Advocates for Human Potential, Inc.

Scope of Services and Deliverables

Harm Reduction Education and Access to Resources and Treatment (HEART)

Applications due December 28, 2026

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About This Document

This document contains sections A.1. Executive Summary, C.2. Need, C.3. Funding Purpose and Scope of Services, and C.4. Deliverables and Performance Measures of the Harm Reduction Education and Access to Resources and Treatment (HEART) Notice of Funding Opportunity (NOFO). All application materials are available on the Illinois Regional Care Coordination Agency website via the Funding Opportunities page.

List of Acronyms

The following acronyms are used in this document.

Acronyms and definitions

Acronym	Definition
AHP	Advocates for Human Potential, Inc.
CDC	Centers for Disease Control and Prevention
CLAS	Culturally and Linguistically Appropriate Services
CPRS	Certified Peer Recovery Specialist
CQI	Continuous Quality Improvement
DBHR	Division of Behavioral Health and Recovery
DPR	Delivery and Performance Report
ERJ	Equity and Racial Justice
HEART	Harm Reduction Education and Access to Resources and Treatment
IDHS	Illinois Department of Human Services
IDPH	Illinois Department of Public Health
ISP	Implementation and Sustainability Plan
NIDA	National Institute on Drug Abuse
NOFO	Notice of Funding Opportunity
PFR	Periodic Financial Report
PPR	Periodic Performance Report
PSM	Project Status Meeting
PWUD	People Who Use Drugs

Acronym	Definition
RCCA	Regional Care Coordination Agency
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder
TTA	Training and Technical Assistance

A.1. Executive Summary

This new Notice of Funding Opportunity (NOFO) sets forth the requirements for applications to establish Harm Reduction Education and Access to Resources and Treatment (HEART) programs in Illinois. HEART subrecipients develop, launch, and evaluate evidence-informed statewide public education campaigns made up of hyperlocal, multi-channel components that feature real stories from people with lived or living experience and carry culturally responsive, inclusive messaging that balances statewide reach with messages tailored for different audiences. The goal of these campaigns is to increase awareness of the dangers of substance use, reduce stigma and encourage recovery, and increase engagement with local harm reduction and treatment resources.

The goal of HEART is to be achieved through the following objectives:

- Educate the public about the dangers of substance use, including recreational drug use, and the principles and effectiveness of harm reduction, including naloxone access, safer-use education, syringe services, fentanyl test strips, and overdose prevention and response.
- Reduce stigma experienced by people who use drugs through culturally inclusive, person-centered messaging by targeting health care providers and first responders and tailoring messaging to resonate with them and ensure that people seeking help are met with compassionate care, as well as reducing stigma among the general public to promote help-seeking behaviors.

Increase service engagement by promoting awareness of accessible harm reduction and treatment resources statewide, including in rural and under-resourced communities where overdose data is suppressed or limited.

To accomplish these objectives, subrecipients of HEART funding will:

- Incorporate the needs-assessment findings into a strategic communications plan (audiences, messaging framework, media mix, cultural/linguistic tailoring, accessibility, lived-experience integration, partner strategy, evaluation) addressing all required HEART messaging topics; obtain RCCA approval before full launch.
- Establish a structure for recruiting and engaging people with lived/living experience across campaign design, storytelling, dissemination, and evaluation in a meaningful, non-tokenizing

manner, with ethical and fair compensation.

- Build on the ISP's ERJ self-assessment to submit a complete ERJ Plan addressing implicit organizational bias, equitable access and outcomes, engagement of priority populations, and staff ERJ training.
- Conduct formative research; identify high-need regions and priority audiences
- Develop, test, translate/transcreate, and adapt recovery, treatment and harm reduction stories, campaign messages, content concepts, campaigns and assets that represent diverse demographic and cultural identities.
- Develop, produce, place, and disseminate culturally and linguistically appropriate, evidence-based, stigma-free, person-first, accessible materials across approved channels; report reach by channel and service area.
- Conduct community engagement and partnership activities supporting reach, trust-building, and connection to local harm reduction, treatment, and recovery resources; maintain ≥ 2 active partnerships, including 1 harm reduction partner and 1 treatment partner, per rural / data-suppressed service area. Required collaborations include public health experts, community leaders, community-based organizations, local media, local health departments, and culturally specific organizations.
- Evaluate implementation, reach, effectiveness, outcomes, and differences in impact; conduct pre- and post-implementation surveys with the target audience, reporting progress, reach, effectiveness, and lessons learned; use findings for CQI; cooperate with RCCA-designated evaluation.

Up to three (3) organizations will be awarded funds to fulfill the requirements of the subaward.

Services provided under this NOFO shall reflect the Illinois Department of Human Services' (IDHS) commitment to advancing equity and racial and social justice by enabling all to thrive, regardless of race, ZIP Code, and disability.

C.2. Need

The funds from the settlements will support prevention efforts in communities hit hardest by the opioid crisis and throughout the state. Fund distributions must be used equitably in service areas disproportionately affected by the opioid crisis as outlined in the Illinois Opioid Allocation Agreement, such as areas with the following characteristics:

- High opioid fatality rates, including: counties other than Cook County with a crude rate of one and eight tenths (1.8) or greater per one hundred thousand (100,000) capita people; and community areas within Cook County with more than one hundred (100) overdoses (fatal and nonfatal) within the most recent year included in the Chicago Health Atlas' drug overdose mortality rate dashboard.
- Concentrated poverty, including: counties other than Cook County with a poverty rate greater than twelve percent (12%); and community areas within Cook County with a poverty rate

greater than twelve percent (12%), per the Chicago Health Atlas' poverty rate dashboard.

- Concentrated firearm violence, including communities eligible for Reimagine Public Safety Act funding.
- Other conditions that hinder the communities from reaching their full potential for health and well-being, including counties other than Cook with a crude nonfatal overdose rate of four (4.0) or greater per one hundred thousand (100,000) people, as listed in the Illinois Overdose Data Dashboard.

In 2013, 1,072 people in Illinois died of an opioid overdose; by 2023 that number had more than doubled to 2,855. Opioid settlement funds negotiated by the Illinois Attorney General support recovery in the communities hardest hit. Recent declines in overdose fatalities are encouraging, but racial and geographic inequities persist and new threats such as xylazine complicate the risk environment. A culturally responsive, statewide campaign that centers lived and living experience, promotes harm reduction, and builds trust in under-resourced communities can help sustain gains and address disparities. The approach is consistent with NIDA guidance on person-first, non-stigmatizing language; a 2024 scoping review finding that education, contact with people with lived experience, narrative strategies, and multi-component approaches reduce stigma; and CDC health-literacy and health-communication practice.

Additionally, there is a need to combat the biases held by health care providers and first responders who carry their own trauma and see people who use drugs only on their worst days, influencing stigmatizing attitudes and creating barriers to compassionate care and pathways to recovery. The field of medicine includes terminology that can have a de-humanizing effect, and this campaign must support health care providers and first responders in unlearning some of what they've been taught or assumed based on experiences and relearning how to provide more trauma-informed care. There is a need to "re-humanize" people with substance use disorders (SUD) through reframing, such as flipping "drug-seeking behavior" to "person seeking withdrawal management support." Building trust requires acknowledging the sources of earned distrust and actively working to repair relationships between providers and community members to prevent future harm.

HEART subrecipients shall prioritize services for Illinois residents at heightened risk of fatal overdose, including but not limited to:

- People who use drugs and their families
- Communities with high overdose mortality
- Residents of rural counties with suppressed or limited data
- Black, Hispanic/Latino, and Indigenous populations disproportionately harmed by the overdose crisis
- Youth and young adults
- Older adults
- LGBTQ+ individuals
- Individuals experiencing poverty or limited access to care

C.3. Funding Purpose and Scope of Services

Advocates for Human Potential, Inc. (AHP), as the Regional Care Coordination Agency (RCCA), anticipates awarding up to three (3) subawards for comprehensive public education and awareness campaigns. HEART subrecipients develop, launch, and evaluate evidence-informed statewide public education campaigns made up of hyperlocal, multi-channel components that feature real stories from people with lived or living experience and carry culturally responsive, inclusive messaging that balances statewide reach with messages tailored for different audiences. The goal of these campaigns is to increase awareness of the dangers of substance use, reduce stigma and encourage recovery, and increase engagement with local harm reduction and treatment resources.

The goal of the HEART program is to be achieved through the following objectives:

- Educate the public about the dangers of substance use, including recreational drug use, and the principles and effectiveness of harm reduction, including naloxone access, safer-use education, syringe services, fentanyl test strips, and overdose prevention and response.
- Reduce stigma experienced by people who use drugs through culturally inclusive, person-centered messaging by targeting health care providers and first responders and tailoring messaging to resonate with them and ensure that people seeking help are met with compassionate care, as well as reducing stigma among the general public to promote help-seeking behaviors.
- Increase service engagement by promoting awareness of accessible harm reduction and treatment resources statewide, including in rural and under-resourced communities where overdose data is suppressed or limited.

To carry out these objectives, HEART subrecipients shall:

- Incorporate the needs-assessment findings into a strategic communications plan (audiences, messaging framework, media mix, cultural/linguistic tailoring, accessibility, lived-experience integration, partner strategy, evaluation) addressing all required HEART messaging topics; obtain RCCA approval before full launch.
- Establish a structure for engaging people with lived/living experience across campaign design, storytelling, dissemination, and evaluation in a meaningful, non-tokenizing manner, with ethical and fair compensation.
- Build on the ISP's ERJ self-assessment to submit a complete ERJ Plan addressing implicit organizational bias, equitable access and outcomes, engagement of priority populations, and staff ERJ training.
- Conduct formative research; identify high-need regions and priority audiences; develop, test, translate/transcreate, and adapt campaign messages, content concepts, and assets.
- Develop, produce, place, and disseminate culturally and linguistically appropriate, evidence-based, stigma-free, person-first, accessible materials across approved channels; report reach by channel and service area.

- Conduct community engagement and partnership activities supporting reach, trust-building, and connection to local harm reduction, treatment, and recovery resources; maintain ≥ 2 active partnerships, including 1 harm reduction partner and 1 treatment partner, per rural / data-suppressed service area. Required collaborations include public health experts, community leaders, community-based organizations, local media, local health departments, and culturally specific organizations.
- Evaluate implementation, reach, effectiveness, outcomes, and differences in impact; conduct pre- and post-implementation surveys with the target audience, reporting progress, reach, effectiveness, and lessons learned; use findings for CQI; cooperate with RCCA-designated evaluation.

Approach

HEART funds evidence-informed, culturally responsive statewide public education campaigns, built from hyperlocal, multi-channel components and centered on real stories from people with lived or living experience. Materials are disseminated through digital, social, radio, print, transit, outdoor, local media, grassroots, and community-based channels, and the program coordinates with sibling harm-reduction and treatment programs in the continuum of care throughout the state of Illinois. The work is guided by established standards of practice: person-first, non-stigmatizing communication (NIDA), Community-based Participatory Research, the SAMHSA Harm Reduction Framework, the National CLAS Standards, CDC health-equity/inclusive-communication and health-literacy guidance, and alignment with the State Overdose Action Plan (see Standards and Evidence-Based Practices).

The theory of change for the HEART program is that if evidence-informed, culturally responsive campaigns that center lived experience are delivered through hyperlocal, multi-channel components, then public awareness rises, stigma falls, and engagement with harm reduction and treatment resources increases, because education and contact with people with lived experience reduce stigma and connect people to accessible resources.

To ensure that the campaign messaging resonates with its intended audiences, HEART awardees must form an advisory board that includes the following at a minimum: people with lived and living experience, peer recovery support specialists, family members of PWUD, first responders, and clinicians, with a facilitator to mitigate power dynamics. Ideally, the facilitator hired would be a Certified Peer Recovery Specialist (CPRS) and the project leadership team would include representation reflective of the priority populations outlined above. This helps reduce putting the onus on people experiencing harm from constantly having to educate others without adequate compensation.

Additionally, the HEART awardees must engage with trusted messengers to deliver messages that will resonate with different audiences (e.g., including first responders as messengers intended for other first responders, etc.). A trusted messenger is a person whose profession, community role, or lived or living experience gives them credibility with the intended audience. Applicants must describe who will serve as trusted messengers, how they will be selected, and how they will be engaged (for example, as staff, volunteers, advisory board members, or contractors). Trusted messengers paid as

contractors or consultants must be procured and budgeted in accordance with 2 CFR Part 200.

Campaign content must recognize trauma as one of the root causes of substance use disorders and promote alternatives to pain management or using substances to numb emotions (e.g., prescribers referring patients to physical therapy or behavioral health services). The campaign content targeting health care providers and first responders must socialize destigmatizing and trauma-informed language, such as the trauma-informed language choices that providers can use with patients instead of the clinical language listed in electronic medical records for insurance billing purposes.

Geographic Service Area

Campaigns shall be delivered statewide, delivered through hyperlocal, community-tailored components, with emphasis on rural and under-resourced communities where overdose data is suppressed or limited. All seven IDPH regions must be covered: if one award is made, the awardee covers all seven; if more than one award is made, the awardees together cover all seven. In the event no eligible and otherwise qualified applicants can serve all seven regions, either alone or collectively, the RCCA may, in its discretion and in consultation with DBHR, make awards that cover the majority of the regions, if it is possible to do so without overlapping, duplicating, or otherwise generating redundant expenses. If otherwise qualified applications propose overlapping regions, the RCCA may, in consultation with DBHR, adjust proposed service areas before award to avoid duplication. Opioid settlement funds must be used equitably in areas disproportionately affected by the opioid overdose crisis.

Standards and Evidence-Based Practices

Subrecipients shall deliver services in accordance with the following standards of practice and evidence-based practices.

Standards and evidence-based practices

Standard / practice	What subrecipients must follow	Source / basis
Person-first, non-stigmatizing language	Evidence-based, person-first, non-stigmatizing messaging	Program scope; NIDA
Alignment with State Overdose Action Plan & harm reduction policies	Campaign content aligns with statewide policy	Program scope; most recent State Overdose Action Plan and IDHS harm reduction resources
Cultural & linguistic responsiveness; accessibility	Culturally/linguistically appropriate, accessible materials	Program scope
Evidence-based / evidence-informed practice	Use current research and best available data	Program scope; CDC health literacy

Standard / practice	What subrecipients must follow	Source / basis
Lived/living experience engagement	Meaningful, non-tokenizing engagement with ethical, fair compensation	Program scope
Equity and Racial Justice (ERJ)	Complete ERJ Plan; disaggregated reporting	Program scope; IDHS
SAMHSA Harm Reduction Framework (2023)	Apply the framework's harm-reduction pillars and principles	SAMHSA
National CLAS Standards	Culturally and linguistically appropriate services	HHS Office of Minority Health
CDC Health Equity Guiding Principles for Inclusive Communication	Equity-centered public health messaging	CDC
Accessibility: Alignment with State of Illinois Accessibility Standards	Accessible materials across digital, social, print, transit, and outdoor, in accordance with IDHS: Affirmative Action Program for Employing People with Disabilities	IDHS: Affirmative Action Program for Employing People with Disabilities
Plain language / CDC Clear Communication Index	Message clarity and health literacy	CDC

The required tasks, organized by phase as in the RCCA Statement of Work, are as follows. Associated performance measures, standards, and potential metrics to be collected are detailed in Section C.4.

Phase 1: Initiation

Task 1.1 Award Activation and Onboarding

The Subrecipient shall complete all steps required to formally activate the award and complete RCCA onboarding.

Task 1.2 Implementation and Sustainability Plan (ISP) Submission

The Subrecipient shall submit an ISP using the current RCCA-provided template. The ISP is the program plan describing how the Subrecipient will deliver the program, including the HEART needs assessment. It is supported by an ISP Data Workbook that establishes the approved delivery and performance baseline, including what will be delivered, in what volume, and how performance will be measured.

The ISP also includes the Subrecipient's Equity and Racial Justice (ERJ) self-assessment and preliminary equity and racial justice approach. These are components of the ISP and are not separately submitted; they inform the complete ERJ Plan required under Task 2.4.

Phase 2: Development

Task 2.1 Program-Specific Readiness Requirements

The Subrecipient shall establish the following program-specific readiness requirements needed to begin program delivery. Each requirement is established prior to the start of program delivery and maintained throughout the Period of Performance, except where a requirement states otherwise. Readiness status is described in the ISP under Task 1.2; the deliverables below are satisfied by the underlying documentation, not by the ISP submission itself.

Establish the licenses, staffing, data systems, and partnership/data-sharing agreements required to begin delivery, or document through the ISP that none are required.

Task 2.2 Strategic Communications Plan

The Subrecipient shall incorporate the needs-assessment findings into a strategic communications plan (audiences, messaging framework, media mix, cultural/linguistic tailoring, accessibility, lived-experience integration, partner strategy, evaluation) addressing all required HEART messaging topics; obtain RCCA approval before full launch.

Task 2.3 Lived/Living Experience Engagement Structure

The Subrecipient shall establish a structure for engaging people with lived/living experience across campaign design, storytelling, dissemination, and evaluation in a meaningful, non-tokenizing manner, with ethical and fair compensation.

Task 2.4 Equity and Racial Justice Plan

The Subrecipient shall build on the ISP's ERJ self-assessment to submit a complete ERJ Plan addressing implicit organizational bias, equitable access and outcomes, engagement of priority populations, and staff ERJ training.

Phase 3: Implementation

Task 3.1 Campaign Research, Strategy, and Message Development

The Subrecipient shall conduct formative research; identify high-need regions and priority audiences; develop, test, translate/transcreate, and adapt campaign messages, content concepts, and assets.

Task 3.2 Public Education Campaign Dissemination

The Subrecipient shall develop, produce, place, and disseminate culturally and linguistically appropriate, evidence-based, stigma-free, person-first, accessible materials across approved channels; report reach by channel and service area.

Task 3.3 Community Engagement, Partnerships, and Resource Connection

The Subrecipient shall conduct community engagement and partnership activities supporting reach, trust-building, and connection to local harm reduction, treatment, and recovery resources; maintain ≥ 2 active partnerships, including 1 harm reduction partner and 1 treatment partner, per rural / data-suppressed service area. Required collaborations include public health experts, community leaders, community-based organizations, local media, local health departments, and culturally specific organizations.

Task 3.4 Campaign Evaluation and Continuous Quality Improvement

The Subrecipient shall evaluate implementation, reach, effectiveness, outcomes, and differences in impact; conduct pre- and post-implementation surveys with the target audience, reporting progress, reach, effectiveness, and lessons learned; use findings for CQI; cooperate with RCCA-designated evaluation.

Phase 4: Monitoring

Task 4.1 Performance and Fiscal Reporting

The Subrecipient shall complete all recurring performance, delivery, and fiscal reporting on the State Fiscal Year (FY) calendar through the RCCA-prescribed system. Invoices are due monthly, by the 15th of the following month; DPRs are due quarterly, by the 15th following the close of the reporting period; PPRs and PFRs are due quarterly, by the 20th after each State Fiscal Year quarter ends. The monthly Invoice is RCCA's monthly financial report under the prime award and also serves as the payment request.

Each PPR addresses, as applicable, staffing, service-model implementation, policies and procedures, Equity and Racial Justice (ERJ) and sustainability activities, material changes, implementation barriers, and corrective or continuous-improvement actions.

Task 4.2 Staffing Maintenance

The Subrecipient shall ensure that required personnel and staffing remain in place throughout the Period of Performance, including designated program leadership. Staffing shall remain consistent with the approved staffing plan, the approved Budget, and the program model. Staffing status shall be reported through the PPR.

C.4. Deliverables and Performance Measures

The following table details (a) the deliverables required according to the scope of services and (b) associated performance measures, standards, and potential metrics to be collected by task.

NOTE: *Time periods refer to the days from the commencement of the period of performance, unless otherwise specified. Standards for activities refer to percentages of those established in the approved ISP Data Workbook.*

Phase 1: Initiation

Task 1.1 Award Activation and Onboarding

Task 1.1 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Attend the RCCA kickoff meeting (Program Director plus at least one program staff).	100%	Day 30
(b) Submit organizational chart with all budgeted positions, names or TBH designations, FTE allocations, and reporting lines.	100%	Day 60
(c) Complete RCCA onboarding TTA (Program Director or designee).	100%	Day 75

Task 1.2 Implementation and Sustainability Plan (ISP) Submission

Task 1.2 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Submit ISP and ISP Data Workbook using the current RCCA template.	100%	Day 90
(b) Incorporate any RCCA-required revisions.	100%	Within 15 days of RCCA feedback
(c) Submit an ISP amendment for a material change.	100%	Within 30 days of identifying the need for the change; the change may not take effect until RCCA approves the amendment

Note: If RCCA delays issuance of the applicable template or adjusts an administrative due date,

RCCA may revise the submission deadline so the Subrecipient retains the intended preparation period.

Phase 2: Development

Task 2.1 Program-Specific Readiness Requirements

Task 2.1 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Obtain required licenses, registrations, certifications, and credentials, or confirm via the ISP that none are required	100%	Prior to service delivery
(b) Establish program staffing per the approved plan	≥80% of the approved staffing plan	Prior to service delivery
(c) Establish data systems, records, and collection processes	100%	Prior to service delivery
(d) Execute required partnership / data-sharing agreements	100%	Prior to service delivery

Task 2.2 Strategic Communications Plan

Task 2.2 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Submit the strategic communications plan	Approved before campaign launch	Day 105

Task 2.3 Lived/Living Experience Engagement Structure

Task 2.3 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Establish and document the lived/living experience engagement structure	100%	Day 90
(b) Document lived/living experience participation in campaign work	100%	Ongoing; via DPR/PPR

Task 2.4 Equity and Racial Justice Plan

Task 2.4 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Submit the complete ERJ Plan	Accepted	Day 180
(b) Incorporate any RCCA-required revisions	100%	Within 15 days of RCCA feedback

Phase 3: Implementation

Task 3.1 Campaign Research, Strategy, and Message Development

Task 3.1 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Develop and obtain RCCA approval of campaign research, strategy, and messages	Per the approved ISP Data Workbook	Day 120
(b) Conduct and report campaign research and message development	Per the approved ISP Data Workbook	Ongoing; each period

Task 3.2 Public Education Campaign Dissemination

Task 3.2 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Implement the approved campaign across channels; first placement within 180 days	Per the approved ISP Data Workbook	Launch within 180 days; ongoing
(b) Report dissemination and reach through the DPR	100%	Ongoing; each period

Task 3.3 Community Engagement, Partnerships, and Resource Connection

Task 3.3 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Conduct community engagement, partnership, and resource-connection activities	Per the approved ISP and ISP Data Workbook	Ongoing; each period
(b) Engage individuals with lived/living experience	Per the approved ISP	Ongoing

Performance Measures	Standards	Metrics
(c) Report engagement, partnership, and resource-connection activities	100%	Ongoing; each period

Task 3.4 Campaign Evaluation and Continuous Quality Improvement

Task 3.4 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Collect, analyze, and report campaign evaluation data	100%	After launch; quarterly via DPR
(b) Submit the annual HEART Campaign Evaluation Summary Report	100%	20th day following the Period of Performance

Phase 4: Monitoring

Task 4.1 Performance and Fiscal Reporting

Task 4.1 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Submit Financial Reports (Invoices) in RCCA-prescribed format.	100%	15th day of the month following each reporting month *
(b) Submit Delivery and Performance Reports (DPRs) in RCCA-prescribed format.	100%	Quarterly, by the 15th following the close of the reporting period *
(c) Submit Periodic Performance Reports (PPRs) in RCCA-prescribed format.	100%	20th day after each FY quarter end *
(d) Submit Periodic Financial Reports (PFRs) in RCCA-prescribed format.	100%	20th day after each FY quarter end *
(e) Cooperate with RCCA-designated program evaluation activities.	100%	Throughout the Period of Performance, as prescribed
(f) Participate in RCCA-scheduled Project Status Meetings (PSMs).	≥75%	Quarterly
(g) Participate in RCCA TTA Activities.	≥75%	Onboarding TTA sessions (up to three (3)); cohort-focused TTA (as scheduled, up to quarterly); and TTA based upon performance needs or request (ad hoc).

Performance Measures	Standards	Metrics
(h) Submit the Performance Close-out Report.	100%	Within 30 calendar days after the Period of Performance ends
(i) Submit the Financial Close-out Report and Final Invoice, and liquidate all obligations.	100%	Within 45 calendar days after the Period of Performance ends

Note: If a due date falls on a weekend or holiday, the report is due the following business day.

Task 4.2 Staffing Maintenance

Task 4.2 performance measures, standards, and metrics

Performance Measures	Standards	Metrics
(a) Ensure required personnel and staffing remain in place, including designated program leadership.	≥80% of the approved staffing plan	Ongoing; reported through each PPR

Program Performance Measures

Activity and output measures: what the program does and how many it reaches. Counted by the subrecipient and reported through the DPR.

Program activity and output measures

Measure	Type	Definition / unit
Campaign content assets produced (by type)	Output	Assets produced, by type
Campaign placements / dissemination units delivered (by channel)	Output	Placements or units delivered, by channel
Estimated unduplicated reach (by channel and service area)	Output	Estimated unduplicated individuals reached
Community engagement activities conducted (by type)	Activity	Engagement activities, by type
Resource-connection activities or referrals completed	Output	Resource-connection activities / referrals

Outcome and utilization measures: the results of the campaign, drawn from the activity and output measures and the objectives in the approved ISP Data Workbook. Harm reduction literacy,

stigmatizing attitudes, and awareness are measured with an approved instrument.

Program outcome and utilization measures

Measure	Type	Definition / unit
Campaign reach: unduplicated individuals, by channel and service area	Utilization	Unduplicated individuals reached, from DPR data
Engagement with harm reduction and treatment services	Outcome	Help-seeking / engagement-depth actions relative to reach
Equitable campaign reach across priority populations	Outcome	Disaggregated reach vs. targets
Campaign improvement actions implemented	Output	Documented actions from evaluation findings
Harm reduction literacy	Outcome	Respondents demonstrating knowledge ÷ surveyed (approved instrument)
Reduced stigmatizing attitudes	Outcome	Change in stigmatizing attitudes via approved instrument
Awareness of treatment and recovery resources	Outcome	Change in awareness via approved instrument

References

- National Institute on Drug Abuse (NIDA): person-first, non-stigmatizing language
- State of Illinois Overdose Action Plan (most recent) and IDHS harm reduction resources
- SAMHSA Harm Reduction Framework (2023)
- National Culturally and Linguistically Appropriate Services (CLAS) Standards (HHS Office of Minority Health)
- CDC Health Equity Guiding Principles for Inclusive Communication
- CDC Clear Communication Index
- State of Illinois accessibility standards (IDHS: Affirmative Action Program for Employing People with Disabilities)