



**EVALUATION PROFILE FOR**  
**Technical Assistance**  
**to Disproportionately**  
**Affected Communities**

**OVERDOSE**  
**DATA2ACTION**



**Centers for Disease**  
**Control and Prevention**  
National Center for Injury  
Prevention and Control

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# Purpose of the Evaluation Profile

**This evaluation profile  
PROVIDES GUIDANCE  
in designing evaluations  
of technical assistance  
to disproportionately  
affected communities.**

This resource is meant to demonstrate how to conduct evaluations, in many cases using existing programmatic data, to produce actionable and timely findings. These findings will be used to inform program managers and stakeholders about how well initiatives are being implemented, and how effective they are at bringing about desired outcomes. This profile provides guidance on the types of evaluation questions, indicators, data sources, and data collection methods that can be used to evaluate technical assistance to disproportionately affected communities.

## EVALUATION CONSIDERATIONS

CDC funded entities<sup>1</sup> should tailor their evaluations to stakeholders' needs and the stage of development for each activity. Evaluations should serve programmatic needs to ensure high quality initiatives are developed, reach program goals, and are tested for effectiveness.

The evolving nature of drug overdoses requires that programs strategically pivot to address emerging needs. Evaluators should remain vigilant to changing needs and look for ways to provide practical and actionable information to program implementers and decision makers.<sup>2</sup> Decisions surrounding the level of rigor needed for a given evaluation should be weighed and balanced by the evaluation standards of utility, feasibility, propriety, and accuracy.<sup>3</sup> Examples are provided throughout the profiles to show where less rigorous, but potentially more accessible, data (e.g., discussions with stakeholders, program recipient logs, meeting notes) may be useful in evaluations.

## CONTENT ORGANIZATION

The following items are included:

### 1. Evaluation Profile

The profile is organized by process and outcome evaluation subcategories to demonstrate aspects that stakeholders may want to explore at various stages of an initiative's life cycle. Evaluations often touch upon multiple subcategories; therefore, a glossary is included to provide detailed information on each subcategory.

### 2. Description and Logic Model

The description highlights core components of each activity, and the logic model shows expected outputs and outcomes. These may help implementers and evaluators see how their own activities or initiatives may be similar or differ from the ones presented.



# Technical Assistance<sup>4</sup> to Disproportionately Affected Communities<sup>5</sup>

Health departments (HDs) provide technical assistance (TA) to stakeholders<sup>6</sup> to enhance their capacity to **UNDERSTAND AND INTERPRET** local overdose trends and burden; **IDENTIFY POPULATIONS** or communities most impacted; and select and **COORDINATE IMPLEMENTATION** of appropriate evidence/practice-based interventions to respond to their community's needs.

HDs may prioritize technical assistance to disproportionately affected populations/communities to implement prevention efforts. These efforts aim to enhance organizational capacity to translate and use data to better address burden; tailor interventions for various populations (e.g., people in recovery, justice involved populations, pregnant women, African American or American Indian/Alaskan Native); identify gaps in services (e.g., linkage to care); address problems on a systematic level (e.g., problematic prescribing); and collaborate with multidisciplinary partners.

# Core components of this activity may include the following:

## 1. Develop planning and TA resources for overdose prevention efforts (e.g., overdose burden data reports and menu of evidence/practice-based prevention interventions)<sup>7</sup>

- Assess TA needs and determine resources available for TA delivery system
- Contextualize and describe local trends in drug use, misuse, and overdose (may include non-public health sources of data<sup>8</sup>)
- Create and provide materials outlining strategies for local planning, implementation, and evaluation of overdose prevention activities (e.g., action plans,<sup>9</sup> menus of evidence/practice-based initiatives,<sup>10</sup> presentations or written guidance materials that accompany overdose and drug use trend data<sup>11</sup>)

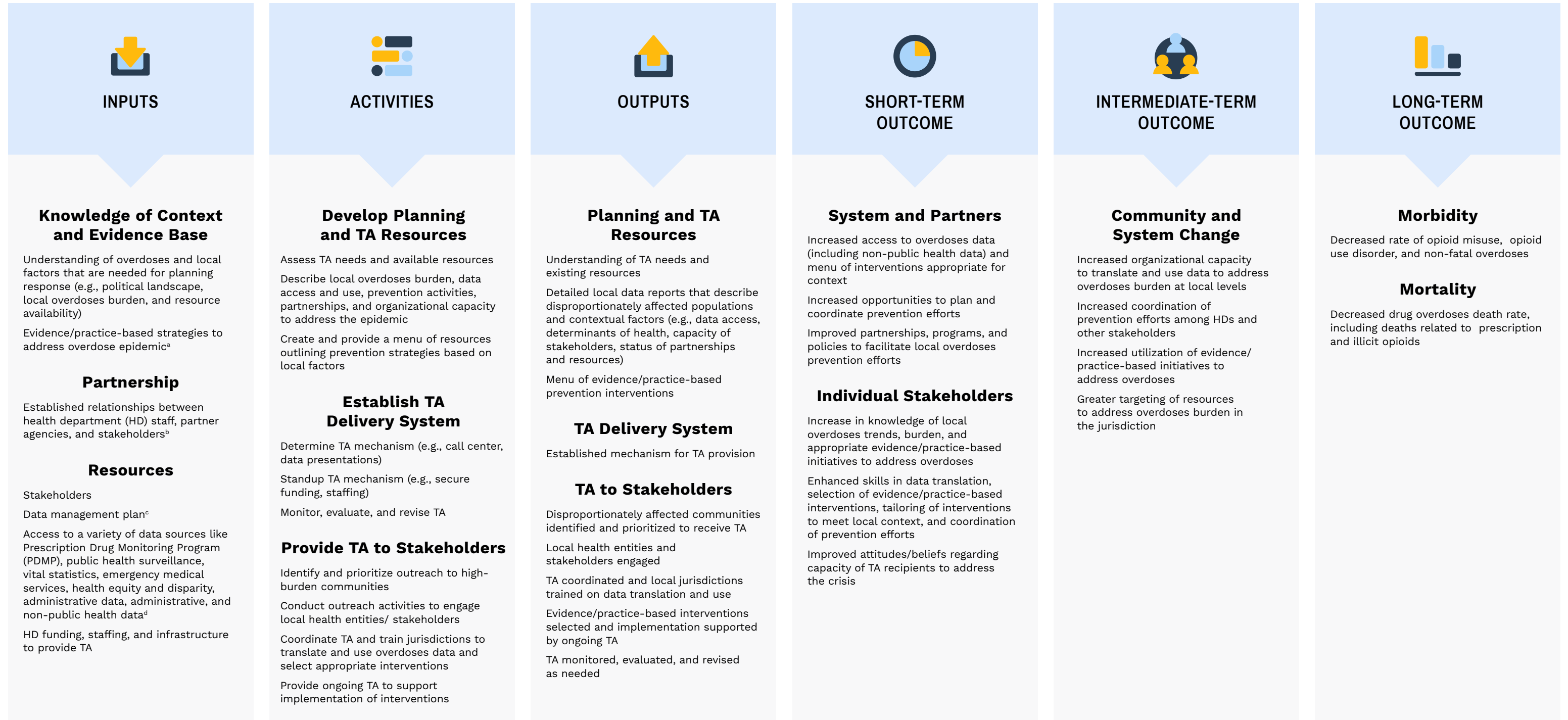
## 2. Establish TA delivery system

- Determine TA mechanism (e.g., TA call center, data presentations to partners, funded coalitions, or funded partners conduct TA via trainings and meetings)
- Stand up TA mechanism (e.g., secure funding and staffing and develop TA resources and materials)
- Monitor and evaluate ongoing needs, and adjust TA response and resources accordingly

## 3. Provide TA to stakeholders:

- Identify and prioritize outreach efforts to disproportionately affected communities (e.g., specific populations, counties, or regions)
- Conduct outreach activities to engage health entities and their stakeholders
- Coordinate TA and train jurisdictions on interpretation<sup>10</sup> and utilization of overdose-related data to inform intervention selection
- Disseminate menu of evidence/practice-based interventions, and provide tailored TA as needed to guide implementation<sup>10</sup> (e.g., how to convene multidisciplinary workgroups, facilitate partnerships between HDs and community organizations)





See Also: [PDMP Surveillance Evaluation Profile\\*](#)

<sup>a</sup> [Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States](#)

<sup>b</sup> Stakeholders may include city or county health departments, community organizations, local coalitions, harm reduction organizations, first responders, clinicians, social service organizations, etc.

<sup>c</sup> CDC requires recipients who collect or generate data with federal funds to develop, submit, and comply with a data management plan (DMP) for each collection or generation of public health data undertaken as part of the award and, to the extent appropriate, provide access to and archiving/long-term preservation of collected or generated data. For more information, please see [CDC's DMP policy](#).

<sup>d</sup> Non-public health data are data from other sources that help to further contextualize local drug trends and burden. It may include data from harm reduction organizations, drug seizure, drug court, foster care, social services, commerce, etc.



# Process Evaluations

**Process evaluations DOCUMENT AND DESCRIBE HOW A PROGRAM IS IMPLEMENTED. They normally occur when programs or initiatives are early in their development and are based on stakeholders' needs.<sup>B</sup>**



# Context

## Evaluation Question

What factors influence community burden (e.g., economic and health disparities; rural, urban, and tribal location; cultural and religious values; appropriate, audience-specific messaging; and availability and access to healthcare)?

What existing data are currently used to understand the epidemic at the local level?

To what extent have evidence/practice-based interventions been developed to address the epidemic locally?

## Sample Indicators

### Develop Planning and TA Resources

- Description of variation across local subpopulation and factors that influence burden (e.g., drug trafficking patterns)
- Description of efforts to understand and prioritize determinants of health (e.g., personal, social, environmental, and economic factors) in the development and implementation of evidence/practice-based interventions
- Description of organizational capacity of local agencies, including their capacity to partner on prevention efforts (e.g., access to data sources; methods of data synthesis, analysis, and translation to partners)
- Descriptions of overdose prevention activities in the community (e.g., naloxone distribution and administration, clinicians' MOUD waived, opioid prescribing behavior)
- Description of current data landscape, including public health surveillance, PDMP, and non-traditional data sets (e.g., law enforcement, criminal justice, naloxone administrations, Overdose Detection Mapping Application Program (ODMAP)<sup>12</sup>, rates of neonatal opioid withdrawal and syringe-associated infections, social service or child welfare, Medicaid, worker's compensation, Veteran's Administration) and their use
- Description of menu of evidence/practice-based interventions and prevention strategies
- Description of existing TA delivery system and/or infrastructure
- Description of community perceptions and acceptance of evidence/practice-based interventions and strategies<sup>13</sup>

## DATA SOURCES

- Stakeholders (from demographically diverse communities)
- Administrative records (meeting minutes, reports, strategic plan)
- Vital statistics/census/ Behavioral Risk Factor Surveillance System (BRFSS)<sup>14</sup>
- PDMP
- Public safety and criminal justice data (e.g., Emergency Management System [EMS], diversion data)
- Health systems data (i.e., Emergency Department [ED] visits, hospitalizations and deaths)
- Policies (e.g., state, municipal, organizational)
- Children and family services department

## DATA COLLECTION METHODS

- Asset mapping (e.g., document review, availability of stakeholders data sources, existing data sharing agreements, participatory approaches,<sup>15</sup> etc). Example: NACHHO's Mobilizing for Action through Planning and Partnerships

# Reach

## Evaluation Question

To what extent has relevant data and TA been made available to stakeholders?

## Sample Indicators

### Provide TA to Stakeholders

- Number of entities (e.g., disproportionately affected communities, intended audience[s]) provided with access to relevant data, outreach materials, training, or information (e.g., detailed surveillance reports, discussion of menu of prevention initiatives, etc.)
- Number of technical assistance contacts made (e.g., phone calls, emails, trainings, presentations, webinars)

### DATA SOURCES

- Logs of TA requests and TA provided
- Evaluation findings from trainings/workshops

### DATA COLLECTION METHODS

- Document review of logs or program reports
- Training/workshop evaluations

# Dose Delivered or Received

## Evaluation Question

How much TA is provided and to whom?

## Sample Indicators

### Provide TA to Stakeholders

- Amount and type of TA provided to a stakeholder (e.g., number of phone calls per contact or number of hours TA provided to a given contact)

### DATA SOURCES

- Logs of TA requests and TA provided

### DATA COLLECTION METHODS

- Document review of logs or program reports

# Fidelity

There may be circumstances in which strict fidelity to the original plan may actually work against an intended outcome. In this case, adaptation is necessary and expected. Tracking fidelity and purposeful/ data-informed deviations is important to understand implementation; however, strict fidelity should not supersede necessary adaptations that will facilitate outcomes.

## Evaluation Questions

To what extent has the HD provided disproportionately affected communities with technical assistance as intended?

## Sample Indicators

### Establish TA Delivery System

- Descriptions of adherence to or adaptations in TA provision plan

## DATA SOURCES

- Administrative data (TA logs, meeting minutes)

## DATA COLLECTION METHODS

- Document review of logs or program reports and meeting minutes



# Implementation

## Evaluation Questions

Are there appropriate resources to support TA provision?

To what extent does TA meet the needs of local public health entities and their stakeholders?

## Sample Indicators

### Establish TA Delivery System

- Descriptions of how TA was coordinated and tailored to serve the unique needs of recipients throughout the jurisdiction
- Descriptions of barriers (and how they were addressed), facilitators, and lessons learned
- Description of cost of providing and maintaining TA delivery system (e.g., actual and in-kind)

### Provide TA to Stakeholders

- Description of the TA topics and materials provided
- Description of HD efforts to engage TA recipients in key capacity building activities (e.g., interpretation and translation of overdose data; identification of priority intervention targets; and coordination of local prevention efforts)
- Description of ability of HD to meet TA needs of their recipients and stakeholders
- Descriptions of receptivity of recipients to TA
- Description of timeliness of TA to recipients

## DATA SOURCES

- Stakeholder feedback
- TA records or meeting notes
- Budget

## DATA COLLECTION METHODS

- Feedback survey of stakeholders
- Discussions or interviews with TA recipients
- Document review of program budget allocated to TA

# Individual-Level and Organizational Outcomes

The extent to which the intervention has affected changes in intended audience's knowledge, attitudes, skills and/or behaviors.

## Evaluation Question

To what extent does TA increase or improve the knowledge, attitudes, skills, and behaviors of recipients and stakeholders to address overdose burden in their jurisdiction?

## Sample Indicators

### Short-Term

- Increase in TA recipients' and stakeholders' knowledge of trends in local drug use and overdose burden
- Increase in TA recipients' and stakeholders' knowledge of and attitudes toward evidence/practice-based interventions and other mechanisms to address overdose burden in their local context
- Increase in number of TA recipients who report ability to accurately interpret and translate overdose data
- Increase in the number of TA recipients who report the ability to prioritize interventions (e.g., tailor interventions for intended audience[s] and coordinate local prevention efforts)

### Intermediate-Term

- Description of changes in organizational capacity (e.g., improvements in TA recipient staff's and stakeholders' ability to translate data; identify and tailor evidence/practice-based interventions; and coordinate prevention efforts to address overdose burden)

## DATA SOURCES

- Stakeholder feedback
- Administrative data (TA records or meeting notes)
- Progress reports

## DATA COLLECTION METHODS

- Feedback survey or interviews with stakeholder TA recipients
- Document review of programmatic materials

# Community and System Change Outcomes

The extent to which the intervention has effected changes in a community, organization, or system(s).

## Evaluation Question

How and to what extent has TA to a disproportionately affected area/county/jurisdiction brought about changes in the community or systems?

## Sample Indicators

### Short-Term

- Description of changes to access and type of overdose related data
- Description of any modifications to existing partnerships, programs, and policies by community stakeholders
- Descriptions of new partnerships, programs and policies implemented by community stakeholders

### Intermediate-Term

- Description of change in overdose-related social determinants of health or factors that influence burden (e.g., access to prevention and treatment services, number and percentage of clinicians within a jurisdiction receiving academic detailing or clinician education on the [CDC Guideline for Prescribing Opioids for Chronic Pain<sup>16</sup>](#))
- Description of use among stakeholders of evidence/practice-based initiatives (e.g., implementing more effective interventions over less effective interventions)
- Description of changes in local prevention activities and initiatives to disproportionately affected populations (e.g., expansion or tailoring of initiative to meet needs of populations most affected)

## DATA SOURCES

- Stakeholder feedback
- Progress reports or administrative data (e.g., strategic plans, work plans, websites)

## DATA COLLECTION METHODS

- Feedback survey or interviews with TA recipients
- Document review of programmatic materials
- Follow up asset mapping with the community to identify changes (e.g., NACHHO's [Mobilizing for Action through Planning and Partnerships](#))

# Unintended Outcomes

The extent to which the intervention had unplanned or unanticipated effects.

## Evaluation Question

Which unintended outcomes (positive and negative) resulted from TA provided to stakeholders?

## Sample Indicators

### Long-Term

- Descriptions of unintended outcomes (e.g., positive—acceptance of naloxone after initial community resistance; negative—refusal or resistance to treat pain patients by clinicians receiving academic detailing)
- Positive or negative changes in indicators of federal, state, or local importance (e.g., positive—improved policies regarding overdose reporting facilitate more accurate and timely data availability; negative—PDMP data used to criminalize patients with OUD, rather than to facilitate treatment and recovery)

## DATA SOURCES

- Stakeholders
- Administrative data (e.g., meeting notes)
- Community Health Needs Assessment

## DATA COLLECTION METHODS

- Document review of meeting notes, work plans, strategic plans, health system or law enforcement policy changes, etc.
- Informal discussion with project staff and/or stakeholders
- Interviews/surveys with stakeholders

# Morbidity and Mortality Outcomes

## Evaluation Question

What were the changes in opioid-related morbidity and mortality when comparing before and after provision of TA to stakeholders (and their targeted actions)?

## Long-Term Sample Indicators

Number and percentage changes in morbidity and mortality indicators

### Morbidity

- Patients receiving multiple naloxone administrations (MNAs) from emergency medical services (EMS)
- Patients transported to the emergency department (ED) for overdose by EMS where primary impression recorded in National Emergency Medical Services Information System (NEMSIS) is drug overdose
- Patients refusing transport by EMS where primary impression recorded in NEMSIS is drug overdose
- EMS calls where naloxone was administered
- All-drug non-fatal overdose emergency department visits
- Emergency department visits involving non-fatal opioid overdose, excluding heroin
- Emergency department visits involving non-fatal heroin overdose with or without other opioids
- All-drug non-fatal overdose hospitalizations
- Hospitalizations involving non-fatal opioid overdose, excluding heroin
- Hospitalizations involving non-fatal heroin overdose with or without other opioids

### Mortality

All drug overdose deaths

- Drug overdose deaths involving opioids
- Drug overdose deaths involving prescription opioids
- Drug overdose deaths involving heroin
- Drug overdose deaths involving synthetic opioids other than methadone

## DATA SOURCES

- Jurisdictional mortality and morbidity data
- ED/health department morbidity and mortality data
- [CDC WONDER](#)
- National Emergency Medical Services Information System (NEMSIS) and/or local EMS data
- PDMP data
- Private data sources (e.g. IQVIA, hospital discharge/billing)
- Local syndromic surveillance systems
- SUDORS
- BioSense

## DATA COLLECTION METHODS

- Reviews of jurisdictional reports (e.g. annual progress reports)
- Secondary data analysis
- Review of opioid morbidity and mortality data dashboards or reports



# Glossary

**Capacity building** refers to a process to increase the skills, infrastructure, and resources of individuals, organizations, and communities. In public health, capacity building is often a critical step in the development, implementation, and sustainability of prevention programs.

**Evidence/practice-based** describes interventions or practices that have been developed based on high-quality research, professional experiences, and opinions of experts in the field. Practice-based interventions may reflect the preferences, priorities, and values of those who will receive, or be affected by, the interventions or practices.

**Disproportionately affected communities** may be a defined geographic region or a disproportionately affected population. They are determined by health departments and their stakeholders. High rates for factors such as prescribing, morbidity or mortality, or naloxone administration, or a combination of these and other non-public health data, may be used to define disproportionately affected communities or regions. Disproportionately affected communities also include disproportionately affected populations, such as people with OUD; justice-involved populations; specific demographic groups (e.g., African Americans, Native American/American Indian, pregnant women, seniors, people who lack access to health insurance); or those who experience high rates of opioid prescribing, morbidity, mortality, naloxone administration, etc.

**Outcome evaluations** assess progress on the sequence of outcomes (e.g., short-, intermediate-, and long-term) the intervention aims to achieve. Outcome evaluations normally occur when an intervention is established, and it is plausible to expect changes in a given timeframe. They should be planned from the beginning of an intervention, as they often rely on baseline data that need to be collected before the intervention starts.<sup>A</sup> Outcome evaluations may examine the following areas:

- **Individual-level Outcomes:** The extent to which the intervention has affected changes in a given audience's knowledge, skills, attitudes, intentions, efficacy, and/or behaviors.
- **Community and System Change Outcomes:** The extent to which the intervention has affected changes in a community, organization, or system(s).
- **Unintended Outcomes:** The extent to which the intervention had unplanned or unanticipated effects—either positive or negative.
- **Morbidity/Mortality Outcomes:** The extent to which the intervention has affected changes in target audience's morbidity or mortality.

**Participatory approaches** refer to a range of activities conducted to enable stakeholders to play an active and influential role in the decision-making process at each step of a project or program cycle that may affect them.

**Process evaluations** document and describe how a program is implemented. Process evaluations normally occur when programs or initiatives are early in their development, and are based on stakeholders' needs.<sup>B</sup> Process evaluations may examine the following areas:

**Context:** Aspects of the larger social, political, and economic environment that may influence an activity's implementation.

**Reach:** The extent to which the intended target audience(s) is exposed to, or participates in an activity. If there are multiple interventions, then *reach* describes the proportion that participates in each intervention or component.

**Doses delivered/received:** The number (or amount) of intended units of each intervention, or each component that is delivered or provided.

- **Dose delivered** is a function of efforts of the people who deliver the intervention. The extent to which the intervention staff member (e.g., academic detailers, educators, etc.) actively engaged with, interacted with, were receptive to, and/or delivered intervention materials and resources to the target audience(s).
- **Dose received** is a characteristic of the target audience(s), and it assesses the extent of engagement of participants with the intervention.

**Fidelity:** The extent to which the intervention is delivered as planned. It represents the quality and integrity of the intervention as conceived by the developers. (Note: In some circumstances, strict fidelity to the original plan may actually work against an intended outcome. In these cases, adaptation is necessary and expected. Tracking fidelity and purposeful/data-informed deviations is important to understand implementation; however, strict fidelity should not supersede necessary adaptations that will facilitate outcomes.)

**Implementation:** The extent to which the intervention is feasible to implement and sustain, is acceptable to stakeholders, and is done with quality. Examination of these dimensions may also result in noted lessons learned, barriers, and facilitators that can help others when replicating similar initiatives.

**Technical assistance** refers to the process of providing targeted support to an organization with a development need or problem. It is an effective method to build the capacity of an organization.

# References

<sup>A</sup> Rossi, PH., Lipsey, MW., & Freeman, HE. Measuring and Monitoring Program Outcomes. In: Rossi, PH., Lipsey, MW., & Freeman, HE. *Evaluation a Systematic Approach*. 7. Thousand Oaks, CA: Sage Publications; 2004.

<sup>B</sup> Steckler, A., & Linnan, L. Process evaluation for public health interventions and research: An overview. In: A. Steckler & L. Linnan (Eds.), *Process Evaluation for Public Health Interventions and Research*. San Francisco, CA: Jossey-Bass; 2002.



# Endnotes

- <sup>1</sup> Recipients can be state, district, county, or city health departments, tribal health organizations, or other bona fide agents of the health department.
- <sup>2</sup> See [Improving the Use of Program Evaluation for Maximum Health Impact: Guidelines and Recommendations](#) for more information on how large programs use evaluation findings to improve their interventions and inform strategic direction. Furthermore, evaluation approaches like [developmental evaluation](#) or [rapid feedback evaluations](#) may be helpful models for evaluators to use while working on overdose prevention efforts.
- <sup>3</sup> CDC Evaluation Standards: <https://www.cdc.gov/eval/standards/index.htm>
- <sup>4</sup> Technical assistance may include training, consultation, resource provision, or any activity aimed at enhancing capacity of city or county health departments and stakeholders to address the overdose epidemic.
- <sup>5</sup> Health departments and their stakeholders should determine their criteria to define disproportionately affected populations/communities they would like to reach. Disproportionately affected communities may be regions with high rates of prescribing, morbidity or mortality, naloxone administration, or a combination of these data points and/or other non-public health data points. Disproportionately affected populations may include people with opioid use disorder (OUD), justice-involved populations, specific demographic groups (e.g., African Americans, Native American/American Indian, pregnant women, seniors, people who lack access to health insurance), or those who experience high rates of opioid prescribing, morbidity, mortality, or naloxone administration.
- <sup>6</sup> Stakeholders may be other health departments (city or county), community organizations, local coalitions, harm reduction organizations, law enforcement officials, first responders, healthcare providers, treatment providers, social service organizations, etc.
- <sup>7</sup> See evaluation profile titled *Public Health Surveillance Activities with Prescription Drug Monitoring Program (PDMP) Data and Public Dissemination of Results*
- <sup>8</sup> Non-public health data are data from other sources that help to further contextualize local drug trends and burden. It might include data from harm reduction organizations, drug seizure, drug court, foster care, social services, commerce, etc.
- <sup>9</sup> Examples of action plans are [Ohio's Community Response Plan Template: Guidance for Coordinated Response to Rapid Increase in Drug Overdoses](#) and [North Carolina's Opioid Action Plan](#)
- <sup>10</sup> [Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States](#)
- <sup>11</sup> For an example of written guidance materials, see [North Carolina's Essential Actions to Address the Opioid Epidemic: A Local Health Department's Guide](#) and [California Opioid Safety Network's Utilizing the Opioid Surveillance Dashboard](#)
- <sup>12</sup> ODMAP is an application-based mapping system in which first responders (EMS, law enforcement, and fire) can track overdoses along with other relevant descriptors like fatal vs. non-fatal, or the number of naloxone administrations per event. ODMAP is free and displays overdose activity across multiple jurisdictions. Health departments may request access to this database. For more information, see their website: <http://www.odmap.org/>
- <sup>13</sup> Stratified by subpopulation (e.g., race/ethnicity, age, etc.) when relevant and data are available
- <sup>14</sup> For more information on BRFSS visit <https://www.cdc.gov/brfss/index.html>
- <sup>15</sup> Participatory approaches may include methods of stakeholder engagement, such as community resource mapping, listening sessions, World Café, ranking exercises, etc.
- <sup>16</sup> The number and percentage of clinicians for this indicator may be defined as the number of clinicians registered with the PDMP receiving academic detailing or clinician education within a jurisdiction/the total number of clinicians registered with the PDMP.