

Virginia Department of Health

Needs Assessment Tool for Drug Overdose and Related Outcomes: Frequently Asked Questions (FAQs)

Methodology

Why were these indicators selected?

The indicators were selected because they are:

- Directly related to drug overdose burden, such as drug overdose emergency department visits or deaths.
- Disease outcomes that can be spread through injection drug use, like hepatitis C or HIV.
- Indicators related to the economic health of a community, such as poverty or unemployment. Communities with lower income and fewer jobs can be at increased risk for drug overdose.

Are all the indicators given the same weight when determining the score, and if so, why was that method chosen?

Yes, each indicator is weighted the same. All indicators show potential higher risk for drug overdose in a community.

Why were both counts and rates considered?

Counts and rates can better identify localities at higher need, than looking at only counts or only rates.

Rates

Benefits:

- Used to compare equally across different population sizes
- Allows for smaller and sometimes more rural localities to be considered

Limitations:

- May underestimate burden in localities with larger population sizes

Counts

Benefits:

- Reflects higher number of cases (like nonfatal drug overdose) and/or death (to assess burden)
- Easy to understand by different audiences

Limitations:

- Counts are typically higher in areas with larger population sizes (more drug overdoses where there are more people). Counts may leave out smaller and sometimes more rural localities from being considered.

Why do the indicators include all drugs versus only opioids (e.g., all-drug overdose deaths, all-drug overdose emergency department visits, etc.)?

The indicators include all drugs for a few reasons.

- Not all drug overdose deaths involve an opioid.
- There is an increasing trend in use of more than one substance (polysubstance) in drug overdose deaths. There is also an increase in drug overdose deaths due to cocaine or methamphetamine, which are not opioids.
- Sometimes a less lethal drug used by a person is unknowingly mixed with a more lethal drug, like fentanyl.

Were data sources counted at the individual level?

Not all indicators were able to be counted at the individual level. Several data sources lack direct person-level identifiers. For example, hospitalizations are the number of hospital stays, not the number of people who stayed at the hospital. Even if an indicator is not at the individual level, it still shows drug overdose burden or risk in an area.

Indicator-Specific

Why were socioeconomic indicators such as poverty and unemployment included?

Communities with lower income and fewer jobs can be at increased risk for drug overdose and related health outcomes.

Why was the emergency department indicator changed from rate per 10,000 ED visits to rate per 100,000 population?

Using rates per 100,000 population better align with how other indicators in the tool are calculated. Rates per 10,000 ED visits is often used when the number of emergency department reporting data to VDH changes over time. Emergency department coverage was stable for all years of the assessment, which supported the change to rates per 100,000 population.

If a locality does not have an emergency department, how does that impact the data for the second indicator?

Data for drug overdose emergency department visits in this tool are based on where the patient lived at the time of their visit, regardless of where in Virginia the emergency department is located. The data are not impacted if a locality does not have an emergency department.

Why does the Hepatitis C indicator only include 15-34-year-olds?

Injection drug use is the most common risk factor for hepatitis C in younger adult age groups.

Why was the Hepatitis C indicator changed from 18–30-year-olds to 15-34-year-olds after 2021?

Population estimate data changed. The 2021 version of this tool used bridged-race population estimates from the National Center for Health Statistics, which included more locality-level age groupings. These bridged-race estimates were discontinued in 2021. Subsequent versions of this tool use the single-race population estimates from the United States Census Bureau, which has different locality-level age groupings and does not include an exact match for an 18–30-year-old group. A VDH evaluation found that counts and rates among Virginia hepatitis C cases among 18–30-year-olds and 15–34-year-olds were not considerably different. It remains that injection drug use is the most common risk factor for hepatitis C in younger adult age groups.

Why did the indicator for treatment admissions change after 2021?

The previous iteration of the tool in 2021 included substance use-related treatment admissions. VDH learned from the Virginia Department of Behavioral Health and Developmental Services (DBHDS) when updating the 2022 overdose needs assessment tool that the data could be stratified by primary drug or substance used. VDH requested that subsequent data from DBHDS exclude alcohol and cannabis as the primary substances to align with the other drug overdose indicators in the tool.

Which population estimates were used for the tool?

The 2020 bridged-race population estimates from the National Center for Health Statistics were used for the 2021 version of the tool. The National Center for Health Statistics stopped producing bridged-race population estimates in 2021. Beginning in 2022, the tools now use single-race population estimates from the United States Census Bureau.

General

Which year of data should my locality use to inform prevention efforts?

Localities should use the most recent data year to inform prevention efforts where available. The tool presents more than one year of data to show trends over time.

Will the tool be updated, or will it be a one-time document?

VDH plans to update the model on an annual basis as data become available. Previous years of data will continue to be available to compare scores across time. The state score is also reassessed with each iteration of the tool.

If my locality is identified as higher need, where can I find more information about available drug overdose prevention resources or programs?

Resources and programs can be found on the [VDH website](#). If you have any questions, please email overdose@vdh.virginia.gov.

If my locality is identified as higher need, does this mean that my locality's available drug overdose prevention and intervention services are not doing what they should be doing to prevent drug overdose death?

No, drug overdose and substance use impact all Virginia communities. This tool does not assess a locality's capacity or ability to implement drug overdose prevention and intervention strategies, and it cannot monitor a locality's progress in addressing the drug overdose crisis. It is just a descriptive way to summarize and compare a locality to the statewide average using a variety of indicators.

If my city or county is not identified as higher need, does that mean that there is not an issue in my area?

No, drug overdose and substance use impact all Virginia communities. Together with state and local partners, VDH's goal is to support all communities in their efforts to reduce the harms of drug use as resources allow.

If I have more questions about the needs assessment tool or my locality score, who do I contact?

Please contact overdose@vdh.virginia.gov with your question(s). More information can also be found on the Overdose Needs Assessment Tool Methodology document.