Technical Guidance for OD2A: LOCAL Linkage to and Retention in Care Surveillance

Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL) (CDC-RFA-CE-23-0003)

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List of acronyms and abbreviations

CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
CoC	Cascade of Care
ED	Emergency Department
EMS	Emergency Medical Services
MOUD	Medications for Opioid Use Disorder
OD2A: LOCAL	Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities
OEND	Overdose Education and Naloxone Distribution
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
SSP	Syringe Services Program
StUD	Stimulant Use Disorder
SUD	Substance Use Disorder
TEDS	Treatment Episode Data Set

1. Introduction

This document describes the guidance for data collected in CDC's Overdose Data to Action: Limiting Overdoses Through Collaborative Actions in Localities (OD2A: LOCAL), optional Component C: Linkage to and Retention in Care Surveillance. The overall purpose of this component is to collect and analyze standardized information on a set of key surveillance indicators to measure linkage to and retention in care and treatment among persons with an opioid use disorder (OUD) and/or stimulant use disorder (StUD). This information can be used to inform prevention activities, and direct public health resources where they are most needed. The following guidance will orient OD2A: LOCAL recipients to all aspects of Linkage to and Retention in Care Surveillance, including:

- data sharing,
- linkage to and retention in care surveillance indicators and case definitions,
- data aggregation in the standard data submission templates, and
- reporting timelines.

For questions about this guidance, please email OD2A_L_linkage2care@cdc.gov.

We look forward to working in partnership with OD2A: LOCAL recipients and providing technical support to ensure the success of the cooperative agreement and support data sharing between your jurisdiction and the OD2A: LOCAL surveillance support team. We also look forward to learning from you throughout OD2A: LOCAL about your ongoing efforts to ensure high data quality to better understand linkage to and retention in care for substance use disorder in your jurisdiction.

Sincerely,
The CDC OD2A: LOCAL Surveillance Support Team

2. Purpose of Reporting Standardized Linkage to Care Indicators

Local health departments are uniquely well-suited to implement surveillance systems for standardized Linkage to and Retention in Care (LTC) indicators. Following an extensive environmental scan and with input from local and state overdose prevention and response programs, the CDC defined a substance use disorder cascade of care (CoC) and set of minimum, standard measures to asses local LTC efforts. Linkage to care connects at-risk individuals to evidence-based treatment, services, and supports, thereby reducing the risk of overdose and other harms associated with substance use. Comprehensive data on the efficacy of these efforts is needed so that health departments can measure the impact of their linkage to care programs, inform overdose prevention activities, and appropriately allocate public health resources where they are most needed.

Adopting standardized indicators for Linkage to and Retention in Care helps ensure not only data quality and comprehensiveness but also fosters a robust foundation for deriving insights into disparities, unmet needs, and optimal practices across the care cascade. Collecting data for standardized linkage to care indicators will facilitate:

- **Consistency:** Standardized indicators ensure that data collection, measurement, and reporting practices remain consistent across various jurisdictions and health departments. This consistency enables meaningful comparisons and benchmarking, allowing for a comprehensive understanding of the Linkage to and Retention in Care landscape across different contexts.

- **Accuracy**: With standardized indicators, health departments can accurately assess the effectiveness of their Linkage to Care initiatives and programs. Consistent measurement methodologies enable reliable tracking of progress over time, providing insights into the success of interventions and identifying areas needing improvement.

- **Identification of gaps and disparities**: Standardized indicators reveal gaps, disparities, and variations in Linkage to Care outcomes across different populations, geographic regions, and demographic groups. This knowledge is crucial for tailoring interventions to address specific needs and ensuring equitable access to care.

- **Research and evaluation efforts:** Standardized data supports research and evaluation efforts. Meaningful insights can be drawn from the data, contributing to the development of best practices, evidence-based interventions, and policy recommendations.

- **Reporting and accountability**: Standardized indicators enhance accountability and transparency. Health departments can accurately report on their Linkage to Care efforts and demonstrate the impact of their programs and initiatives.

- **Resource optimization**: By adopting standardized indicators, health departments can optimize the allocation of resources. They can focus their efforts on strategies that have demonstrated

effectiveness and discontinue or modify less impactful initiatives.

- **Cross-jurisdictional collaboration**: Standardized indicators facilitate collaboration and knowledge sharing among health departments and jurisdictions. Common indicators enable the exchange of insights, lessons learned, and best practices, fostering a collective effort to improve Linkage to Care outcomes.

Ultimately, a standardized approach ensures that a greater number of individuals access the care they require and drives meaningful change in how individuals are connected to care. Health departments may need or desire to measure additional indicators specific to their communities and programs. As relationships, data access, and technologies improve, health departments will have the data to assess program reach, effectiveness, impact, and equity. The CDC intends to foster a dynamic partnership and a continuous learning process with funded recipients to understand and implement effective strategies for enhancing Linkage to and Retention in Care surveillance.

3. General Data Sharing for OD2A: LOCAL

3.1 Background

This section describes key data dissemination and data sharing requirements for health departments that receive an Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL) award from CDC (*CDC-RFA-CE-23-0003)*.

Public dissemination and sharing of data submitted by recipients to CDC is governed by general requirements that apply to all OD2A: LOCAL recipients. Federal mandates to both disseminate and secure data collected from entities is briefly described. Requirements set forth in the Office and Management and Budget (OMB) memo, "Open Data Policy–Managing Information as an Asset" (OMB M-13-13)[1]; Executive Order 13642 titled "Making Open and Machine Readable the New Default for Government Information"[2]; and the Office of Science and Technology Policy (OSTP) memorandum titled "Increasing Access to the Results of Federally Funded Scientific Research" (OSTP Memo)[3] mandate that CDC is responsible for disseminating data it has collected from funded entities, subject to limits imposed by law, resources, confidentiality, technology, and data quality.

CDC recognizes the critical importance of maintaining standards of data quality, upholding individual and institutional privacy and confidentiality, and ensuring impartiality in the sharing of public health data. CDC stores all data received by recipients in an access-controlled share folder, which resides on the CDC Network. The CDC Network follows all National Institute of Standards and Technology (NIST) requirements for data security.

[1] https://project-open-data.cio.gov/policy-memo/
[2] https://obamawhitehouse.archives.gov/the-press-office/2013/05/09/executive-order-making-open-and-machine-readable-new-default-government-
[3] https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/ostp_public_access_memo_2013.pdf

3.2 CDC's data dissemination and data sharing requirements for all OD2A: LOCAL recipients

CDC, in partnership with recipients, will use submitted data to improve linkage to care surveillance and further refine the reporting requirements. Information about how jurisdictions can securely submit data and share data products with CDC will be provided in future guidance. CDC will provide feedback on data received by recipients on such things as data quality, data entry errors, the application of case definitions, continuous quality improvement, and dissemination of success stories to a broad audience. CDC will work collaboratively with jurisdictions to improve the quality, completeness, and timeliness of data shared with CDC. CDC will review and conduct quality control checks on data submitted by the jurisdiction prior to conducting analysis; if discrepancies are identified, CDC staff will reach out to the jurisdiction to identify the problem and facilitate correction or resubmission of the data. Once data are submitted by the jurisdiction and verified by CDC, they are considered validated, and CDC is permitted to disseminate results widely and publicly. In coordination with funded jurisdictions, CDC may share analyses and results to highlight progress in establishing standardized linkage to care surveillance. Below are several examples:

- Print, including publications in peer-reviewed literature, MMWRS, published reports, data briefs, periodicals, brochures, books, and media correspondence,
- Electronic, such as the CDC website (e.g., dashboards), listserv, and e-mail,
- Audiovisual, broadcast scripts, audio or videotapes, and video casting,
- Oral, formal speeches, oral presentations, and interviews, or commentaries for publication or broadcast,
- Data briefs or tables shared with CDC, HHS, and other governmental leaders in response to internal or external requests,

Across all CDC dissemination products, data suppression rules will be used to prevent possible identification through publication of tables combining characteristics that could be used to identify an individual (e.g., age, sex, race/ethnicity, and geographic location). CDC will suppress data for case counts ranging from 1 to 9 cases at the jurisdiction level. CDC aims to provide recipients with advance notification before CDC publicly releases any print publications (e.g., peer-reviewed publications, MMWRs) or web data (e.g., website updates using the data) that use data submitted by recipients.

4. Cascade of Care for Substance Use Disorder

Component C: Linkage to and Retention in Care Surveillance involves reporting standardized Linkage to Care indicators across stages of the Cascade of Care (CoC) for persons identified with OUD and/or StUD. The stages of the CoC include: 1) Identification of need, 2) Engagement with linkage to care programs, 3) Referral to care and treatment, 4) Linkage to care/Treatment initiation, and 5) Treatment retention (see Figure 4.1). These stages are described in more detail in the Linkage to and Retention in Care Surveillance Toolkit, which is provided as an attachment.

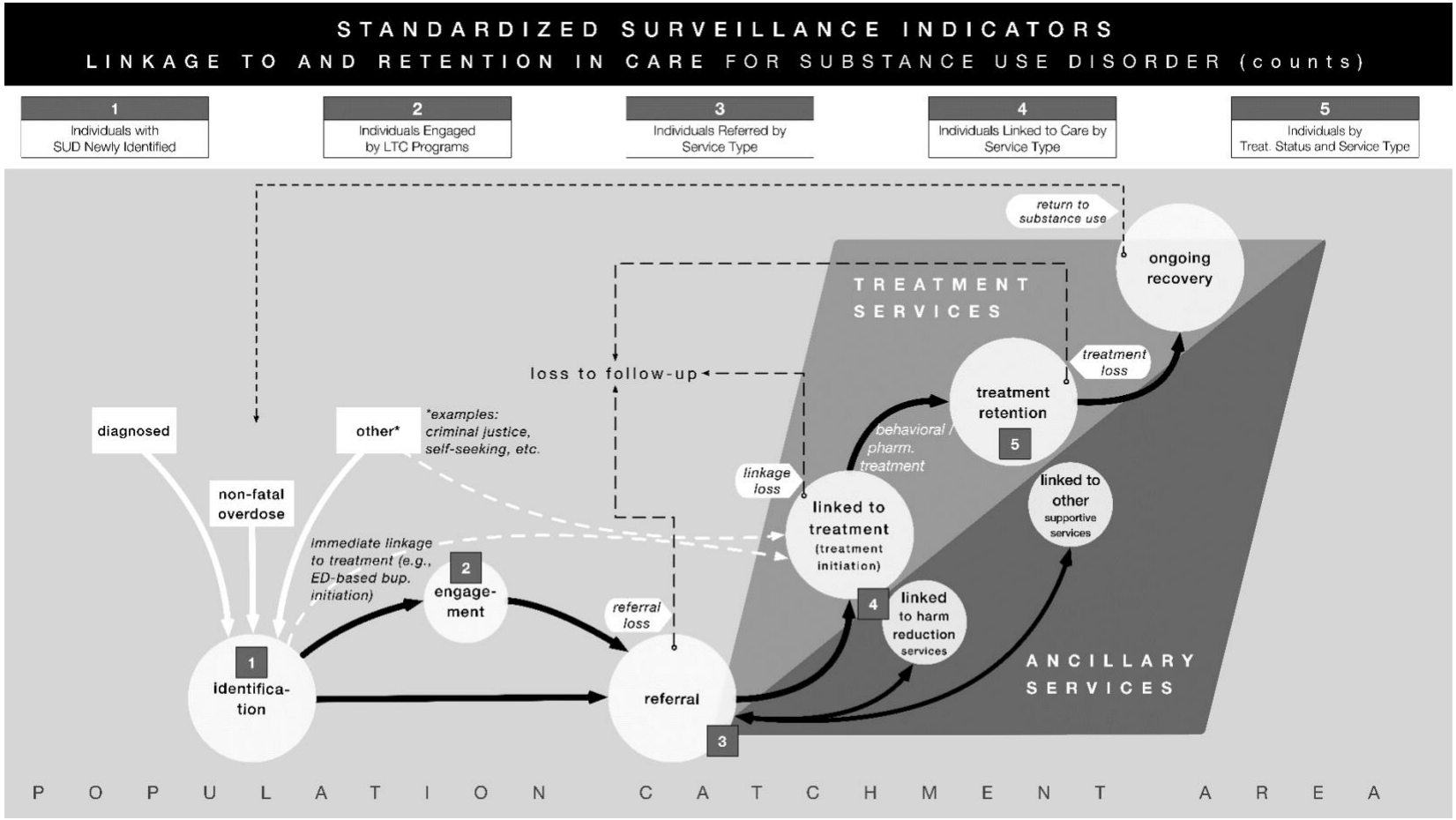


Figure 4.1. *A generalized representation of the Cascade of Care (CoC) for Substance Use Disorder (SUD) illustrates how persons with a SUD may progress along the CoC to receive care and treatment services and the linkage to care surveillance indicators used to measure each stage.*

5. Linkage to and Retention in Care Surveillance Indicator Definitions

Indicator 1: Individuals with OUD and/or StUD Newly Identified

Variable name:

- identified_n

Description: This indicator measures the number of newly[4] identified individuals with a treatment need during the reporting period. This indicator establishes the cohort that will be followed through the cascade of care (CoC). These cohorts are defined based on the entry point to care where they are identified (see Entry Point Criteria section below). Individuals who are identified across multiple entry points can be counted more than once e.g., an individual can be counted once for the nonfatal overdose entry point/cohort and again for the second entry point. The treatment need is assessed according to the General Inclusion and Exclusion Criteria listed below that are Applicable to all Entry Points.

Measurement: Count (n) of unique individuals.

General Inclusion Criteria Applicable to All Entry Points:

- Individuals with a diagnosed OUD and/or StUD, including any positive screening or assessment results that indicate a potential OUD and/or StUD or identify them as being at risk of overdose.
- Individuals who are experiencing symptoms consistent with an OUD and/or StUD in the absence of a clinical diagnosis or any positive screening or assessment results.
- Individuals who are accessing health services with a primary focus on addressing OUD and/or StUD, including those who are seeking assistance with managing their opioid and/or stimulant use in a clinical or specialized treatment setting.
- Individuals who are accessing harm reduction or social support services for opioid and/or stimulant use, including injection drug use.
- Individuals who self-report or express concerns related to their opioid and/or stimulant use or identify themselves as being at risk of overdose.
- Individuals with a history of any previous substance use disorder, including those who have received treatment or engaged with harm reduction services, who are now using opioids and/or stimulants.
- Individuals with a co-occurring Substance Use Disorders (SUDs), who also meet the criteria for OUD and/or StUD.

General Exclusion Criteria Applicable to All Entry Points:

- Individuals with multiple encounters in an entry point during a single reporting period should only be counted once to avoid double-counting.
- Individuals with any other substance use disorder who do not also meet the above criteria for OUD

[4] "Newly" in this context is relative to the reporting period, encompassing individuals who are entering the Cascade of Care for the first time known to the given reporting locality. This term aims to capture individuals who haven't been included in previous data calls.

and/or StUD.

- Individuals who have been identified and counted in previous reporting periods and are currently retained in substance use services or treatment programs.

Entry Point Criteria

The entry point describes a setting where a jurisdiction may first interact with, or identify, an individual with OUD and/or StUD. The following table includes a description of suggested populations for inclusion and potential data sources for each entry point.

Entry Point	Suggested Populations for Inclusion	Possible Data Sources
Nonfatal Overdose	• Individuals who have experienced a nonfatal overdose during the reporting period (regardless of substance involved) who also have an OUD and/or StUD diagnosis or are experiencing symptoms consistent with an OUD and/or StUD. • Individuals who have experienced an opioid-involved and/or stimulant-involved nonfatal overdose during the reporting period, in the absence of information on an OUD or StUD diagnosis.	• EMS system - responses for suspected nonfatal overdoses • ED syndromic surveillance - substance-specific overdose syndrome visits • Hospital discharge data - nonfatal overdose hospital discharges • Overdose reportable condition surveillance systems - individuals identified through mandatory case reporting in jurisdictions where overdose is a reportable condition
Other Clinical Care	• Individuals with a confirmed or suspected OUD and/or StUD diagnosis who are seeking care in a clinical setting (e.g., primary care, ED, inpatient hospitalization) for conditions other than a nonfatal overdose. This could include co-morbid conditions like HIV or Hepatitis C, infections related to drug injection or other injuries, prenatal or postpartum care, among others.	• Reportable case management systems - acute viral hepatitis cases, other reportable comorbidities for people who inject drugs • Electronic health records diagnosis data, all-payers claim databases, Medicaid claims data, and other clinical data sources with diagnosis data • Data from healthcare facilities, clinics, or hospitals where individuals receive diagnoses and treatment for substance use disorders. This could include electronic health records or administrative databases.
Criminal Justice-Involved	• Individuals involved in the criminal justice system, which may include those who are incarcerated in jails or prisons, those who are released from incarceration, or those who are eligible for pre-trial diversion programs, who screen positive for possible OUD and/or StUD.	• Criminal justice release records • Department of Corrections data
Harm Reduction Services	• Individuals actively participating in community-based harm reduction and syringe services programs.	• Program-collected data on harm reduction program service utilization

Other Community-Based Programs	• Individuals actively participating in other community-based programs (beyond harm reduction), including homeless services and groups like Alcoholics Anonymous or Narcotics Anonymous, that work with individuals at increased risk for overdose.	• Program-collected data on community-based program service utilization
Self-Referrals	• Individuals who self-identify as having an OUD and/or StUD or being at risk of overdose by accessing SUD hotlines, accessing coordination services, or being referred by family or friends.	• Program-collected data from substance use hotlines or coordination services
Other	Program-defined entry point not otherwise described. Must be approved by CDC.	

Indicator 2: Individuals Engaged by Linkage to Care Programs

Variable name:

- engaged_n

Description: Among those identified with a treatment need during the reporting period, the number of individuals engaged by linkage to care program staff through in-person contact, phone calls, or other personal interactions like text messaging. Individuals who are engaged by LTC programs should be counted regardless of their intention to seek care or treatment and regardless of the length of interaction with program staff. A period of 60 days is set from the date of identification to the date of engagement. This 60-day window establishes a timeframe for engagement; individuals who are not engaged by staff within this period will not be counted in the indicator.

Linkage to care program staff includes any professional who assists individuals in accessing treatment and harm reduction services. Linkage to care program staff may provide any of the following: assessment, information and education, referrals and coordination, support and guidance, and follow-up and monitoring. Possible roles that linkage to care program staff may have include:

- Medical professionals
- Administrative staff
- Social workers
- Peer support specialists or Recovery coaches
- Outreach workers
- Case managers
- Addiction/Substance use counselors

Measurement: Count (n) of unique individuals. Should be a subset of individuals identified during the reporting period (identified_n) who are engaged *within a period of 60 days* from the date of identification.

Possible data sources:

Overdose prevention and response program data systems:

- Case investigations or individual follow-up
- Outreach program records or staff interviews
- Program enrollment or registration records, including referral and case management systems
- Tally of program coordinator activity logs or tracking forms
- Reports or notes from other service providers

Indicator 3: Individuals Referred by Service Type

Variable names:

- referred_MOUD_n
- referred_behavioral_n
- referred_unspecified_n
- referred_anytreatment_n
- referred_harmred_n

Description:

- referred_MOUD_n: Among those identified with a treatment need during the reporting period, the number of individuals who were referred to MOUD treatment *within a period of 60 days*. See Service Type section for a description of MOUD treatment.
- referred_behavioral_n: Among those identified with a treatment need during the reporting period, the number of individuals who were referred to behavioral treatment *within a period of 60 days*. See Service Type section for a description of behavioral treatment.
- referred_unspecified_n: Among those identified with a treatment need during the reporting period, the number of individuals who were referred to treatment *within a period of 60 days, but the specific type of treatment was not specified*.
- referred_anytreatment_n: Among those identified with a treatment need during the reporting period, the total number of individuals who were referred to any treatment type *within a period of 60 days*, including MOUD, behavioral or unspecified. See Service Type section for descriptions of MOUD and behavioral treatment.
- referred_harmred_n: Among those identified with a treatment need during the reporting period, the number of individuals who were referred to harm reduction services *within a period of 60 days*. See Service Type section for a description of harm reduction services.

A referral includes any formal connection to support services or treatment options. This includes referrals made by healthcare providers, social workers, social service providers, community organizations, law enforcement, navigators, peer support specialists, or other relevant sources. Referred individuals should be included regardless of whether they were engaged by linkage to care program staff. This indicator could also include self-referrals if those individuals are also included in the initial cohort of identified individuals. Duplicate or redundant referrals made for the same individual for the same service type should only be counted once. The <referred_unspecified_n> variable allows for flexibility in capturing referrals to treatment services when the exact treatment type is not clearly defined at the time of referral or information on treatment type is not available.

A period of 60 days is set from the date of identification to the date of referral. This 60-day window establishes a timeframe for referral; individuals who are not referred to treatment or harm reduction services within this period will not be counted in the indicator.

Measurement: Count (n) of unique individuals. Should be a subset of individuals identified during the

reporting period (identified_n) who are referred within a period of 60 days from the date of identification. This count *does not* need to be a subset of individuals engaged by linkage to care program staff (engaged_n).

- referred_MOUD_n should also be a subset of referred_anytreatment_n
- referred_behavioral_n should also be a subset of referred_anytreatment_n
- referred_unspecified_n should also be a subset of referred_anytreatment_n
- Individuals referred to multiple service types should be counted only once for <referred_anytreatment_n>.

Possible data sources:

Treatment provider data systems:

- Substance use treatment data collected by state agencies for submission to SAMHSA's Treatment Episode Data Set (TEDS)[5]
- Provider reports from treatment provider data system

Clinical EHR systems:

- Referrals made by healthcare providers to specialized treatment services
- Reporting modules that track and generate reports on referral activities

Overdose prevention and response program data systems:

- Case investigations or individual follow-up
- Outreach program records or staff interviews
- Program enrollment or registration records
- Tally of program coordinator activity logs or tracking forms
- Referral records from other service providers or agencies
- Reports or notes from social workers or counselors

Indicator 4: Individuals Linked to Care by Service Type

Variable names:

- initiated_MOUD_n
- initiated_behavioral_n
- initiated_unspecified_n
- initiated_anytreatment_n
- initiated_harmred_n

Description:

- initiated_MOUD_n: Among those identified with a treatment need during the reporting period, the number of individuals who were successfully linked to/initiated MOUD treatment *within a period of 60 days*. See Service Type section for a description of MOUD treatment.

[5] May only include data from facilities that receive public funding.

- initiated_behavioral_n: Among those identified with a treatment need during the reporting period, the number of individuals who were successfully linked to/initiated behavioral treatment *within a period of 60 days*. See Service Type section for a description of behavioral treatment.
- initiated_unspecified_n: Among those identified with a treatment need during the reporting period, the number of individuals who initiated treatment *within a period of 60 days*, but the specific type of treatment was not specified.
- initiated_anytreatment_n: Among those identified with a treatment need during the reporting period, the number of individuals who were successfully linked to/initiated any treatment type within a period of 60 days, including MOUD, behavioral or unspecified. See Service Type section for descriptions of MOUD and behavioral treatment.
- initiated_harmred_n: Among those identified with a treatment need during the reporting period, the number of individuals who were successfully linked to/initiated harm reduction services *within a period of 60 days*. See Service Type section for a description of harm reduction services.

Individuals who initiate multiple service types should only be counted once for <referred_anytreatment_n>. The <initiated_unspecified_n> variable allows for flexibility in counting individuals who initiate treatment when the exact treatment type is not clearly defined or information on treatment type is not available.

The definition of successful linkage to care or initiation may vary depending on the service type:

- *MOUD treatment* – Filling a prescription for, or directly receiving one of the three FDA-approved MOUD medications: buprenorphine, methadone, or naltrexone. In cases where data on prescription fulfillment is not available, receipt of a prescription could also be considered initiation, although prescription fulfillment is preferable. For methadone treatment, initiation is recognized when an individual starts receiving methadone directly at a methadone clinic. MOUD initiation may also include initiation of MOUD that occurs immediately at identification before further engagement or referral by linkage to care program staff (e.g., initiation of buprenorphine in the emergency department).
- *Behavioral treatment* – Initiation refers to an initial consultation with a service provider.
- *Harm reduction services* – Initiation may include accepting naloxone through overdose education and naloxone distribution (OEND) programs, utilizing drug checking services, accessing syringe services programs (SSP), participation in Hepatitis C (HCV) services, and other services provided by harm reduction service providers.

A period of 60 days is set from the date of identification to the date of initiation for treatment or harm reduction. This 60-day window establishes a timeframe for being successfully linked to care; individuals who do not initiate treatment or harm reduction services within this period will not be counted in the indicator.[6]

[6] Note that individuals who do not initiate treatment, could still be referred, and linked to harm reduction or other ancillary services. Once in harm reduction, these individuals could then be considered a new cohort for the harm

This indicator should not include the following:

- Individuals who only undergo short-term detoxification without any initiation of MOUD for maintenance or other evidence-based treatment for OUD. Although short-term detox may involve the use of medications used for MOUD (e.g., buprenorphine, methadone), this alone is not considered evidence-based treatment and may increase the risk of adverse events, such as overdose.
- Individuals who receive opioid medications solely for pain management purposes and do not meet the criteria for substance use disorder treatment or support services.

Measurement: Counts (n) of unique individuals. Should be a subset of individuals identified during the reporting period (identified_n). This count *does not* need to be a subset of individuals engaged by linkage to care program staff (engaged_n) or individuals referred to treatment or harm reduction services (referred_n). *Note: Individuals who are identified during Q1 and linked to care during Q2 should be reflected in the Linked to Care indicator counts for Q1, provided that the time between identification and linked to care does not exceed 60 days.*

- initiated_MOUD_n should also be a subset of initiated_anytreatment_n
- initiated_behavioral_n should also be a subset of initiated_anytreatment_n
- initiated_unspecified_n should also be a subset of initiated_anytreatment_n

Possible data sources:

Self-report data:

- Program data system – case investigations or individual follow-up

Treatment provider data systems:

- Treatment claims from state Medicaid data
- Substance use treatment data collected by state agencies for submission to SAMHSA's Treatment Episode Data Set (TEDS)
    - May only include data from facilities that receive public funding
- Provider reports from treatment provider data system
- Data on buprenorphine prescriptions from state Prescription Drug Monitoring Program (PDMP)

reduction entry point, facilitating measurement of linkage to treatment services and contributing to a more comprehensive understanding of the care continuum.

Indicator 5: Individuals by Treatment Status and Service Type

Variable names:

Treatment Status	***Service Type***		
	MOUD	**Behavioral treatment**	**Treatment unspecified**
Retained	status_MOUD_ retained_n	status_behavioral_ retained_n	status_unspecified_ retained_n
Completed	status_MOUD_ completed_n	status_behavioral_ completed_n	status_ unspecified_ completed_n
Incarcerated	status_MOUD_ incarcerated_n	status_behavioral_ incarcerated_n	status_ unspecified_ incarcerated_n
Deceased	status_MOUD_ deceased_n	status_behavioral_ deceased_n	status_ unspecified_ deceased_n
Other	status_MOUD_ other_n	status_behavioral_ other_n	status_ unspecified _ other_n
Unknown/ missing	status_MOUD_ unknown_n	status_behavioral_ unknown_n	status_unspecified_ unknown_n

Description: Among those identified during the reporting period who were successfully linked to care, the number of individuals who are retained in treatment, completed treatment, are incarcerated, are deceased, or are lost to follow-up (e.g., status unknown or missing) six months after being linked to care. This indicator is reported separately for the following service types: MOUD, behavioral treatment and treatment unspecified. See Service Type section for descriptions of MOUD and behavioral treatment. *Note: This indicator is not reported for the harm reduction service type, due to the difficulty in defining and measuring retention in harm reduction services.*[7]

Status definitions:

Status	***Definition***
Retained	Individuals who are active in the treatment program at six months follow-up.
Completed	Individuals who completed the treatment program prior to six months follow-up.
Lost to Follow-up	Individuals who did not complete the treatment program and are no longer active. Includes individuals who "drop out" of treatment for unknown reasons, or for whom treatment is terminated by the facility.

[7] Harm reduction services often have different service structures and objectives compared to MOUD and behavioral treatment, cater to individuals with varying levels of engagement, and may offer support services without requiring ongoing participation. Limited longitudinal record keeping, and concerns about erosion of trust with more extensive data collection are additional factors underlying the omission of harm reduction services from the treatment status indicator.

Status	*Definition*
Incarcerated	Individuals who are incarcerated prior to six months follow-up.
Deceased	Individuals who died prior to six months follow-up.
Other	Individuals with a status other than those in this list.
Unknown	Individuals for whom status at six months is not known because, for example, discharge record is lost or incomplete.

Measurement: Count (n) of unique individuals. Should be a subset of individuals identified during the reporting period (identified_n).

- status_MOUD_retained_n should also be a subset of initiated_MOUD_n
- status_MOUD_completed_n should also be a subset of initiated_MOUD_n
- status _MOUD_incarcerated_n should also be a subset of initiated_MOUD_n
- status _MOUD_deceased_n should also be a subset of initiated_MOUD_n
- status _MOUD_other_n should also be a subset of initiated_MOUD_n
- status _MOUD_unknown_n should also be a subset of initiated_MOUD_n
- status _behavioral_retained_n should also be a subset of initiated_behavioral_n
- status _behavioral_completed_n should also be a subset of initiated_behavioral_n
- status _behavioral_incarcerated_n should also be a subset of initiated_behavioral_n
- status _behavioral_deceased_n should also be a subset of initiated_ behavioral_n
- status _behavioral_other_n should also be a subset of initiated_ behavioral_n
- status _behavioral_unknown_n should also be a subset of initiated_behavioral_n
- status_unspecified_retained_n should also be a subset of initiated_unspecified_n
- status_unspecified_completed_n should also be a subset of initiated_unspecified_n
- status_unspecified_incarcerated_n should also be a subset of initiated_unspecified_n
- status_unspecified_deceased_n should also be a subset of initiated_unspecified_n
- status_unspecified_other_n should also be a subset of initiated_unspecified_n
- status_unspecified_unknown_n should also be a subset of initiated_unspecified_n

Possible data sources:

- See data sources listed under Linked to Care indicator.

Reporting Timeframe and Reporting Lag

The "Identified" indicator provides an aggregate count of individuals identified during each three-month quarter. Subsequent indicators ("Engaged", "Referred", "Linked to Care", "Treatment Status") track identified individuals as they move through the cascade of care and should include a subset of those identified individuals within that specific quarter, regardless of when the subsequent event occurred. Therefore, indicators are reported according to the quarter during which the individuals were identified, not during the quarter during which the events occurred. It's important to note that the "Engaged", "Referred", and "Initiated" indicators are only included in the aggregate data submitted to CDC if these events occur within a 60-day window following identification.[8] For example:

- An individual was identified on February 20th, engaged on March 2nd, referred on March 10th, linked to/initiated care on April 10th, and retained in care as of October 7th.
- Since this individual was identified during Q1 (Jan – Mar), counts for the "Identified", "Engaged", "Referred", "Linked to Care", and "Treatment Status" indicators should all be reported for Q1, even though the last two indicators in the cascade ("Linked to Care" and "Treatment Status") occurred after the end of Q1.

Data are submitted to CDC every six months, and each data submission should include two quarters of aggregate data. "Identified", "Engaged", "Referred", and "Linked to Care" indicators are defined as "short term" indicators while the "Treatment Status" indicator is defined as a "follow-up" indicator. Short term indicators for each quarter have a 2-month reporting lag, while the follow-up indicator for each quarter has an 8-month reporting lag. See the Reporting Timelines section for data submission deadlines and quarters that should be included with each data submission. See Table 4.1 below for a list of short term and follow-up indicators.

Required and Optional Indicators

Some indicators will be required in Years 2 & 3 and/or in Years 4 & 5, while others will be optional in Years 2 & 3 and/or in Years 4 & 5. See Table 4.1 below for a summary of required and optional indicators for each year of data submission.

Table 5.1. Indicators by Required versus Optional and Short Term versus Follow-up

Variable Name of Indicator	Year 2 & 3: Required or Optional	Year 4 & 5: Required or Optional	Short term or Follow-up
identified_n	Required	Required	Short term
engaged_n	Required	Required	Short term
referred_MOUD_n	Required	Required	Short term
referred_behavioral_n	Optional	Required	Short term

[8] The 60-day window for "Engaged", "Referred", and "Initiated" indicators is a necessary limitation for reporting aggregate data to CDC and ensures these indicators can be collected within a single reporting period.

referred_unspecified_n	Optional	Optional	Short term
referred_anytreatment_n	Optional	Required	Short term
referred_harmred_n	Required	Required	Short term
initiated_MOUD_n	Required	Required	Short term
initiated_behavioral_n	Optional	Required	Short term
initiated_unspecified_n	Optional	Optional	Short term
initiated_anytreatment_n	Optional	Required	Short term
initiated_harmred_n	Required	Required	Short term
status_MOUD_retained_n	Required	Required	Follow-up
status_MOUD_completed_n	Required	Required	Follow-up
status_MOUD_incarcerated_n	Required	Required	Follow-up
status_MOUD_deceased_n	Required	Required	Follow-up
status_MOUD_other_n	Required	Required	Follow-up
status_MOUD_unknown_n	Required	Required	Follow-up
status_behavioral_retained_n	Optional	Required	Follow-up
status_behavioral_completed_n	Optional	Required	Follow-up
status_behavioral_incarcerated_n	Optional	Required	Follow-up
status_behavioral_deceased_n	Optional	Required	Follow-up
status_behavioral_other_n	Optional	Required	Follow-up
status_behavioral_unknown_n	Optional	Required	Follow-up
status_unspecified_retained_n	Optional	Required	Follow-up
status_ unspecified _completed_n	Optional	Required	Follow-up
status_ unspecified _incarcerated_n	Optional	Required	Follow-up
status_ unspecified _deceased_n	Optional	Required	Follow-up
status_ unspecified _other_n	Optional	Required	Follow-up
status_ unspecified _unknown_n	Optional	Required	Follow-up

Disaggregation of Indicators by Key Characteristics

Disaggregation by demographic variables provides more information about *who* is moving through the CoC. Understanding the demographics of individuals entering and engaging in the CoC can guide programming and outreach efforts supportive of equitable linkage to care. Some disaggregates will be required in Years 2 & 3, while others will be optional in Years 2 & 3. All disaggregates will be required in Years 4 & 5. See Table 4.2 below for a summary of planned required and optional disaggregates for each year of data submission.

Table 5.2. Disaggregates by Required versus Optional

Variable Name of Disaggregate	Year 2 & 3: Required or Optional	Year 4 & 5: Required or Optional
jurisdiction	Required	Required
quarter	Required	Required

year	Required	Required
entry_point	Required	Required
substance_type	Required (opioids only)	Required (opioids and stimulants)
sex	Optional	Required
age_group	Optional	Required
race	Optional	Required
ethnicity	Optional	Required

Considerations for Geographic Coverage across Indicators

Among those identified during the reporting period, individuals can be counted in subsequent indicators even if they are engaged, referred, initiated, or retained in different geographical regions or jurisdictions outside the catchment area where they were identified. The ability to capture identified individuals across geographical regions and jurisdictions will depend on what data sources are available in the linkage to care surveillance system. Ideally, individuals accessing care for opioid use disorder and/or stimulant use disorder across multiple locations are accounted for and included in the measurement of linkage to and retention in care. This will help provide a more comprehensive view of the linkage to and retention rates, regardless of the specific location or region where individuals are receiving services.

Service Type

Service Type refers to the different treatment and ancillary services options. The current indicator descriptions focus on three service types. A fourth option for unspecified treatment is included for scenarios where a program may not have the immediate capabilities to distinguish between the type of treatment provided.

1. MOUD – This includes FDA-approved medications for treating opioid use disorder, including buprenorphine, methadone, or extended-release naltrexone, alone or in combination with behavioral treatment.
2. Behavioral Treatment – This includes any evidence-based behavioral strategies such as counseling, motivational interviewing, cognitive behavioral therapy (CBT), contingency management, and community reinforcement approach, alone or in combination with MOUD.
3. Unspecified Treatment – This indicates that the type of treatment was not specified because a program did not have the immediate capability of distinguishing between different types of treatment provided or because the treatment type was not clearly defined at the time of referral.
4. Harm Reduction Services – This includes syringe service and overdose education and naloxone distribution (OEND) programs that provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; fentanyl test strip distribution; vaccination, testing and linkage to care and treatment for infectious diseases; and linkage to social services, including housing and transportation services.

6. How to Use the OD2A: LOCAL Linkage to and Retention in Care Surveillance Data Submission Templates

Purpose: This section provides guidance for OD2A: LOCAL-funded jurisdictions to submit linkage to and retention in care surveillance indicators and metadata to CDC. Please refer to the ***Reporting Timelines*** section for the specific dates when data and metadata are due.

To facilitate consistency in these data submissions, CDC developed standardized data submission templates for inputting the required indicators described in previous sections as aggregate counts.

Please note that CDC is requesting that jurisdictions enter all counts — ***please do not suppress small numbers***. If the count is zero, ***please enter "0***." All numbers will be available to the CDC OD2A: LOCAL surveillance support team only, and the team will not share any counts with anyone outside the support team. When aggregating counts, CDC will avoid calculating percentages, rates, or percent change estimates based on small counts.

6.1 Entering Data into Templates

If copying and pasting data from other output files into the data templates, it will be necessary to:

- Copy and paste from a CSV file to avoid receiving false positive error messages in the template. This includes using exported files from SAS and other software used to generate output. Other output files can be saved as CSV files if needed before copying and pasting into the templates.
- Paste data as values into the Excel templates. This can be completed either by:
    - Option 1
        - Right-click in the cell where the data will be pasted.
        - Under the "Paste Options" menu, click on "Values (V)"—the icon is the clipboard with "123".
    - Option 2
        - Click on the "Paste" drop-down menu at the top left of the screen.
        - Under the "Paste Options" menu, click on "Values (V)"—the icon is the clipboard with "123".

6.2 What's in the Template?

There is one data submission template that must be used for OD2A: LOCAL Linkage to and Retention in Care Surveillance data submission: **OD2A_LOCAL_LTC_Data_Submission_Template_Aggregate**. This spreadsheet includes 10 tabs:

1. Introduction: Includes a description and links to each tab within the spreadsheet.
2. Variable_definition: Includes a description of each of the variables in the indicators tabs. The following information is provided for each variable:

- Full Variable Name
- Abbreviated Variable Name
- Description
- Subset of Other Indicators
- Data Type
- Values
- Years 2/3 Required or Optional
- Years 4/5 Required or Optional

3. Metadata_LTC: Includes metadata questions to be completed. This tab is required and must be completed and submitted by all jurisdictions with each data submission.
4. Indicators_nonfatalOD: Includes indicators for the Nonfatal Overdose entry point. This tab is required and must be completed and submitted by all jurisdictions with each data submission.
5. Indicators_otherclinical: Includes indicators for the Other Clinical Setting entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.
6. Indicators_criminaljustice: Includes indicators for the Criminal Justice-Involved entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.
7. Indicators_harmreduction: Includes indicators for the Harm Reduction Programs entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.
8. Indicators_community: Includes indicators for the Other Community-Based Programs entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.
9. Indicators_selfreferral: Includes indicators for the Self-Referral entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.
10. Indicators_other: Includes indicators for the Other entry point. This tab is optional and must be completed and submitted only by jurisdictions who are collecting data for this entry point.

- The “Indicators” tabs have structured fields for data entry to provide a consistent framework for data collection across entry points. Entry points are the settings where data on the cohort of newly identified individuals with a treatment need for opioid use/OUD and/or stimulant use/StUD are collected. Each indicator tab is intended to capture aggregate data related to a distinct entry point for individuals moving through the cascade of care, from identification to engagement, referral, initiation of treatment or harm reduction services, and status at 6 months. The structure of each “Indicators” tab is as follows:
    - **Required Aggregate Information:** The required indicators provide aggregate data for the specific entry point and are in Row 4 for the first quarter of data and Row 80 for the second quarter. Note that only cells in Row 4 that are shaded in green will be required at the start of the funding period (see Required and Optional Indicators).

- **Optional Disaggregated Information:** Following the two rows of aggregate information for both quarters, each row corresponds to the disaggregated data for demographic variables. Only one variable is disaggregated in each row (note that race and ethnicity variables are combined and are therefore the exception).
- **Linkage to Care Indicators:** Columns J to AM are where counts of individuals can be reported across the across stages of the Cascade of Care (CoC). Note multiple columns for Referred, Initiated and Treatment Status 6 Months after Initiation due to stratification by service type.
    - Referred indicators: Columns L to P capture counts for individuals referred by service type.
    - Initiated indicators: Columns Q to U capture counts for individuals linked to care by service type.
    - Status indicators: Columns V to AM capture counts for individuals by treatment status and service type.

6.3 Sections That Need to be Completed

Metadata

- Complete all fields in the metadata tab to provide essential contextual information about the data. Ensure that no fields are left blank.
- Provide a contact for CDC to email with questions about the data submission.
- See Answering the Metadata Questions for further instructions.

Indicators

- Only enter data in tabs for the entry points for which you are collecting data.
    - This must include the Nonfatal Overdose entry point and at least one other entry point.[9]
    - Do not delete the other tabs; include them with your submission but leave all cells blank.
- Enter information for jurisdiction name (i.e., assigned jurisdiction abbreviation, see Appendix 1), quarter, and year for ***each of the 2 quarters*** included in the 6-month reporting period. These fields are pre-filled with different colors to distinguish the 2 quarters:
    - Completing these columns is necessary for ensuring the accuracy of CDC's data management procedures.
    - Cells in Columns A to C are pre-filled in purple for the first quarter of the 6-month reporting period and in blue for the second quarter of the 6-month reporting period.

[9] Entry points are where individuals with an OUD and/or StUD are identified and are a way of defining cohorts as they enter the CoC. Programs should aim to collect data within each entry point-defined cohort to understand at which places they are seeing the most success at identifying, referring, and linking individuals to treatment.

- Cells are programmed to remove the fill colors when information for jurisdiction name, quarter, and year is entered. Please verify that all rows include the correct information for jurisdiction, year, and quarter. Enter all data for the required indicators for each entry point and quarter. Cells corresponding to required indicators and disaggregates for Years 2 & 3 are pre-filled in green. Cells are programmed to remove the fill colors when information is entered. Please ensure that all required cells are completed.
    - Only Rows 4 and 80 contain required indicators.
    - Provide the total counts of identified individuals and engaged individuals for opioid use disorder.
    - Provide the total counts of referred individuals for each required service type (MOUD and harm reduction services).
    - Provide the total counts of individuals linked to care (initiated) for each required service type (MOUD and harm reduction services).
    - Provide the total counts for treatment status at 6 months for each required service type (MOUD and harm reduction services).
    - In cases where the specific treatment type (e.g., MOUD) is unavailable due to data limitations, jurisdictions should utilize the "treatment unspecified" category. Please include a description of the "treatment unspecified" category and its use as a response to reporting limitations in the metadata.

- If available, enter data for the optional indicators and disaggregates. If you are not submitting data for any of the optional indicators, leave those cells blank.
    - Provide the total counts of identified individuals and engaged individuals for stimulant use disorder (Rows 42 and 118).
    - Provide the total counts of referred individuals for each optional service type (behavioral treatment, treatment unspecified and any treatment).
    - Provide the total counts of individuals linked to care (initiated) for each optional service type (behavioral treatment, treatment unspecified and any treatment).
    - Provide the total counts for treatment status at 6 months for each optional service type (behavioral treatment, treatment unspecified and any treatment).
    - Provide the total counts for each indicator disaggregated by sex, age group, race, and ethnicity.
    - Note that the sum of counts within each set of rows for disaggregated counts by sex, age group, race and ethnicity should match the corresponding overall total for that specific quarter (as represented in Rows 4 and 80). For example, any disaggregated data by sex (Column F) in *quarter 1* for Opioids (Rows 5 to 7) should sum to the Overall counts for Opioids in Row 4. Similarly, any disaggregated data by sex (Column F) in *quarter 2* for Opioids (Rows 81 to 83) should sum in each Indicator column to the Overall counts for Opioids in Row 80.
- For rows with corresponding data, ensure that all fields for jurisdiction, quarter, and

year for ***each of the 2 quarters*** are completed for each entry point where any data is submitted.

- Completing these columns is necessary for ensuring the accuracy of CDC's data management procedures.
- Note that there should be no purple or blue cells in any of Columns A to B for rows with required indicators and any additional rows where data has been entered for optional indicators.
- Fields for jurisdiction, quarter, and year do not have to be entered in Columns A to B if there is no corresponding data entered in Columns J to AM.

6.4 Answering the Metadata Questions

Please answer the following questions in the Metadata_LTC tab of the ***OD2A_LOCAL_LTC_Data_Submission_Template_Aggregate*** *spreadsheet.*

Please note that a Data Source Catalogue tool will be provided as a separate resource to create an inventory of information required for answering metadata questions. This tool will help jurisdictions organize existing data assets, understand internal data management processes, and document external data sharing practices. The inventory can be used to help effectively locate, manage, use, and share data assets.

1. Select the entry points for which your jurisdiction is reporting data. (At least two entry points must be selected, one of which must be Nonfatal overdose.)

- Nonfatal overdose (required) is automatically selected.
- Select any additional entry points from the drop-down menus provided.
- If there is no data available for a third or any additional entry points, choose the "N/A" option from the drop-down menu for the remaining entry points.

2. Describe the population captured at each entry point for which your jurisdiction is reporting data.

- Provide a brief description of the population captured at each entry point for which your jurisdiction is reporting data, including relevant characteristics or criteria used for identification. Responses for this section must not exceed a 3000-character limit.
- If the "N/A" option was selected for any additional entry points, the population description for those entry points will automatically update to "N/A."

3. Please identify and describe the data sources that were used to report data on each indicator (e.g., identified_n, engaged_n, referred_n, initiated_n, status_n). Descriptions should comment on data availability, frequency of data availability, data granularity whether the data is identifiable, and whether data is linked to other data sources. Describe any changes or improvements in data sources since the previous reporting period.

The following points should be addressed:

- Indicate the primary sources of data that were used to report data for each indicator.
- Describe the origin, purpose, and any relevant characteristics of the data source.
- Explain if and how the data sources are linked or integrated.
- **Data availability:** Specify whether the data source is publicly available, restricted to partner organizations, sourced from internal records, etc.
- **Frequency of Availability**: Describe how often the data is updated, refreshed, or can be accessed. Mention if there are any delays in data availability.
- **Data Granularity**: Indicate whether the data is collected at an individual level or aggregated.
- **Data Identifiability**: Clarify whether the data contains identifiable information.
- **Changes or Improvements**: Detail any updates, improvements, or changes made to the data sources since the previous reporting period.

4. Please describe partner organizations the local linkage to care surveillance system including their relevance to the CoC for opioid and/or stimulant use disorder and the strength of relationship (*Rate from 1 [weakest; some data sharing, inconsistent] to 5 (strongest; coordination between programs, MOU's between organizations]*). Describe any changes in relationship strength since the previous reporting period.

   The following points should be addressed:

   - **Relevance to the CoC**: Describe how each partner organization contributes to the CoC for opioid and/or stimulant use disorder. Explain their role in the surveillance strategy and their impact on data coverage and quality.
   - **Assign a rating** from 1 (weakest) to 5 (strongest) to indicate the strength of the relationship. Briefly explain the rationale for the assigned rating, considering factors such as data sharing, collaboration, and whether Memorandums of Understanding (MOUs) are established.
   - **Changes in Relationship Strength**: Detail any changes in the strength of the relationship since the previous reporting period (not applicable for first reporting period). Example:
     - "Our collaboration with Organization C has grown stronger (rating increased from 2 to 3) thanks to increased communication and joint efforts in refining data collection processes."
   - The description should offer a clear understanding of how these partnerships contribute to the success of your surveillance strategy.

5. Please describe any facilitating technology or automation that supports the local linkage to care surveillance system. Describe any changes or improvements since the previous reporting period.

   - Provide a description of any technological tools or automation methods that have been used to facilitate or enhance your local linkage to care surveillance system.

- Examples of technology and automation might include:
  - Incorporating interoperable data exchange platforms for sharing patient-level data across various stakeholders.
  - Leveraging big data analytics tools to process and derive insights from large and diverse data sources.
  - Utilizing software or technologies that address challenges such as data privacy, security, data silos, and budget or resource constraints.
  - Developing machine learning or other data analytics algorithms or procedures to facilitate data integration and analysis.
- If applicable, highlight any advancements or modifications that have been implemented since the last reporting period.

6. Please provide a qualitative assessment of the data coverage or representativeness for each reported indicator for the *Nonfatal overdose entry point* (e.g., identified_n, engaged_n, referred_n, initiated_n, status_n).

   - Within the *Nonfatal overdose entry point*, please provide an overall qualitative assessment of the completeness of reported data for each indicator in the CoC, considering reporting coverage and related data gaps and limitations.
   - Be specific regarding challenges that might impact the completeness or representativeness of data submitted.
   - Some examples may include the following, with corresponding details:
     - Incomplete records, missing variables or fields, or instances where key data elements are not fully captured.
     - Underrepresentation or incomplete coverage of individuals e.g., for specific entry points or indicators, for certain demographic groups, geographic areas, etc.
     - Challenges related to data privacy and confidentiality, which might result in data suppression or the exclusion of certain cases or variables.
     - Challenges in data linkage or integration across multiple systems or databases, resulting in incomplete or fragmented data records.
     - Inability to contact or follow up with individuals through the CoC: The completeness of reported data may be affected by individuals who cannot be contacted or followed up with, posing challenges in referring and linking them to linkage to care services. Factors such as disconnected phone numbers, changes in contact information, or individuals who are transient or have unstable housing situations can make it difficult to establish communication and ensure follow-up.

7. Please provide a qualitative assessment of the data coverage or representativeness for each reported indicator for *additional entry points* (e.g., identified_n, engaged_n, referred_n, initiated_n, status_n).

   - Within *additional entry points*, please provide an overall qualitative assessment of the

completeness of reported data for each indicator in the CoC, considering reporting coverage and related data gaps and limitations.

- Be specific regarding challenges that might impact the completeness or representativeness of data submitted.
- Some examples with corresponding details are listed above under metadata question 6.

8. Please identify other strengths and limitations of the data based on other quality attributes of the data, like uniqueness, timeliness, validity, accuracy, and consistency.

- For each quality attribute (uniqueness, timeliness, validity, accuracy, consistency), comment on how your data performs in relation to that attribute.
- Please highlight any notable strengths and areas where your data excels.
- Identify any limitations or challenges that might impact the quality of your data.
- Include details on any improvements or changes since the previous reporting period.
- The following are examples of strengths and limitations for each attribute:
    - **Uniqueness:**
        - Strength: Data benefits from unique identifiers assigned to each individual, minimizing the risk of double-counting or duplication.
        - Limitation: In some cases, individuals might be registered under different identifiers if they interact with multiple care providers.
    - **Timeliness:**
        - Strength: Data reporting process has improved, leading to more frequent updates and timely submissions.
        - Limitation: Delays in data collection and reporting which impact the timeliness of our data.
    - **Validity:**
        - Strength: Data collection methods are aligned with standardized protocols, ensuring the validity of the information gathered.
        - Limitation: Data entry errors or misunderstandings of reporting criteria which may introduce validity concerns.
    - **Accuracy:**
        - Strength: Data validation checks, and quality assurance procedures are implemented.
        - Limitations: Some inconsistencies in data entry or analysis that may affect accuracy of certain data points.
    - **Consistency:**
        - Strength: Data collection guidelines and definitions have remained consistent over time, allowing for meaningful comparisons and trend analysis.
        - Limitation: Data discrepancies or inconsistencies are identified during data reconciliation processes between different reporting entities or levels (e.g., local, regional, national).

- Additional examples of data quality attributes can be found here: https://www.cdc.gov/ncbddd/hearingloss/documents/dataqualityworksheet.pdf

9. Who should CDC contact with questions about this data report?

- Name and contact email

6.5 Other FAQs about the Template

Preparation of Datasets

- ***Q:*** *What date should we use to determine whether to include individuals and in which quarter they belong?*
  A: Use the date of the first encounter at a given entry point to determine whether to include individuals identified within the specified quarter. Individuals counted under other indicators should be a subset of those included in the "Identified" indicator.

- ***Q:*** *Should I enter a 0 for cells with counts equal to zero?*
  A: Yes, if the count is zero, please enter 0. Please leave cells for which you are not submitting data null or blank (e.g., optional indicators or disaggregates, or indicators in tabs corresponding to entry points for which you are not collecting data). If counts are missing for any other reason, also leave the cells blank.

Metadata

- ***Q:*** *How are the metadata going to be used by CDC?*
  A: Metadata help CDC staff better understand issues related to data quality and completeness. Metadata also help us with appropriate interpretation of changes observed. Please reach out directly to the OD2A: LOCAL surveillance support team to alert them to specific issues that should be documented in the metadata tab.

Data Submission and Quality Control

- ***Q:*** *Are there specific file-naming conventions that jurisdictions should use when submitting aggregate data to CDC?*
  A: Yes, please use the following file-naming conventions:
  - First 4-5 letters should be the jurisdiction abbreviation (see Appendix 1 for your jurisdiction's assigned abbreviation).
  - The next space should be an underscore followed by LTC, "_LTC"
  - The next part of the file name includes information on the reporting due date:

  - Use 2 digits for the month and 4 digits for the year to indicate the reporting due date.
  - Ensure that the data collection template is saved in the xlsx format to maintain compatibility with CDC's data management procedures.
  - Examples:
    - ACPA_LTC_12_2024.xlsx
    - PHPA_LTC_06_2025.xlsx

- ***Q:*** *How do I submit the templates to CDC?*
  A: Further guidance about data submissions processes will be provided during Year 1 of the funding period, before the first data submission is due in December 2024.

- ***Q:*** *Can CDC provide any quality control (QC) resources to help jurisdictions ensure data are accepted by CDC?*
  A: CDC will provide jurisdictions with QC programs before the first data submission is due in December 2024. These will most likely be in SAS and/or R formats.

7. Reporting Timelines

Purpose: To outline detailed schedule for reporting requirements of standardized indicators to measure linkage to and retention in care (data submissions) and data products developed by recipients to disseminate findings to key local partners and/or the public.

The following tables indicate deliverable dates for OD2A: LOCAL Linkage to and Retention in Care Surveillance data submissions and data products. Please note that all data submissions and data products are due by 11:59 PM EST on the date specified. Instructions on how to submit data submissions and data products to CDC will be provided prior to the first deliverable date.

7.1 Important Dates/Deadlines for OD2A: LOCAL Linkage to and Retention in Care Data Submissions

Table 7.1. Dates and Deadlines for Short term and Follow-up Indicators

Quarter(s) Included in Data Submission	Submission Date for Short term Indicators (2-month lag)*	Submission Date for Follow-up Indicator (8-month lag)**
Q3 2024 (Sept only) plus any historical data†	December 16, 2024	June 16, 2025
Q4 2024 (Oct-Dec) Q1 2025 (Jan-March)	June 16, 2025	December 15, 2025
Q2 2025 (Apr-Jun) Q3 2025 (Jul-Sept)	December 15, 2025	June 15, 2026
Q4 2025 (Oct-Dec) Q1 2026 (Jan-March)	June 15, 2026	December 21, 2026
Q2 2026 (Apr-Jun) Q3 2026 (Jul-Sept)	December 21, 2026	June 21, 2027
Q4 2026 (Oct-Dec) Q1 2027 (Jan-March)	June 21, 2027	December 20, 2027
Q2 2027 (Apr-Jun) Q3 2027 (Jul-Sept)	December 20, 2027	June 19, 2028
Q4 2027 (Oct-Dec) Q1 2028 (Jan-March)	June 19, 2028	August 21, 2028***

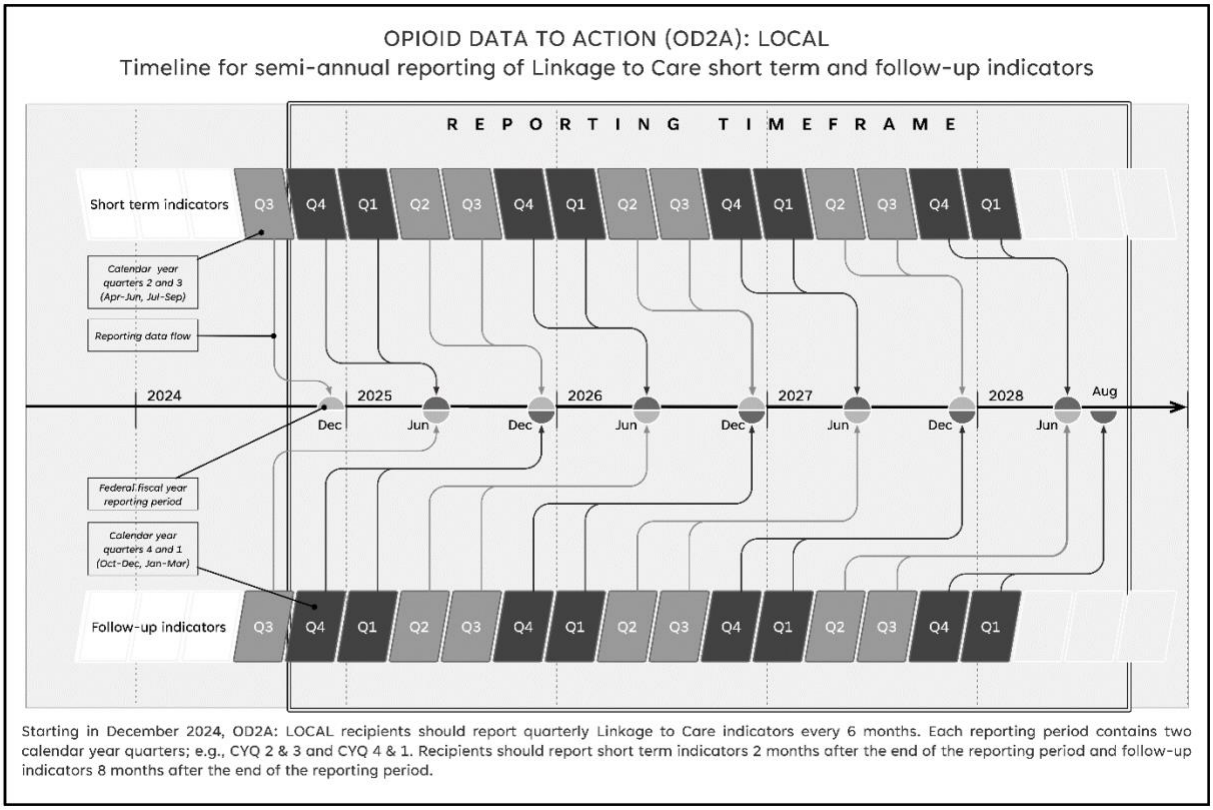
* Short term indicators include: Identified, engaged, referred and initiated. See Reporting Timeframe and Reporting Lag section for more information.

** Follow-up indicator is treatment status. See Reporting Timeframe and Reporting Lag section for more information.

*** Only Q4 2027 required

† Historical data refers to any previous data that jurisdictions may have collected on linkage to and retention in care indicators. For the first data submission (Sept only for Q3 2024), jurisdictions have the option of providing any data they have collected previously in addition to the data for Sept 2024.

Figure 7.1. Linkage to Care leading and lagging indicator reporting timeline



7.2 Important Dates/Deadlines for OD2A: LOCAL Linkage to and Retention in Care Data Products

Data Product	Due Date
Year 2 data product	August 31, 2025
Year 3 data product	August 31, 2026
Year 4 data product	August 31, 2027
Year 5 data product	August 31, 2028

Appendix 1: List of abbreviations for each jurisdiction participating in OD2A: LOCAL Linkage to and Retention in Care Surveillance

Jurisdiction Name	Abbreviation
Allegheny County, PA	ACPA
Baltimore County, MD	BCMD
Broward County, FL	BCFL
Cuyahoga County, OH	CCOH
Duval County, FL	DCFL
Franklin County, OH	FCOH
Hamilton County, OH	HCOH
City of New Haven, CT	NHCT
Palm Beach County, FL	PBCFL
Philadelphia, PA	PHPA
Pima County, AZ	PCAZ
Seattle & King County, WA	SKCWA