested resources	The ability to tailor resource lists to the public's needs screening results and/or other data/location mapping, along with ability to send auto-suggested resources to users by email
Vendor responsiveness and capacity	The vendor's willingness and ability to tailor the product to users' needs
Community Care Coordinators	Staff available 24/7 by phone, email, and chat services for assistance to the public to ensure linkages of services
Outreach/Quality assurance Coordinator	Existing staff to oversee inclusion/exclusion criteria and outreach activities
Disclaimer Capability	This registry is not considered a crisis line. For emergencies, call 9-1-1. Statement: 1) Inclusion in the registry does not imply endorsement of this agency or its services, nor should exclusion be construed to constitute disapproval. 2) VDH does not regulate organizations and the only course it has is to remove the entity off the registry. 3) Individuals seeking resources on the website contact the nonprofit organization directly. 4) VDH reserves the right to refuse listing any agency if such a listing is deemed inappropriate. 5) VDH may cancel a listing when an agency no longer meets the inclusion criteria, or fails to verify information about their services upon request

Pathways	End user can select risk factors and develop a plan for the end user to eliminate identified barriers. These pathways will assist client/family in removing barriers in identifying available service to address the issue with evidence-based or best practice intervention.
Contact Capability	Ability for organizations to upload application documents. Statement: 1) Individuals wishing to contact or express concern about services should contact the service directly. 2)Individuals will not have the capability to enter questions/contact information into the registry so that the system will not be used as a 24/7 crisis intervention tool.

The Common Structure of the Registry



Types of Service Organizations and Services to Be Included in the Registry

Service organization	Description
Libraries	Comprehensive, community-based strategies to address the opioid epidemic, including linkages to Naloxone, mental health support

Support group organizations	Linkages to peer support services and caregiver support
Charitable/prevention organizations	Linkages to social determinants of health support and crisis center support, including suicide prevention, sexual assault prevention, child abuse and neglect, human trafficking
Recovery community organizations	Education, faith-based, community center, ministries, employment, post-incarceration recovery institutions
Nonprofit organizations providing referrals for the following: --Healthcare access and quality: Access to healthcare services, Medicaid/Medicare, primary care, mental health services, health literacy --Access to services in non-English languages: Including language translation, interpretation services to help non-English-speaking people find public resources --Social and community context: Community connection, social support/cohesion --Neighborhood and built environment: Safe housing, transportation, access to nutritious food/local markets, support for persons with disabilities --Economic stability: Employment, quality child-care	
Nonprofit organizations focused on public education and awareness	
Nonprofit organizations that support legal and financial services	
Nonprofit organizations that support caregivers	
Nonprofit organizations that refer to connections with more intensive levels of care, such as intensive outpatient programs, partial hospitalization programs, and/or residential treatment that unstable patients can be referred to when clinically indicated	
Nonprofit organizations that refer to comprehensive harm reduction sites	
Nonprofit organizations that provide or link individuals to drug checking test strips	
Nonprofit organizations that provide or link individuals to Naloxone	
Nonprofit organizations that provide or link individuals to treatment and recovery (87.5%)	
Nonprofit organizations that refer to buprenorphine-waivered practitioner(s)	
Nonprofit organizations that refer to licensed behavioral health practitioners	

** Collection of inventory services will include 1) accessing directories of established organizations and professional services already compiled, 2) disseminating surveys of current providers of service and institutions that control community resources, 3) surveying LHD population health team staff, and 4) surveying community-based organizations likely to be attuned to the current service array in a community.

Inclusion Criteria: Based on 2-1-1 criteria

The following are highlights of these criteria:

Features	Description
Need for resource	High-prioritized degree of demand/need for the service in the service area
Public health service	Organizations that provide free public health linkage services
Service capacity	Organizational and staffing capacity to adjust to increase referrals
Attestation	Attestation from the nonprofit organization that their agency and practitioners meet the VDH requirements for inclusion

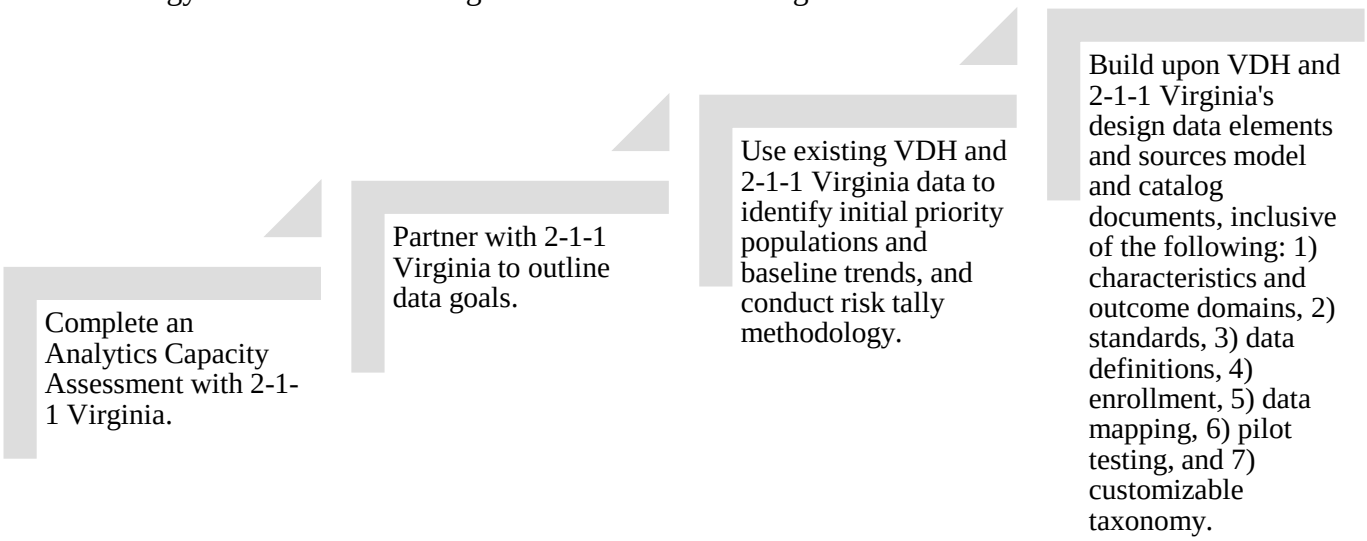
Exclusion Criteria: Based on 2-1-1 criteria

The following are highlights of these criteria:

Features	Description
Operations violation	Organizations that violate federal, state, or local laws or regulations, and those which misrepresent their services or organizational stability in any way
For-profit agencies	This registry will focus on organizations offering a health or human service free of charge to the general public
Lack of information	Agencies who fail to verify information about their services
Organization complaint	Organizations with a substantiated complaint lodged against it by any regulatory body or health and human service organization or one that does not align with VDH's mission.
Misalignment with VDH's mission	

Data Strategy

As part of registry development, VDH will partner directly with 2-1-1 Virginia to create a data strategy. VDH and 2-1-1 Virginia will determine data governance needs.



Metrics

Metrics will be created by VDH in partnership with 2-1-1 Virginia based on the substance use 2-1-1 taxonomy created with the Alliance of Information and Referral Systems, national initiatives prioritizing the social drivers of health (e.g., Institute of Medicine's recommendations, Healthy People 2030 goals), and clinical coding under ICD-I0 Z codes if applicable.

Objective-based Outcomes

- Increased capacity to create, use, and disseminate data from a comprehensive registry system.
- Increased state level dissemination of nonprofit organization overdose prevention resources to the public.
- Increased capacity to disseminate data for social determinants of health resources.

- Increased capacity of VDH to develop and maintain a registry through platform funding and human resources.
- Increased engaged stakeholders and organizations serving the public.
- Increased partner awareness of the registry.
- Increased coordination and collaboration between state (and local) agencies and other sectors.
- Increased understanding of the opioid impact registry.
- Increased capacity to use opioid impact registry data to identify and tailor prevention strategies, improve health equity, and address the social determinants of health.
- Increased knowledge about the effectiveness of opioid registry data.

Process and Program Monitoring Evaluation Outcomes

Number of unique users accessing services online	Screenings, searches, referrals, and referral outcomes
Website traffic	Number of community members accessing services
Service areas	Types of services accessed
Organization services	Breakdown percentage of services (treatment, prevention, Naloxone, etc.)
Organizations selected	User experience evaluation
Number of referred patients to unique community resource providers via telephone and text messaging	Public characteristics

Evaluation

VDH will partner with 2-1-1 Virginia to conduct required evaluation of the system, including economic evaluation; how well the data is capturing meaningful information; how well the process is working for organizations; and the how well implementation is working, particularly for local governments.

Outreach and Training

VDH will partner with 2-1-1 Virginia to disseminate its 2-1-1 University to new partners and educate the public based on a constructed outreach and communication plan.

PHASE FOUR: ADMINISTRATIVE BURDEN

In mid-2023, VDH conducted an internal survey of the VDH Overdose Prevention Workgroup, which is comprised of substance use prevention, treatment, and data analytic experts from across the agency, to understand administrative burdens on local governments in procuring the services of nonprofit organizations to address drug overdose response prevention activities. VDH augmented this data gathering by analyzing publicly available information from state and local government organizations regarding barriers and facilitators to procuring substance use prevention and treatment resources.

Administrative burden actualizes in a variety of ways:

1) Informational and learning costs, including time, effort, money, and resources that organizations need to learn about rules, application, certification, benefits, and post-award reporting.
2) Compliance costs, including time, effort, money, and resources that organizations need to follow through with program application, including filling out paperwork, waiting for correspondence from program agencies, planning for meetings, and producing documentation to confirm eligibility.

An analysis of the public domain resources, inclusive of policy statements, white papers, and a lessons-learned document revealed the following strategies for reducing administrative burden of local governments to work with nonprofit organizations enrolled in the registry:

- Examine government eligibility standards for certain programs to remain nimble during a public health crisis.
- Explore the utilization of Social Care Payment models similar to what was adopted by Unite Us, a community information exchange (CIE) receiving state funding, which enrolls Community Based Organizations (CBOs) for delivery of services and then streamlines billing and reporting infrastructure for social care providers post-delivery of community level services instead of CBOs directly contracting with state funders.
- Cross educate local government and nonprofit organizations in the differences in organizational structure and culture that include government and nonprofit organization staff, elected officials, and community volunteers.
- Coordinate nonprofit organizations' funding applications and presentations to the local government with those to local private-sector grant makers to minimize duplication of efforts.
- Educate nonprofit organizations on government priorities, funding allowances, application and evaluation processes, and expectations for reporting and accountability.
- Undertake joint strategic planning efforts, especially around specific issues.
- Engage nonprofit organizations in local government decision making.
- Provide technical assistance for nonprofit organizations in ways to secure funding, how to execute memorandum of understanding agreements, and receive informational outreach, including posting of funding applications.
- Create and execute Memorandum of Understanding/Agreements that include cooperative agreement technical assistance to build capacity in meeting deliverables.
- Provide additional methods, tools for uploading, and technical assistance in submitting funding applications.
- Use existing administrative records to automatically populate applications or determine eligibility.
- Make in-person options more geographically accessible.
- Reduce unnecessary reporting.
- Inform local governments about nonprofit organization progress throughout the year, not just during the funding-application process.

Limitations

A weakness of qualitative research in administrative burden is its lack of generalizability. Therefore, the final recommendation for this section is to conduct a formal analysis of local

government coalitions, including the Virginia Municipal League, Virginia Association of Counties, and the Virginia Commission on Local Government to refine recommendations.

Utilization of community referral platforms

Organizations are increasingly using community resource referral (CRR) and CIE platforms in their public health settings to provide primary, secondary, and tertiary prevention resources to address health risk and social determinants of health (SDOH) for their populations. These platforms include a resource directory that can filter based on need and geography, services, and eligibility; track referrals; and "close the loop" when the referral outcome is known and/or unresolved. There are several CRR platforms on the market and used in Virginia.

Opioid impact registry approach

For the development of the registry, VDH will take the approach of incorporating the Five Rights of Clinical Decision Support (CDS). While § 54.1-3408 of the Code of Virginia does not call for the registry to be clinical-based and developed as a patient care model with CDS as a centerpiece as with Medicare and Medicaid EHR Incentive Programs, CDS is useful as a framework since its elements align with the vision of the registry.

Five Rights of Clinical Decision Support Adapted for the Registry

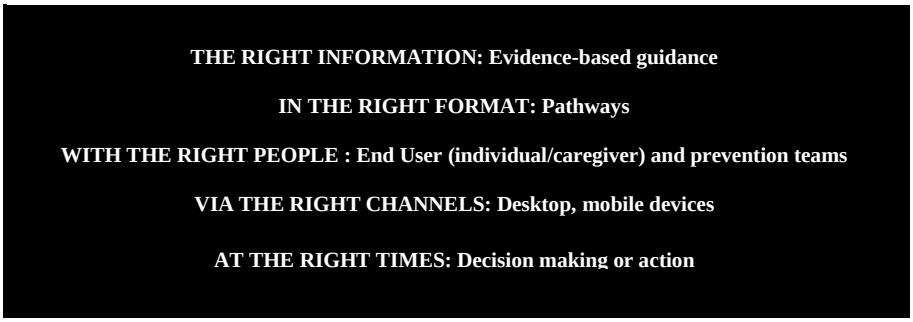


Figure 2: 5 Rights

Principles

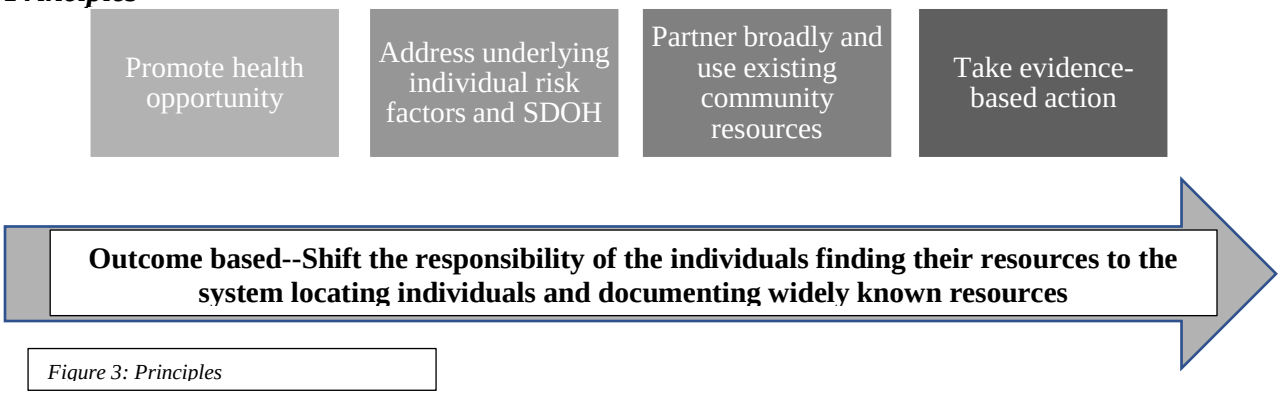


Figure 3: Principles

Value Demonstration

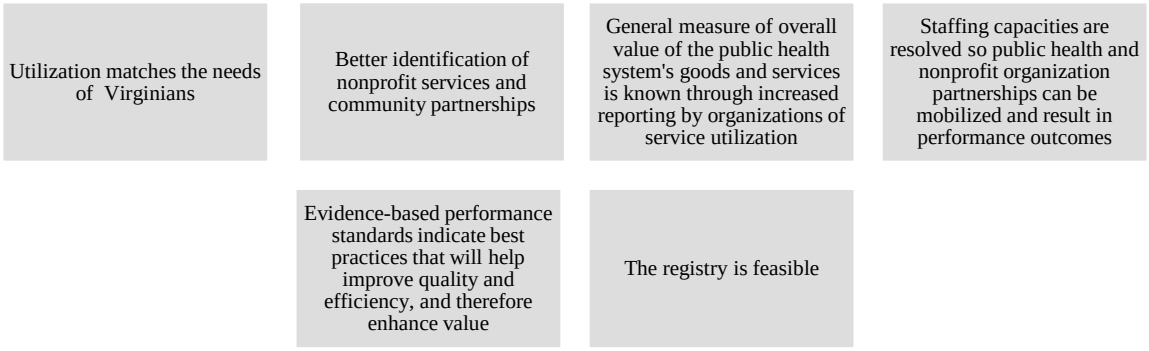


Figure 4: Value demonstration

Recommended partner: As written, § 54.1-3408 of the Code of Virginia has a risk for duplication of existing state level CIEs and "recreating the wheel." During its qualitative analysis, VDH was able to identify an already existing CIE registry partner as a collaborative organization in standing up an informational hub registry.

VDH's recommendations will include partnership with 2-1-1 Virginia to serve as the main operator of the registry. 2-1-1 Virginia is a contracted public/private partnership between the Virginia Department of Social Services (VDSS) and the Council of Community Services in collaboration with the United Way of Central Virginia. In this partnership, VDH will serve as the project administrator and support VDSS and 2-1-1 Virginia as the subject matter expert in state CIE. Both VDSS and 2-1-1 Virginia have been consulted and are supportive of this recommendation.

2-1-1 Virginia is an easy-to-remember, three-digit dialing code connecting people with information on available community services throughout the Commonwealth. 2-1-1 Virginia is a free service available 24 hours a day, 365 days a year. Currently, the system has linkage of care resources for substance use and mental health services through an indexed taxonomy. 2-1-1 Virginia is a contracted public/private partnership between the VDSS and the Council of Community Services in collaboration with the United Way of Central Virginia. 2-1-1 Virginia participates in the 2-1-1 National Data Platform administered by United Way Worldwide and the Washington University in St. Louis's Health Communication Research Laboratory's 2-1-1 Counts. The organization currently partners with VDH and VDH's invested multisectoral stakeholders to refer Virginians to services, including the Virginia Hospital & Healthcare Association, Virginia Department of Housing & Community Development, Virginia Information Technology Agency, VDSS, Virginia Department of Veteran Services, Dominion Energy , Virginia Alliance of Information & Referral Systems, United Way Worldwide/2-1-1 US Virginia, Department of Aging & Rehabilitative Services, Virginia Department of Behavioral Health & Developmental Services, and Virginia Department of Emergency Management Services.

2-1-1 Virginia has considerable experience of supporting Virginians during crisis, most recently during the COVID-19 pandemic. In 2020 alone, more than 260,000 people called or texted 2-1-1 Virginia for help, and over 100,000 users searched 2-1-1 Virginia's publicly available community resource database at 211Virginia.org. From March 2020 through June 30, 2022, 2-1-1 Virginia handled 55,560 contacts from inquirers with one or more COVID-related referrals. Housing and utility assistance remained the top needs for Virginians, and most citizens were referred to the COVID Rent Relief Program (RRP) and local COVID funds (2-1-1 Virginia Annual Report,

2022). 2-1-1 Virginia documented a 34% increase in unmet SDOH needs for Virginians during this time period.

Unique features of 2-1-1 Virginia include:

--Operates two Alliance of Information and Referral Services (AIRS) accredited contact centers and one accredited database center.
--Has 12 trained Certified Community Resource Specialists and three AIRS Community Resource Specialists-Database Curators.
--Operates with the option to engage a community connection specialist through phone, email, or text or individual/caregiver search without connection.
--Stands up an evidence-based long term sustainable system in the Commonwealth that is used nationwide.
--Operates a current one-way informational hub that has all of the elements needed in a one-way informational hub registry design.
--Can be used in partnership with VDH to incorporate a customizable taxonomy.
--Provides 10 major categories 300+ service types with pathways, and a ready-to-use substance use prevention taxonomy.
--Emphasizes a community collaboration model of platform implementation rather than a health-care centric approach.
--Offers a free public-facing online community resource directory that is accessible without logging in.
--Vets organizations with inclusion/exclusion criteria.
--Operates with the option to engage a community connection specialist through phone, email, or text.
--Has capacity to search services by zip code filter and specialty.
--Builds in translation services for Spanish speaking clients and translation for over 240 languages.
--Allows individuals and caregivers to print resources along with location mapping.
--Maintains a database of over 5,500 agencies.
--Contains terms that are clearly named, defined and cross-referenced.
--Differentiates between the services agencies provide and the populations they serve.
--Structures terms in a hierarchical arrangement with mutually exclusive categories, supporting easier and more reasoned indexing.
--Has a flexible structure which permits growth and change as the human services delivery system evolves.
--Is designed specifically for an automated environment.
--Has experience partnering directly with state agencies (VDSS).
--Has an existing 2-1-1 university hub for training.
--Ability to collect intake characteristics and oversee data governance.
--Uses an automated existing intake form and national standardized inclusion/exclusion criteria.
--Uses 2-1-1 Counts as its automatic data dashboard, which is the first tool to provide real-time, searchable, visual presentations from 2-1-1 Virginia. This tool provides a snapshot of community-specific needs displayed by zip code or region, enabling individuals, community leaders, and service agencies to check trends, make comparisons, and share information. 2-1-1 Virginia uses Census Data and has the ability to overlay with 2-1-1 Virginia data.

Unique barriers for people who use drugs in accessing resources

The CDC notes that linking individuals to care can support retention in care and support recovery. The body of literature, however, shows that people who use drugs can experience barriers to care and services that are amplified, such as stigma, legal, access to healthcare, transportation, and social dynamics. As this population is often transient, it is important to have options through a system such as 2-1-1 Virginia for both a one-way informational hub and the ability to connect with a community coordinator as needed for individuals and their caregivers.

Why address social determinants of health resources in a registry such as 2-1-1 Virginia in addition to providing individual support to prevent overdose?

According to Healthy People 2030, social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The body of literature shows that high-risk populations experience a greater number of SDOH needs than general populations, thus impacting their ability to achieve optimal health. The general population of patients faces approximately five simultaneous and compounding SDOH needs, and more complex patients face upwards of ten SDOH needs.

Many SDOH have been directly associated with an increased risk of substance use. For example, neighborhoods with lower rates of economic stability and poorly built environments are significantly associated with increased rates of substance use among residents, even after controlling for individual economic status. People who use drugs or people at risk for using drugs and who don't have access to transportation are less likely to receive healthcare, raising their risk for health conditions, hospitalizations, and overdose.

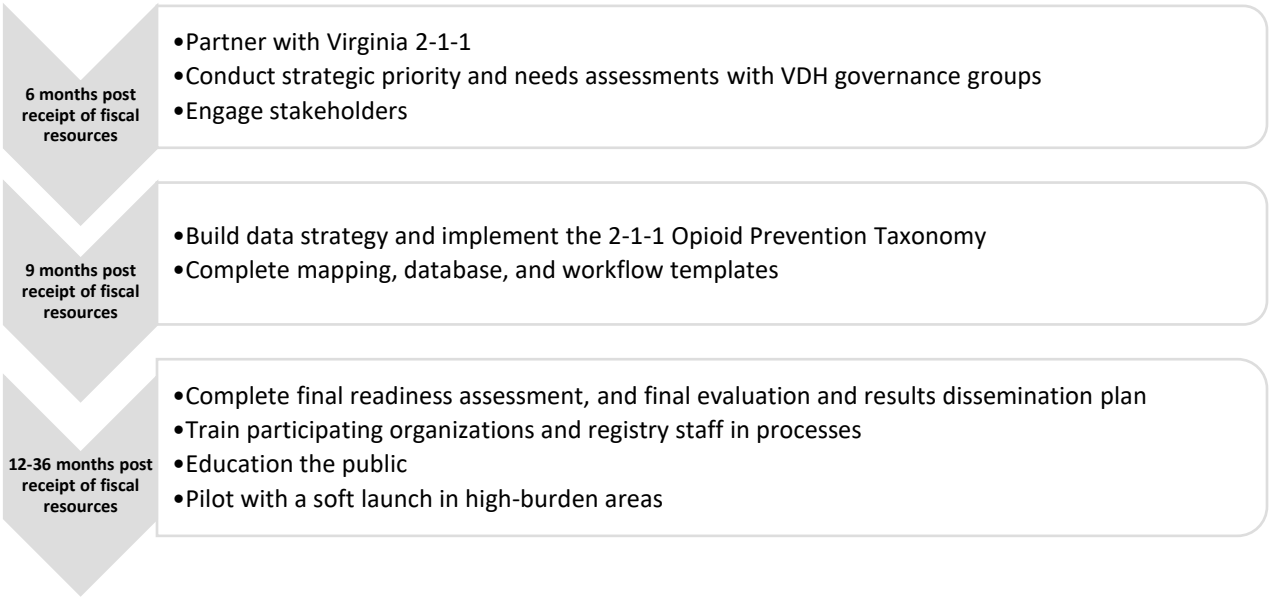
It is well documented in literature that unmet SDOH can create stressors leading to substance use. Addressing SDOH (e.g., resources for safe housing, transportation, access to healthcare, employment) along with a comprehensive individual resource plan (e.g., access to healthcare providers for treatment, harm reduction, Naloxone, peer support) allows prevention to better target the root causes of substance use. Providing resources is not enough, and promoting healthy choices alone won't eliminate these disparities.

RECOMMENDATIONS

1. The Virginia Department of Social Services should submit a budget amendment for general funds to acquire the resources needed to utilize the existing 2-1-1 Virginia system as the framework for the opioid impact registry and expand the taxonomy of, and pathways to, opioid prevention resources. VDH discussed the proposal to expand Virginia 2-1-1 to serve as the registry with DSS. They are in agreement with this proposal. *[Note: As of December 2025, the Governor's Proposed Budget for FY25-26 included $100,000 GF in FY26 for VDH for one-time costs associated with development of the Opioid Impact Reduction Registry (Item 277- I) and $500,000 GF and $500,000 NGF in FY26 for DSS for one-time costs to modernize 2-1-1 to serve as the Opioid Impact Reduction Registry Item 334-C5). The language requires VDH to provide DSS any needed info to support the modernization. It is VDH's understanding that these figures were determined in consultation with DSS.]*

2. The Virginia Department of Health (VDH) should a) create a Registry Governance Team responsible for steering opioid impact registry activities, including major financial, administrative, legal, and scientific decisions that determine the direction of the registry; and b) regularly convene a VDH-led steering committee, comprising VDH LHD representation and state agencies across secretariats, to ensure alignment and coordination of information available in CIE platforms throughout state agencies on separate substance use disorder treatment and recovery resources CIE platforms.
3. 2-1-1 Virginia should consult with VDH to create a data strategy plan and implement the 2-1-1 Alliance of Information Referral Systems opioid misuse prevention taxonomy that aligns with national initiatives prioritizing the social drivers of health (e.g., Institute of Medicine's recommendations, Healthy People 2030 goals), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-I0 Z codes, and agency current reporting requirements.
4. 2-1-1 Virginia should develop workflows, initial focus outcomes, related pathways, and the final product registry based on geographical VDH health district regions, high-burden populations and geographical areas, and resource prioritization models.
5. 2-1-1 Virginia should utilize a combination of active and passive (hybrid) case ascertainment versus requiring a mandate registry reporting.
6. 2-1-1 Virginia should pilot the registry in high-burden areas with a soft launch.
7. 2-1-1 Virginia should vet a master list of community-based services (e.g., non-clinical nonprofits, with or without an IRS Tax Designation) with a service area of the Commonwealth of Virginia to ensure compliance with inclusion criteria.
8. 2-1-1 Virginia should conduct rigorous programmatic and economic evaluation to demonstrate effectiveness and utilization of an opioid impact registry; develop systems to track and evaluate performance; analyze outcomes to demonstrate effectiveness; and utilize the Plan Do Study Act process, a systematic series of steps that can be applied to understand needed improvements to optimize implementation for quality improvement.
9. 2-1-1 Virginia should conduct ongoing outreach to recruit new organizations onto the registry.
10. 2-1-1 Virginia should provide ongoing staff training and technical assistance for registry organizations and the public.
11. The Virginia Department of Social Services should develop a registry sustainability plan.
12. The Virginia Department of General Services should formally analyze the administrative burden to government contracting.
13. All state agencies that address substance use disorder management, and especially those of VDH, DBHDS, VDSS, DMAS, and DVS, should reference methods to access 2-1-1; further, all such agencies should provide links to the other agencies' pertinent SUD assistance sites.

Action Plan Timeline



APPENDIX A – CODE OF VIRGINIA § 54.1-3408

Be it enacted by the General Assembly of Virginia: 1. That § 54.1-3408 of the Code of Virginia is amended and reenacted as follows: § 54.1-3408. Professional use by practitioners. Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023. 3. That the Department of Health (the Department) shall begin development of a Commonwealth opioid impact reduction registry. The registry shall include a list of nonprofit organizations that work to reduce the impact of opioids in the Commonwealth and shall list the services provided by each such organization and contact information for each such organization to be published on the Department's website. The Department shall develop a process to determine which organizations that work to reduce the impact of opioids in the Commonwealth to include in such registry and what criteria and metrics should be utilized to determine their inclusion in such registry. The Department shall examine administrative burdens on local governments in procuring the services of nonprofit organizations on the registry in a timely manner. The Department, within existing resources, may publish an initial list of known nonprofit organizations that work to reduce the impact of opioids on the Department's website that is searchable by zip code. The Department shall report on the process, criteria, and metrics for the registry, including the verification process to ensure an organization meets the criteria to be listed on the registry, and recommendations on reducing administrative burdens on local governments to contract with organizations on the registry to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by September 1, 2023.

APPENDIX B – ACRONYMS AND ABBREVIATIONS

AIRS – Alliance of Information and Referral Services

CBO – Community Based Organization

CDS – Clinical Decision Support

CIE – Community Information Exchange

CRR – Community Resource Referral

EHR – Electronic Health Record

LHD – Local Health Department

RRP – Rent Relief Program

SDOH – Social Determinants of Health

SUD – Substance Use Disorder

VDH – Virginia Department of Health

VDSS – Virginia Department of Social Services

APPENDIX C – VENDOR QUESTIONNAIRE

Phase Two Vendor Questionnaire
General questions: What is your governance and oversight of resource lists?
What are your criteria for inclusion/exclusion of resources?
How do you manage your datasets?
What are considerations when writing protocols on ethics, data ownership, privacy, and adverse event detection related to resource list?
What is your overall design, is your platform available for the public, and do you have community coordination?

1. Needs assessment (if applicable)
a. What kind of needs assessment functionality is available?
b. Are you using an existing screening questionnaire? If so which one(s)?
c. Can users customize screening questions?
d. Is screening self-administered or interviewer administered?
e. Can screening results drive automatic referrals?

2. Community resource identification
a. How do you identify community resources?
b. How do you assess the quality of community resources (both before you include them in the resource directory and on an on-going basis)?
c. How is the list of community resources updated and how often?
d. Can product users contribute information about resources and keep a list of preferred resources?

3. Community resource search
a. How does the search function?
b. Can you do the search without logging in?
c. What needs can be searched for? Can that be customized?

4. Referrals
a. How are referrals made? Is the information given to the patients through download since login will not be required?)
b. How are referrals tracked? Do you have a closed-loop referrals system? If so, how is that done?

5.What kind of case management or longitudinal patient needs tracking is possible?

6. Data analytics
a. What kind of data analytics and reporting are possible?
b. Can users track outcomes for patients by need, geographic area or demographics?
c. Can the data be combined with other data to do predictive modeling?
d. How much customization is possible for reports?
e. How can data be exported?

7. In which states is your product currently used?
8. How long would it take you to deploy it in a community where it hasn't been deployed before?
9. Who is your typical client?
10. What kind of data do you have about the benefits or ROI of using your product?
11. What is the cost structure for your product?
12. What other features/functionality do health care clients particularly like about your product?

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APPENDIX D – OVERDOSE PREVENTION WORKGROUP MEMBERSHIP (AS OF FEBRUARY 2025)

VDH Office of the Chief Medical Examiner
Ryan Diduk-Smith
William Gormley

VDH Office of Communications
Melissa Gilbert
Melissa Gordon
Maria Reppas
Cheryle Rodriguez

VDH Office of Community Health Services
Kyndra Jackson
Jeff Lake

VDH Office of Emergency Medical Services
Jessica Rosner

VDH Office of Emergency Preparedness
Andrea Mackenzie

VDH Office of Environmental Health Services
Lance Gregory
Julie Henderson
Isaiah Omerhi
Rekha Singh
Michelle Yancey

VDH Office of Epidemiology
Alexandra Baldwin
Meredith Davis
Gretchen Dunne
Laurie Forlano
Carolyn Lamere
Michael Landen
Elaine Martin
Samuel Masse
Ashley Matthews
Alexis Page
Bruce Taylor
Stephanie Wheawill
Autumn Yates

VDH Office of Family Health Services
Erin Austin
Lori Beck
Heather Board
Juliana Keeney
Julia Mogren
Vanessa Walker Harris
Lisa Wooten
Lauren Yerkes

VDH Office of Health Equity
Heather Anderson
Sandra Serna

VDH Office of Information Management
Michael Sarkissian
Anup Srikumar
Vinay Suresh

Local Health Districts
Maria Almond, Piedmont Health District
Gloria Addo-Ayensu, Fairfax Health District
Jasmine Blue, Richmond/Henrico Health District
David Goodfriend, Loudon Health District
Adam Hess, Hampton-Peninsula Health District
Taylor "Tes" La Dieu, Hampton & Peninsula Health Districts
Daniel Hunsucker, Lenowisco Health District
Brenna Link, Pittsylvania-Danville Health District
Katherine Schroeder, Lord Fairfax Health District
Melissa Viray, Richmond/Henrico Health District
Michelle Winz, Portsmouth Health District