Engaging People Who Inject Drugs in Healthcare

Oregon AIDS Education & Training Center

Friday, December 4th, 2020

Land Acknowledgement

The Oregon AETC would like to take a moment to recognize the unceded ancestral lands of the first people. We pay respects to their elders, past and present. Please take a moment to consider the many legacies of violence, displacement, migration, and settlement that bring us together here today.

Infectious diseases do not discriminate. As part of our response to the HIV epidemic, we must elevate those groups who have been historically marginalized in our communities. It is our responsibility to listen, recognize, and bring their experiences to the forefront.

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Your Zoom Hosts

Send a private chat to these folks for any technical issues

- Abby Welter
- Rachel Greim
- Ashley Allison
- Dayna Morrison

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Housekeeping

Changing your Name

Select the ellipses symbol "…" on your video square and select "Rename"

Muting Yourself

Select the ellipses symbol "…" on your video square and select "mute my audio"

Or

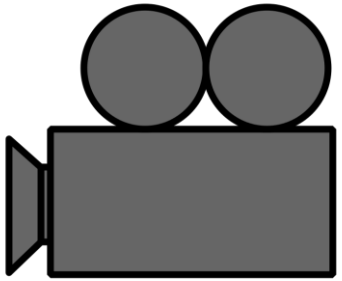
Click the microphone icon on the bottom left ribbon of your Zoom screen

To temporarily unmute, press and hold the spacebar.

Collaborating on Zoom

We'd love to see your face!

Being able to see each other's faces makes it easier for us to feel like a community. If you feel comfortable, keep your video on, especially during breakout sessions. Take breaks if you need to!



We value your voice

Each of you have a valuable perspective and equal stake in this organization. Please be ready to engage and share your ideas.

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This presentation is being recorded

In order to have this presentation as a resource, we are recording this session and will provide the video following the event.

All polling questions are anonymous. Please answer freely as we have no way of linking you to your response.

All chats (private or public) will be automatically downloaded.

You are encouraged to participate!

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Content Acknowledgement

The Oregon AETC and OR-HOPE would like to thank the following team of people who helped inform this curricula:

Todd Korthuis, MD
Tim Menza, MD, PhD
John Nusser, MD
Jude Leahy, MPH
Samantha Byers, MPA
Dayna Morrison, MPH
Sean Mahoney, PWS, CRM
Jessica Gregg, MD
Andy Seaman, MD

Special thanks to Susan Collins, PhD, Director at the Harm Reduction Research and Treatment Lab (HaRRT) Center at the University of Washington – Harborview Medical Center for her research, guidance and insights.

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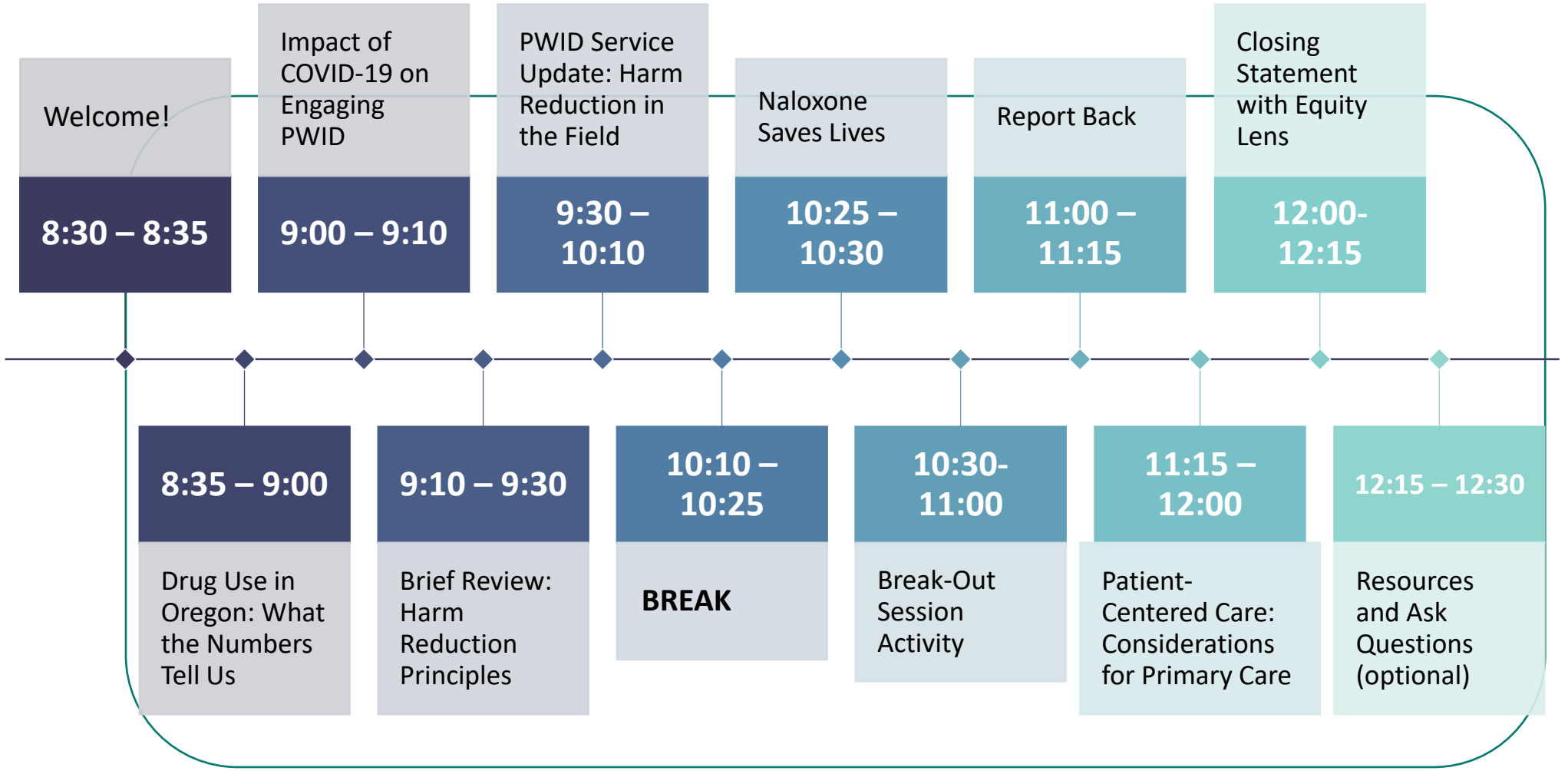
Disclosures

- The presenters for today's event have no commercial interests to disclose.

AGENDA


Welcome!
8:30 – 8:35
Impact of COVID-19 on Engaging PWID
9:00 – 9:10
PWID Service Update: Harm Reduction in the Field
9:30 – 10:10
Naloxone Saves Lives
10:25 – 10:30
Report Back
11:00 – 11:15
Closing Statement with Equity Lens
12:00- 12:15
8:35 – 9:00
Drug Use in Oregon: What the Numbers Tell Us
9:10 – 9:30
Brief Review: Harm Reduction Principles
10:10 – 10:25
BREAK
10:30- 11:00
Break-Out Session Activity
11:15 – 12:00
Patient-Centered Care: Considerations for Primary Care
12:15 – 12:30
Resources and Ask Questions (optional)

IdeaBoardz

https://ideaboardz.com/for/Engaging%20PWID%20-%20Parking%20Lot/3560244

***Video Featuring*:**

Andy Seaman, MD

Addiction Medicine Specialist

Oregon Health & Science University

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The Complex Interactions Between Drug Use and Infectious Disease: HCV, HIV, Congenital Syphilis, and Serious Bacterial Infections

8:35 AM – 9:00 AM

Tim Menza, MD, PhD
Medical Director, HIV/STD/TB Section, OHA
Assistant Professor, OHSU, Infectious Diseases
Provider, Multnomah County STD and HIV Clinics

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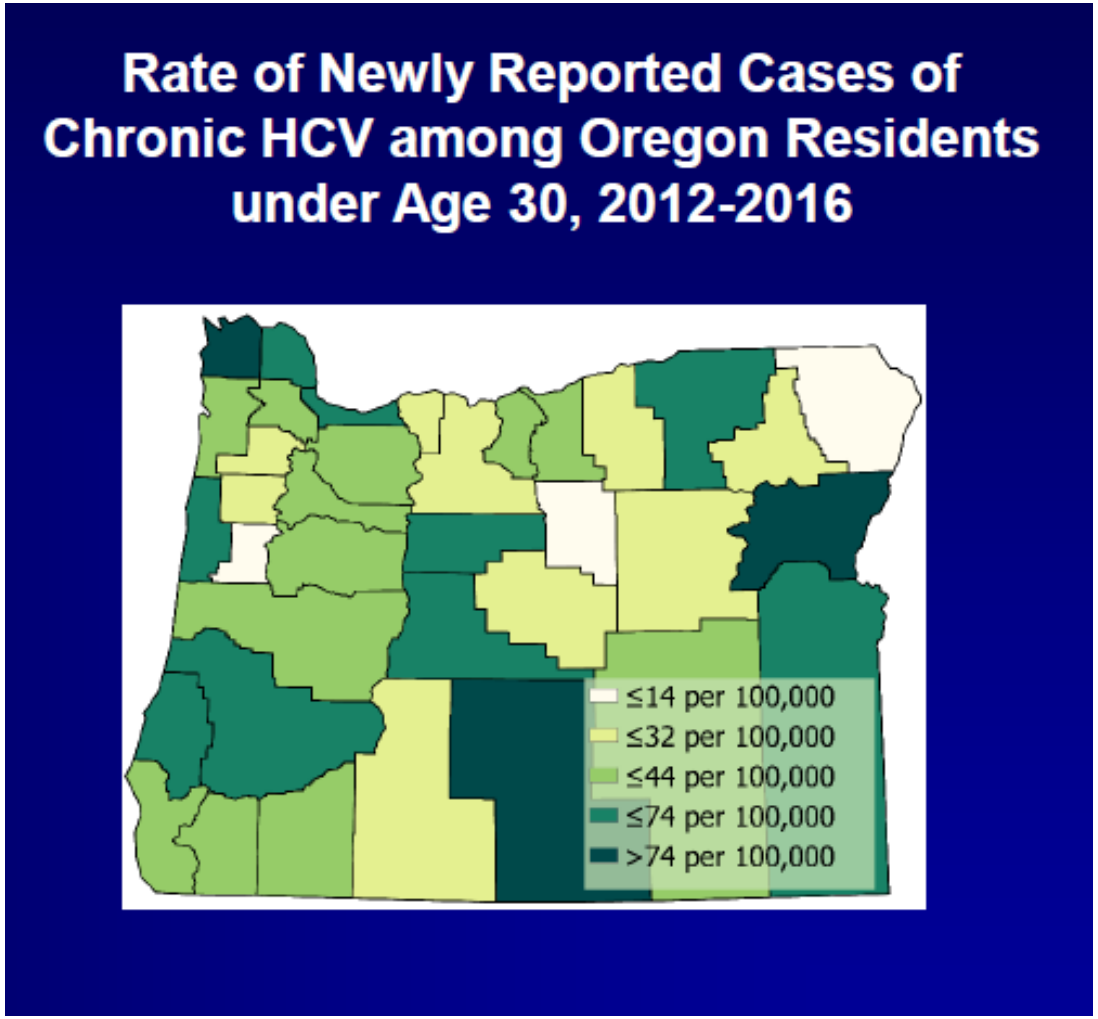
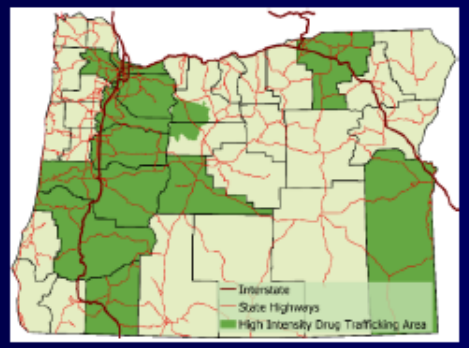
Oregon's IDU-related outbreak vulnerability assessment

- Identify county-level risk factors that predict HCV infections among people under 30 years of age
- Outcome is likely a good proxy for people who acquired HCV through IDU
- Assessment may also identify counties at risk for other IDU-related morbidity

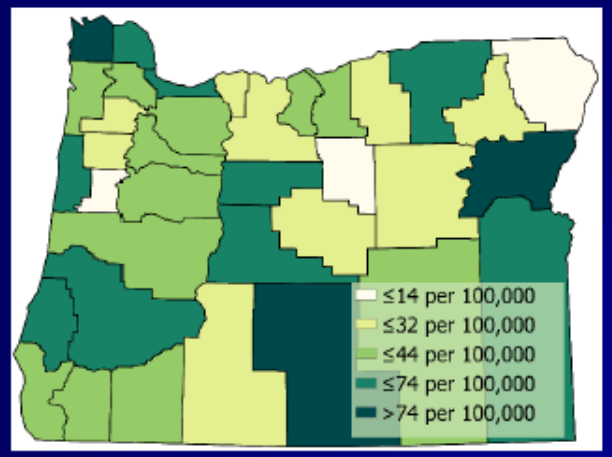


Best predictors of risk for HCV

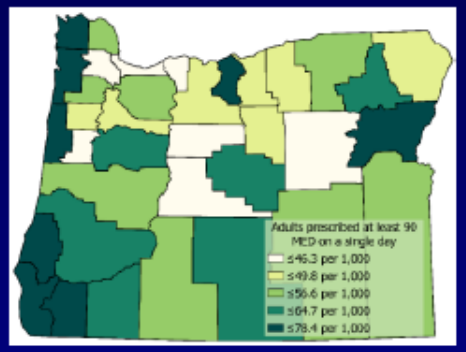
HIDTA



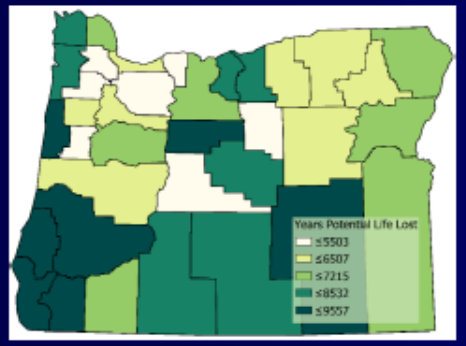
Chronic HCV < 30



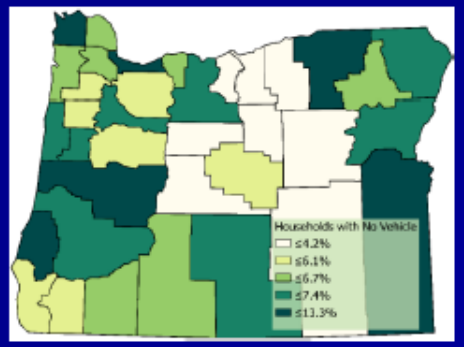
Risky Prescribing



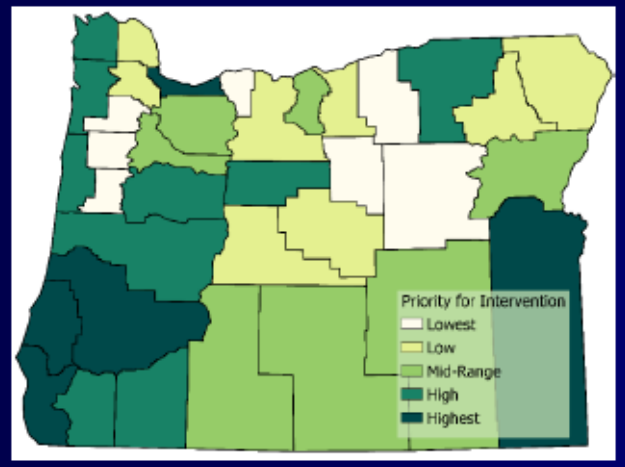
Premature Death



Lack of Transportation



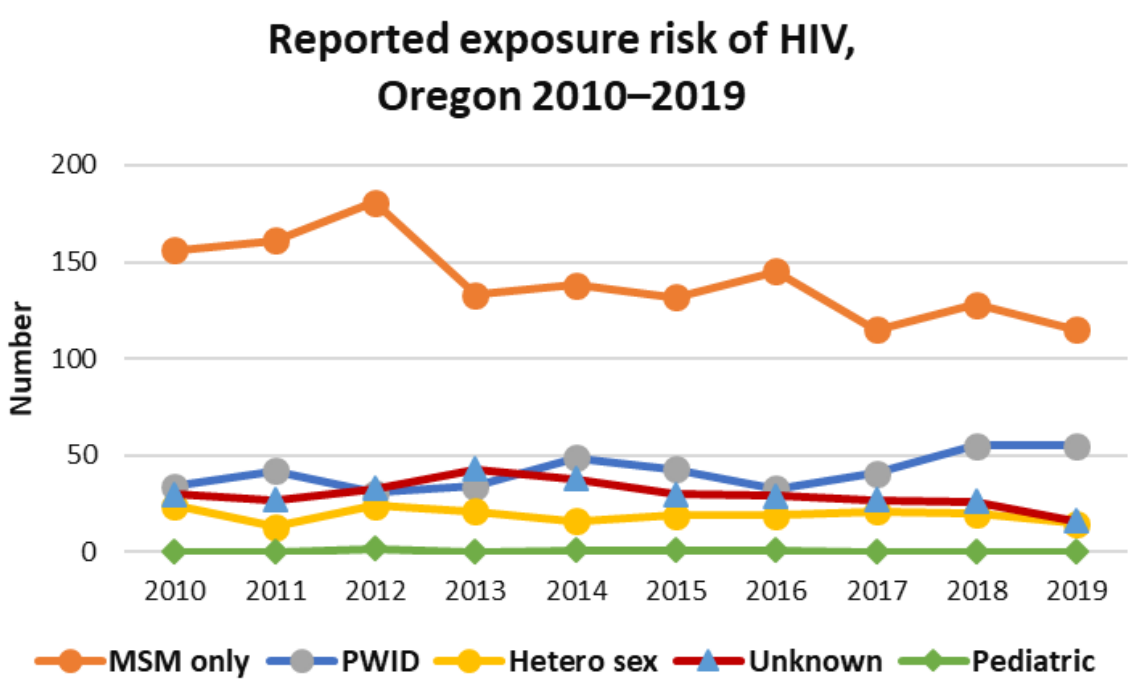
What do the results mean?

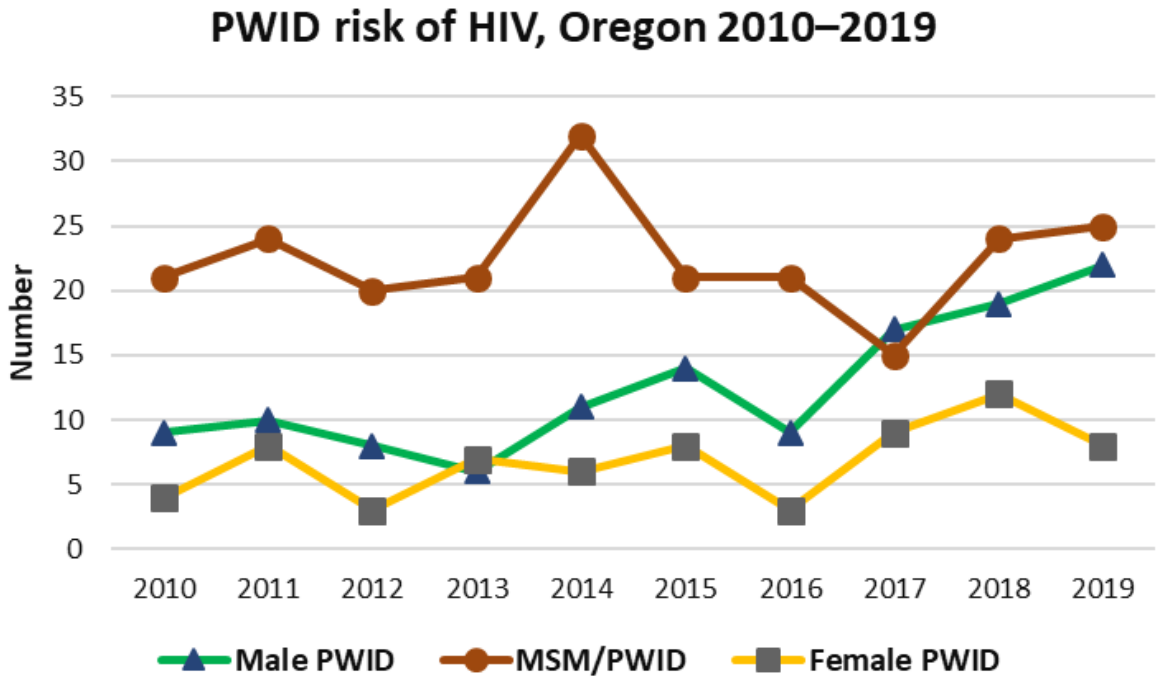


- Calculate a score for each county that predicts their risk of an HCV outbreak—the higher the score, the bigger the risk of having an outbreak.
- For several counties, the vulnerability index score indicated a higher risk of an outbreak than would have been expected from just reviewing reported rates of HCV

Vulnerability				
Highest	High	Mid-Range	Lower	Lowest
Douglas	Jackson	Lake	Wasco	Yamhill
Coos	Lane	Klamath	Crook	Polk
Multnomah	Lincoln	Baker	Union	Morrow
Malheur	Clatsop	Marion	Columbia	Grant
Curry	Linn	Sherman	Gilliam	Wheeler
	Jefferson	Clackamas	Deschutes	Hood
	Tillamook	Harney	Washington	River
	Josephine		Wallowa	Benton
	Umatilla			

Increasing diagnoses of HIV among PWID in Oregon





HIV molecular cluster, Oregon, 2019-2020

- 24 newly diagnosed people living with HIV over 5 counties with genetically similar HIV viruses (a mix of rural and urban counties across Oregon)
- Diagnoses range from 4/2019 to 9/2020 (very recent!)
- Mean age: 36 years, range: 21-59 years
- Sex/gender: 22 cis men, 1 cis woman, 1 trans woman
- Ethnicity: 1 Hispanic/Latinx
- Race: 22 white, 1 Black, 1 AI/AN

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HIV molecular data

- Molecular sequence reporting is the collection and analysis of HIV genetic data generated through HIV drug resistance testing.
  - Molecular sequence data has been used for many years to investigate other conditions such as foodborne infections and tuberculosis.
- Molecular sequence data helps identify a group of related infections that would not otherwise be recognized as related.
  - Helps focus public health efforts where they are needed most
- Molecular sequence analysis *examines the genetics of the virus, not the person*.

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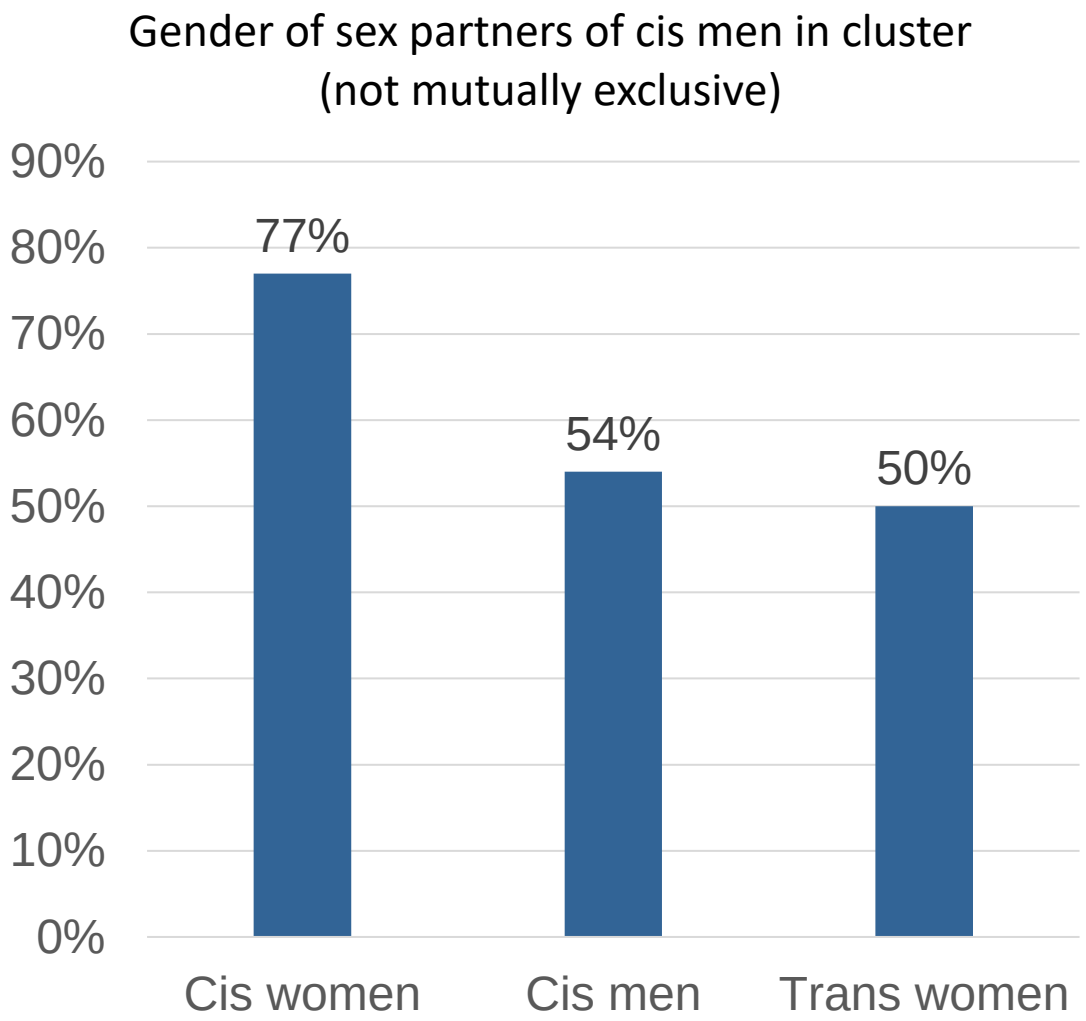
HIV molecular cluster

- A molecular cluster is a group of people living with HIV whose viruses share similar genetic data. A cluster may include people who acquired HIV very recently or sometime in the past.

Sex partners of cluster members, HIV molecular cluster, Oregon 2019-2020



- Cis woman and trans woman both reported sex with cis men
- 10 (42%) named at least 1 partner
- Most named just one partner with a range for 1-29

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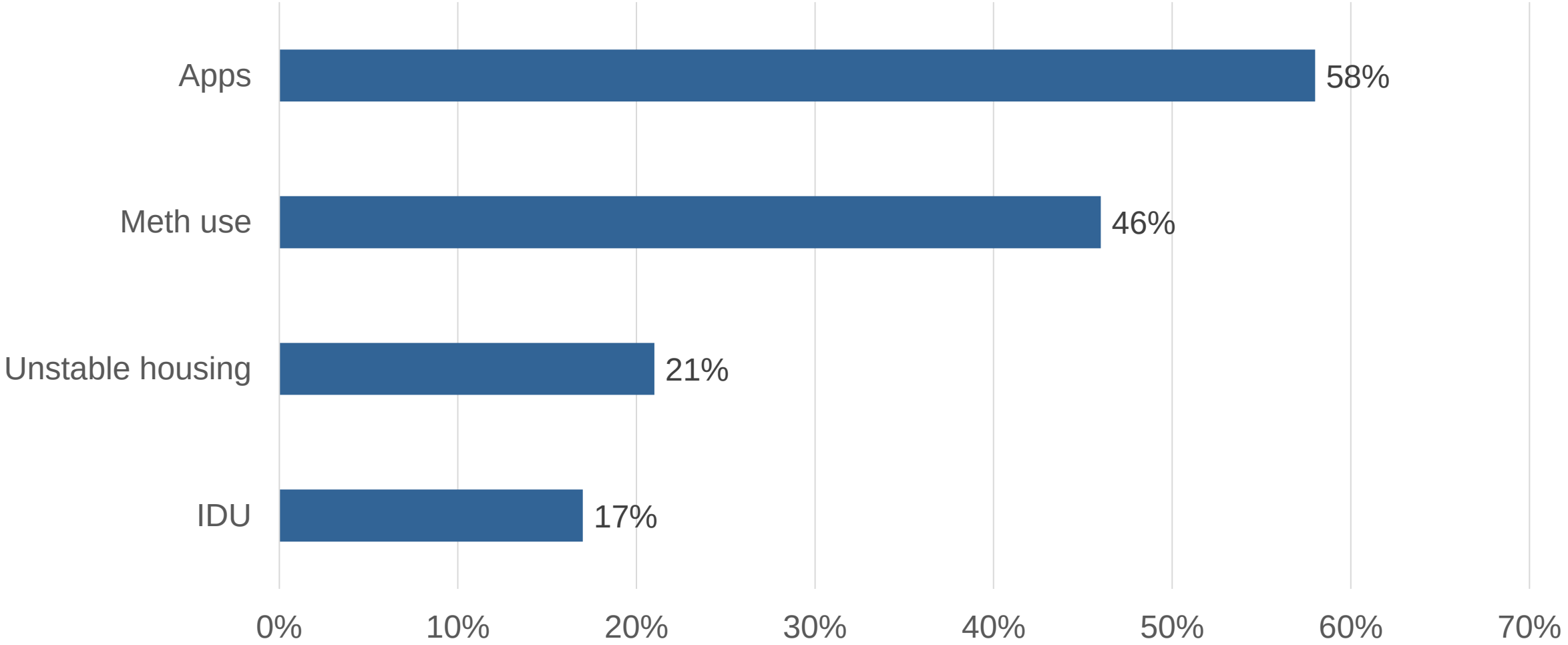
HIV-related risks, HIV molecular cluster, Oregon 2019-2020



HIV testing, prevention, and diagnosis, HIV molecular cluster, Oregon 2019-2020

- 17 (71%) had a negative HIV test in the prior 2 years
- 8 (25%) had an STI in the prior 2 years
- No one was ever on PrEP
- Facilities of diagnosis
  - 6 ER/UC
  - 8 Clinic/Hospital
  - 4 LPHA/Contractor
  - 3 Planned Parenthood
  - 1 Plasma donation
  - 1 VA
- 2 are not in care
- 4 diagnosed in 8/2020 and 9/2020 not yet virally suppressed

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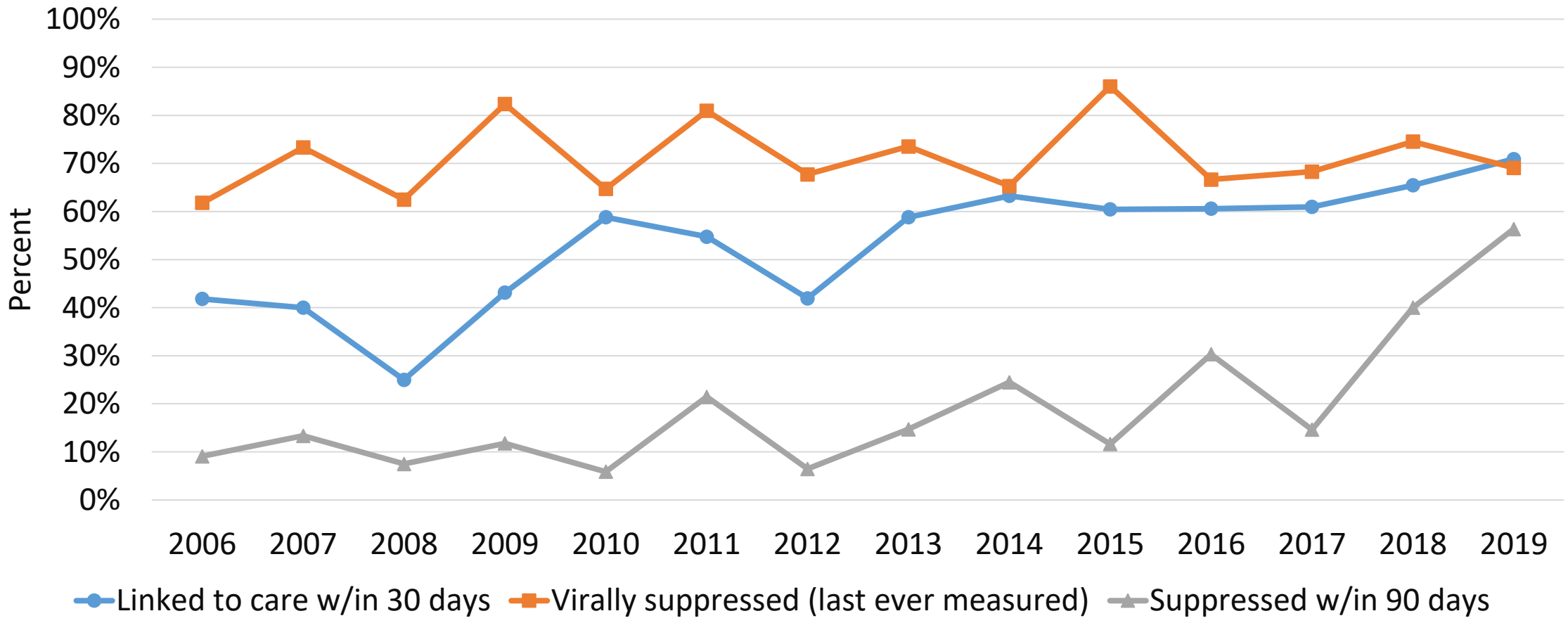
HIV care metrics among PWID, Oregon, 2006-2019



HIV take home points

- HIV diagnoses among PWID have increased and are likely to plateau at a new, higher level than in prior years
  - ER/urgent care, hospital systems diagnosed more than half of the cases in the cluster
- At the same time, HIV care outcomes are improving among PWID
- HIV risk is conditioned by several intersecting factors
- The sexual networks leading to recent HIV transmission are complex
  - The cluster/network would not have been apparent to us without molecular sequence data and we would not have identified trans women as a priority population in this cluster

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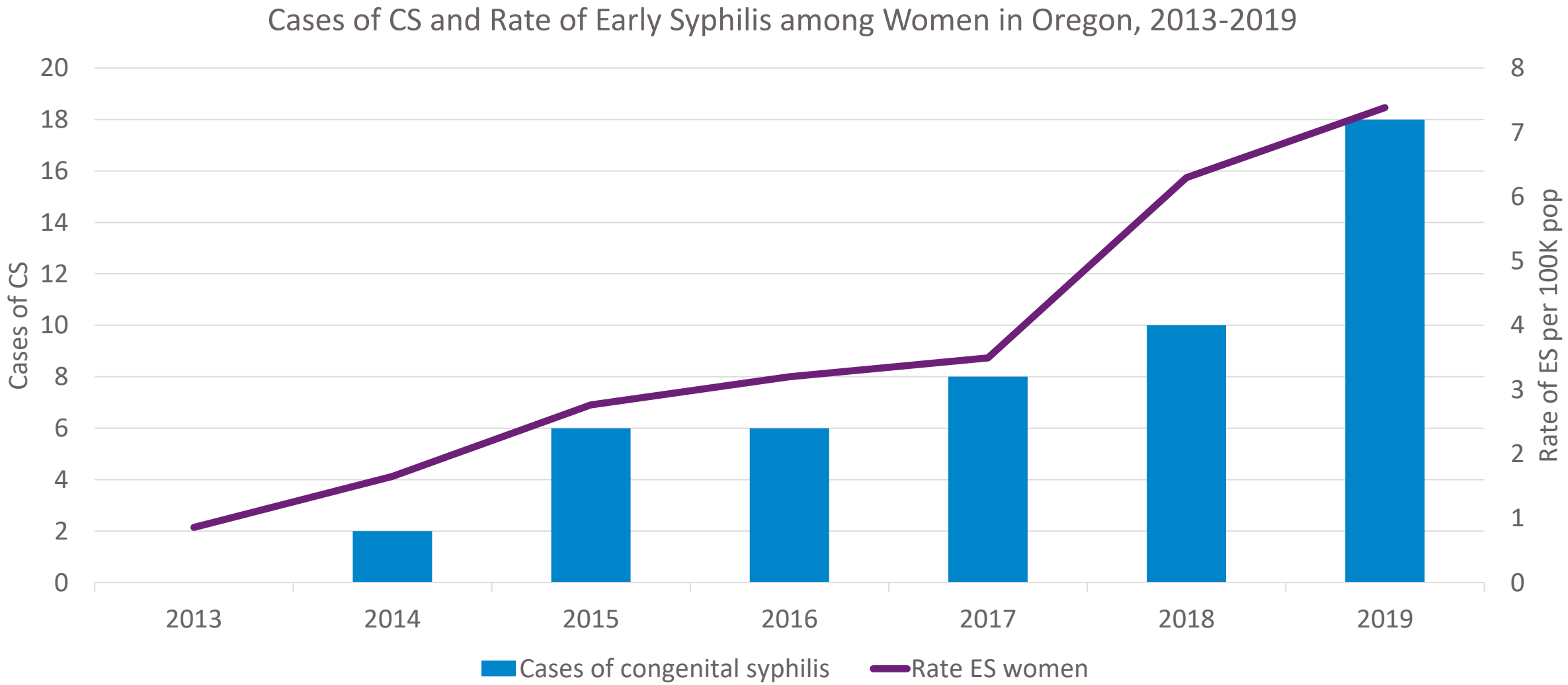
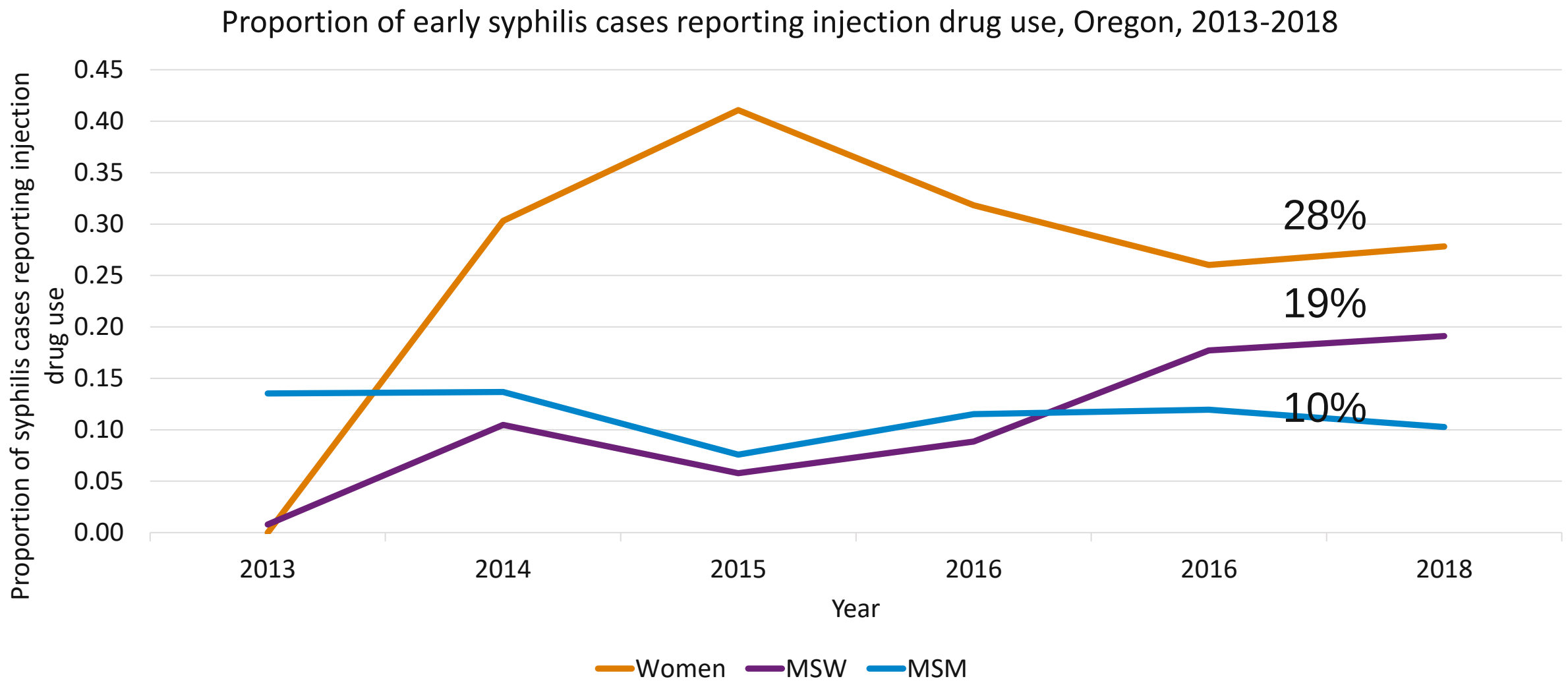
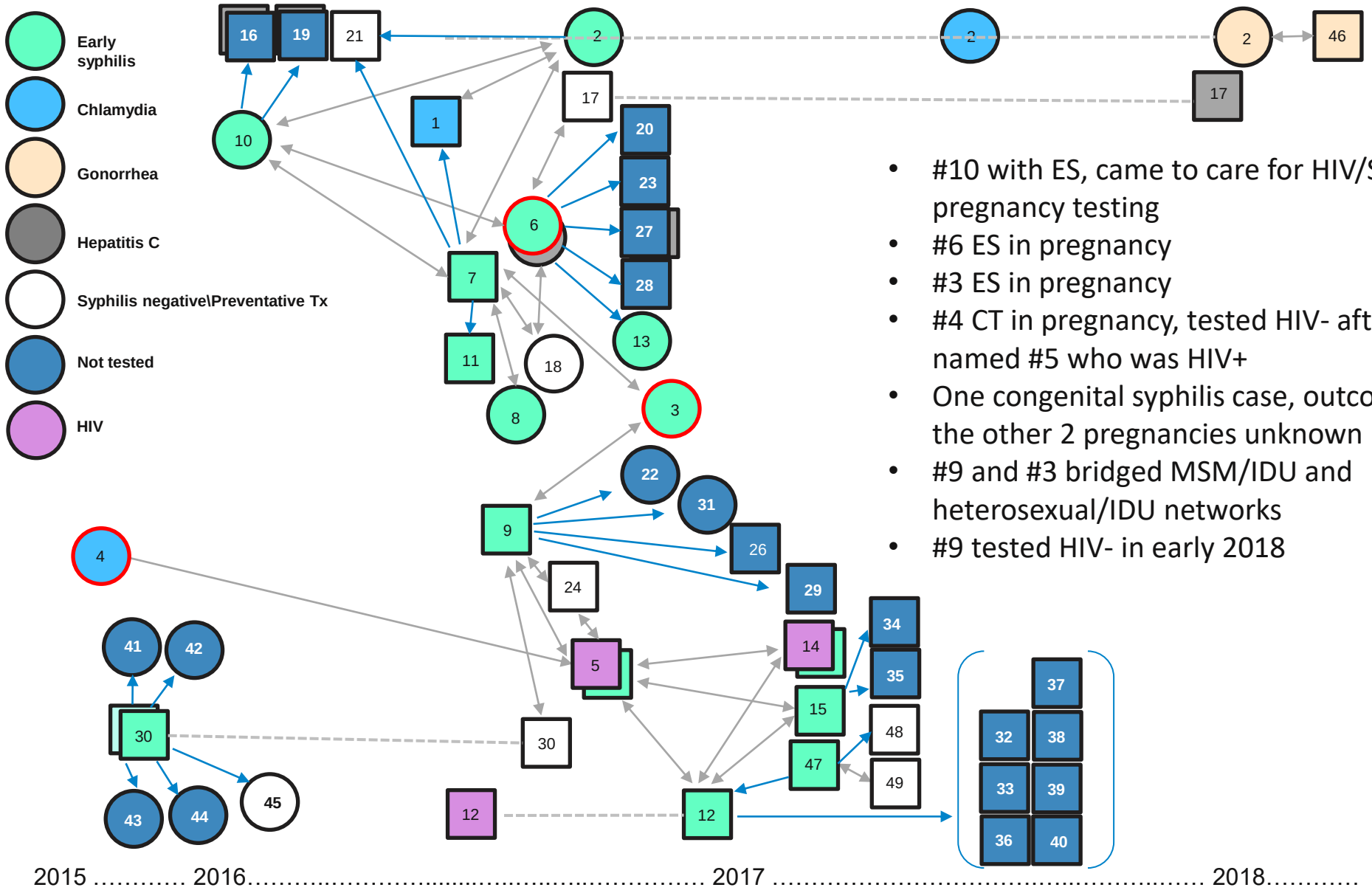
Early syphilis has increased over 600% among women in Oregon since 2013



More heterosexuals with early syphilis are reporting injection drug use





- #10 with ES, came to care for HIV/STI and pregnancy testing
- #6 ES in pregnancy
- #3 ES in pregnancy
- #4 CT in pregnancy, tested HIV- after she named #5 who was HIV+
- One congenital syphilis case, outcomes of the other 2 pregnancies unknown
- #9 and #3 bridged MSM/IDU and heterosexual/IDU networks
- #9 tested HIV- in early 2018

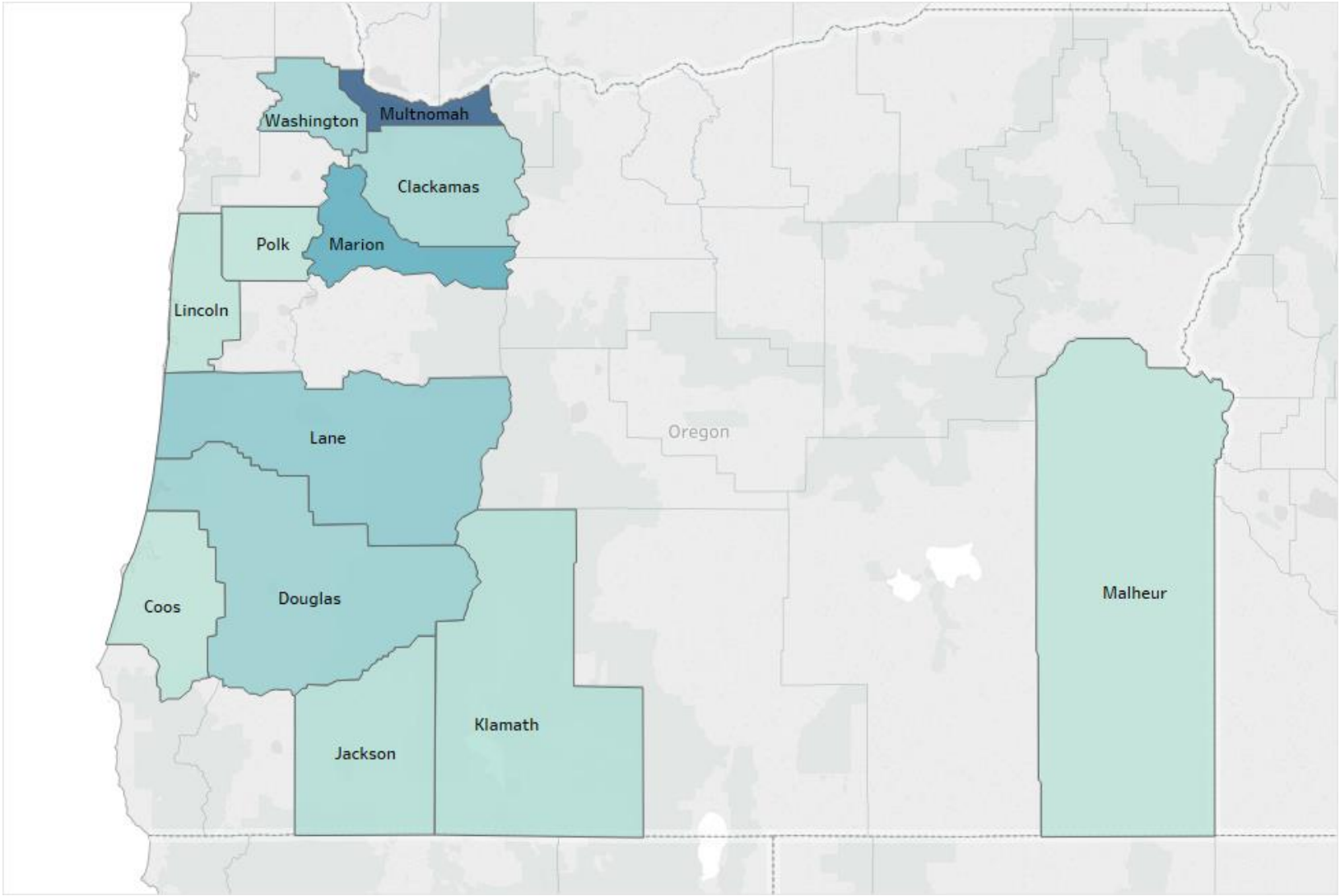
Characteristics of people who delivered an infant with CS (2014-2019, n = 49)

- Median age 27 years (IQR: 23-33, range 20-44)

Race	Percent of pop with CS case	Percent of OR pop
American Indian/Alaska Native	1 (2%)	2%
Black/African American	4 (8%)	2%
Native Hawaiian/Pacific Islander	4 (8%)	0.5%
Other, multiracial	5 (10%)	9%
White	36 (71%)	87%

Ethnicity	Percent of pop with CS case	Percent of OR pop
Hispanic/Latina/o/x	10 (20%)	13%

Geographic distribution of CS cases, Oregon, 2014-2019



Housing and criminal justice involvement

Housing*

- 23/49 (46%) were homeless or unstably housed
  - > Unstable housing includes incarceration, moving homes, or residing in a substance use disorder treatment facility or group residence during pregnancy
  - > *10/49 (20%) were missing housing status

Criminal justice involvement

- 30/49 (61%) had any history of criminal justice involvement
  - > 12/49 (24%) had criminal justice involvement in the 12 months prior to or during pregnancy, including incarceration during pregnancy, community supervision, outstanding cases or warrants

Substance use, HIV/STI and HCV

Substance use*

- 16/49 (33%) had a history of injection drug use
- 24/49 (49%) had a history of methamphetamine use
- 8/49 (16%) had a history of heroin/opiate use
  - > *8/49 (16%) were missing data on injection drug use
  - > *5/49 (10%) were missing data on meth/heroin use

HIV/STI and HCV

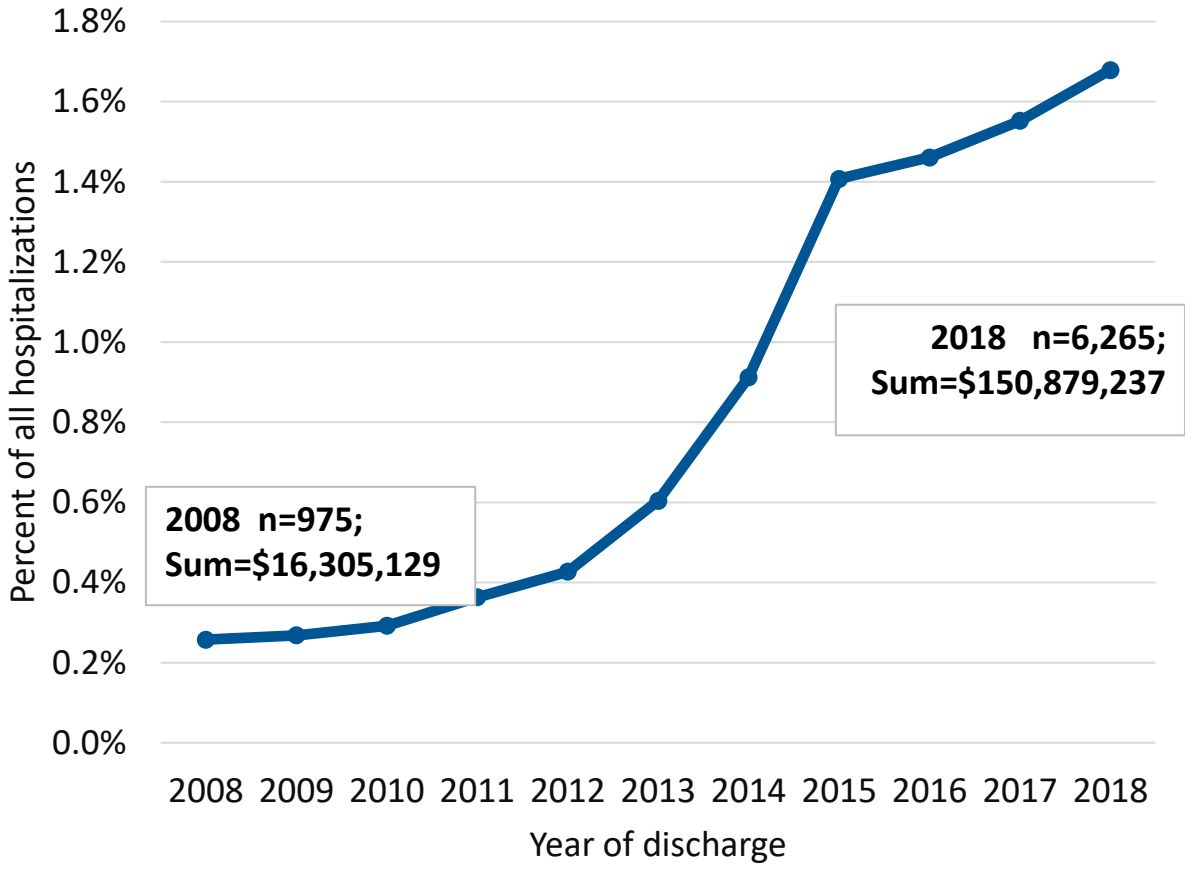
- None were known to be living with HIV
- 19/49 (39%) had a history of chlamydia
- 6/49 (12%) had a history of gonorrhea
- 10/49 (20%) had chronic HCV

Congenital syphilis take home points

- Early syphilis has increased substantially among women in Oregon
  - More women diagnosed with early syphilis reported IDU during the same time period
  - Changes in sexual and substance use networks
- As a result, congenital syphilis has increased
  - Complex interactions between systemic racism, lack of access to safe prenatal care, substance use, criminal justice involvement, and houselessness
    - Safe = without fear of judgment, concern for criminal justice or human services involvement

Trends in hospitalizations and costs associated with IDU-related serious bacterial infections, Oregon, 2008-2018

- 34,404 individuals hospitalized at least once for IDU-related SBI
- IDU-related SBI as a proportion of all hospitalizations increased 6-fold
- The sum of costs related to IDU-related SBI increased almost 10-fold
- Seen in all health systems throughout Oregon



*Sum of charges adjusted by cost-to-charge ratios and adjusted to 2018 dollars

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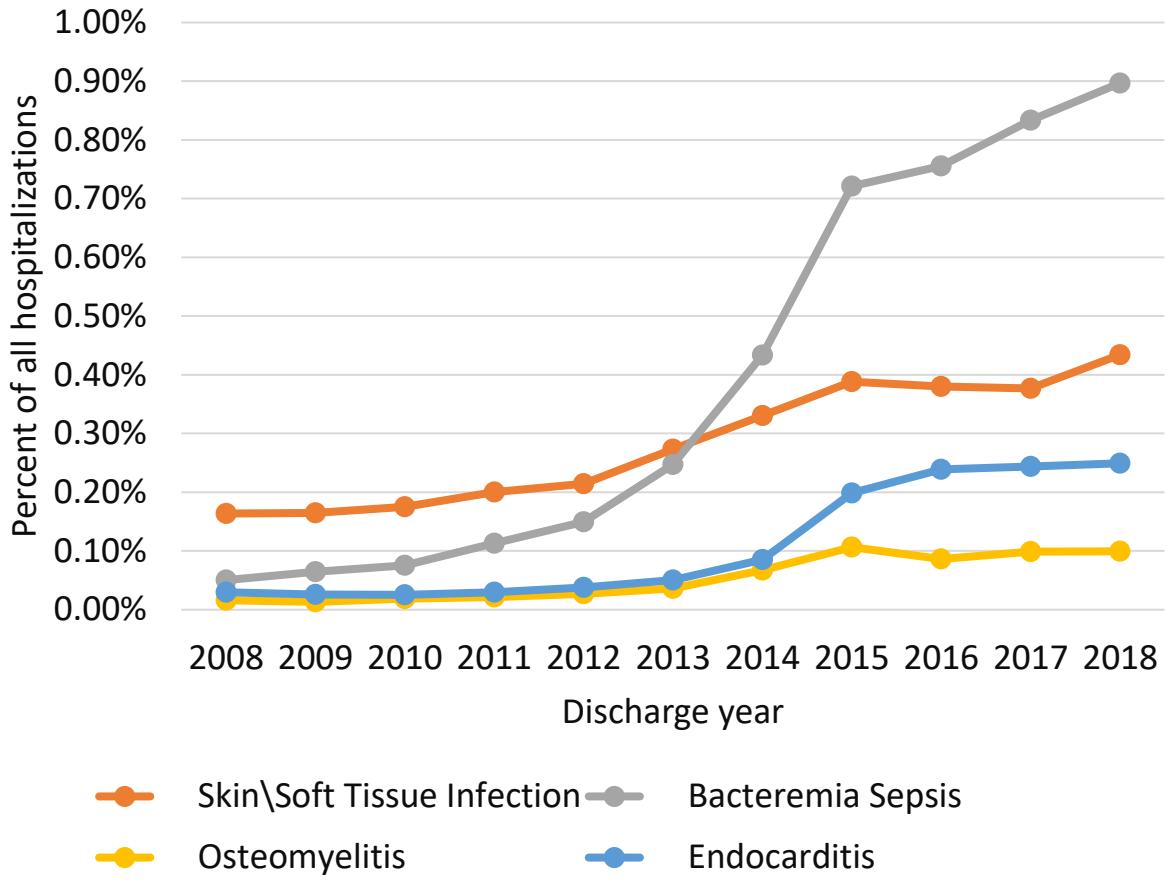
Trends in IDU-related SBI by SBI type

- Bacteremia/sepsis hospitalizations increased 15-fold over 11 years
- Bacteremia/sepsis accounted for the greatest proportion of IDU-related SBI hospitalizations after 2013
- Endocarditis increased 8-fold over the follow-up period



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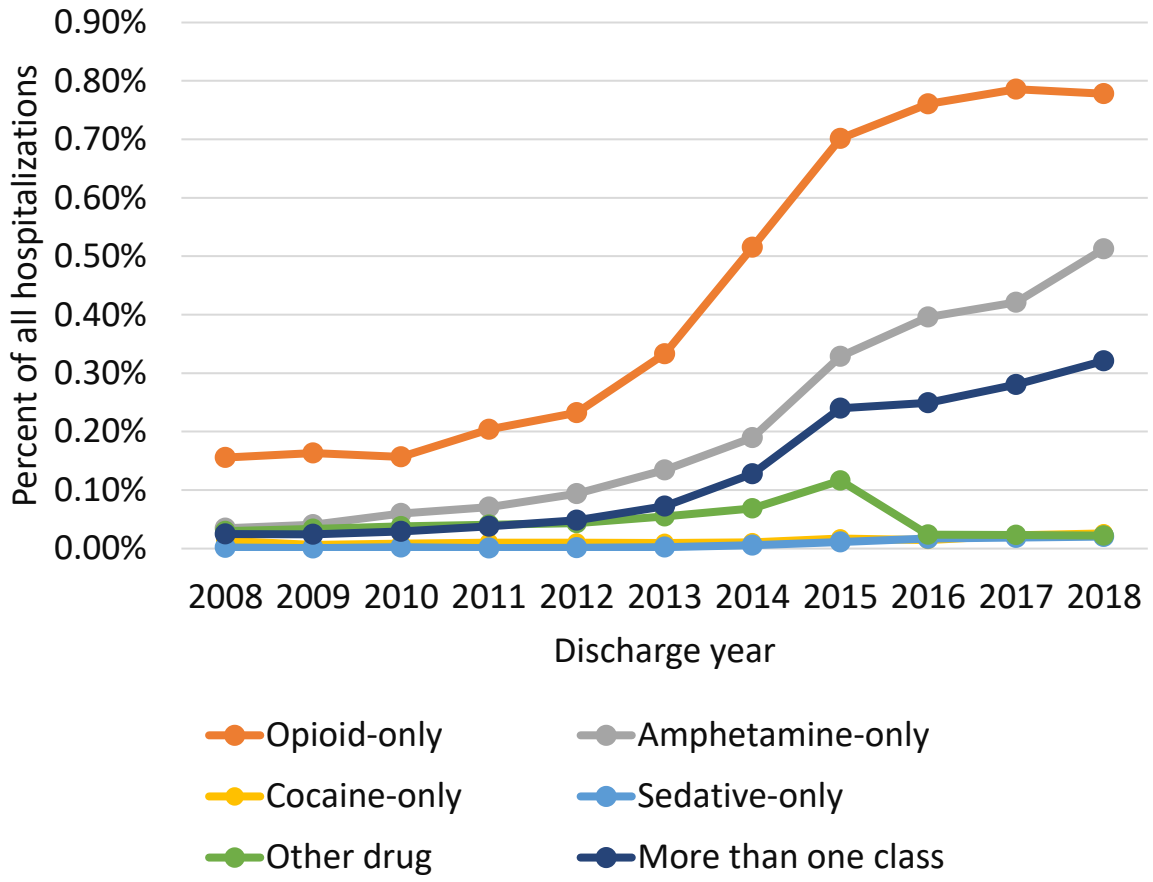
IDU-related SBI by drug class

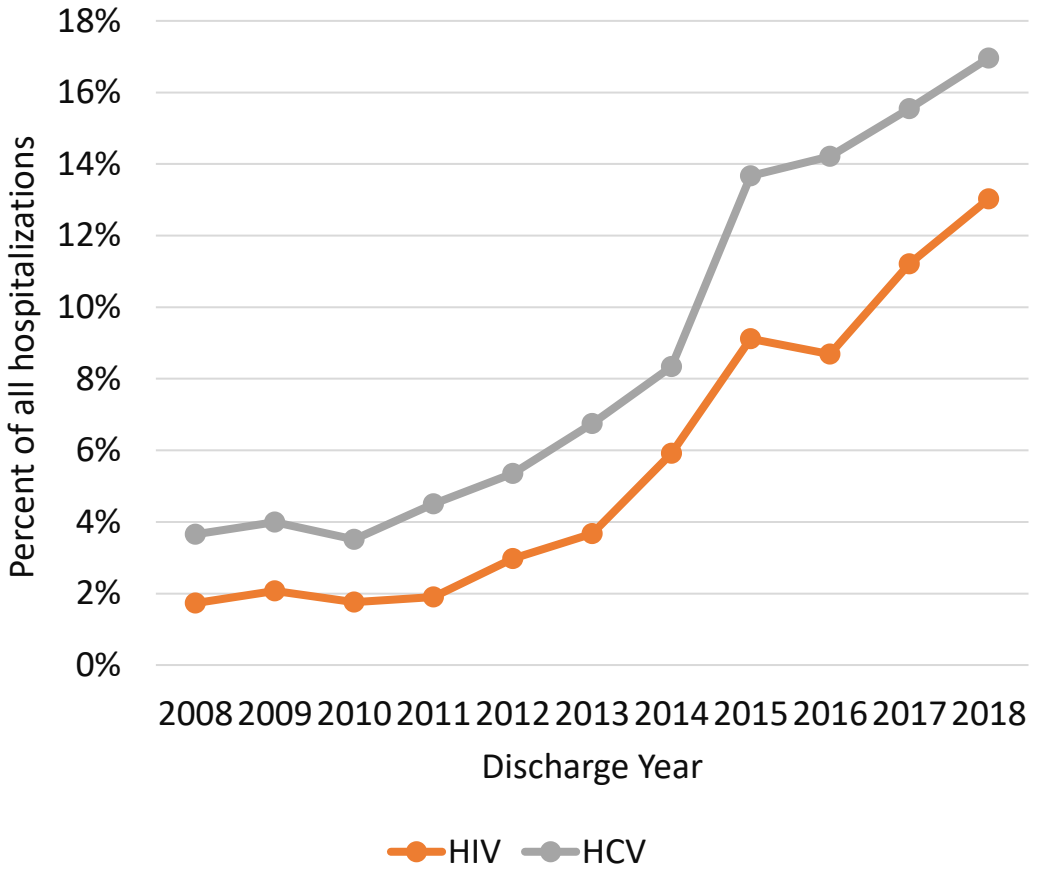
- Opioid use accounted for the greatest proportion of IDU-related SBI and increased 5-fold
- IDU-related SBI associated with amphetamine-type stimulants increased 15-fold
- IDU-related SBI associated with polysubstance use increased 15-fold (mostly amphetamine + opioids)



Oregon Health Authority

Trends in IDU-related SBI among people living with HCV and HIV

- IDU-related SBI increased 5-fold both among people living with HCV and HIV
- Among people living with HIV:
  - Only 42% of those hospitalized with IDU-related SBI were virally suppressed
  - 23% of people living with HIV died a median of 16.4 months after their hospitalization for IDU-related SBI
- 3067 hospitalized patients needed linkage to HCV cure
- 1295 with IDU-related SBI tested HCV-positive >30 days after their hospitalization
  - Could have benefitted from in-hospital testing and preventive services



Oregon Health Authority

IDU-related SBI take home points

- The rate and cost of hospitalizations for IDU-related SBI have increased dramatically over the past decade
- Hospitalizations are key touchpoints for
  - In-hospital initiation of medication for opioid use disorder with connection to peer-based harm reduction services in the community
  - Naloxone prescribing
    - Those with IDU-related SBI are 50 times more likely to die of an overdose than those without an IDU-related SBI
  - HCV testing and linkage to care
  - HIV testing, PrEP initiation, linkage to care, and re-engagement for viral suppression
- The cost of just one hospitalization could pay for syringe service program start-up costs, a year of medication for opioid use disorder, other community harm reduction services

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Conclusion

- Substance use has far-reaching health effects
- Substance use, however, does not operate independently
- Racism, transphobia, stigma, economic instability, lack of care access, criminal justice involvement, and houselessness make the effects of substance use on health even more morbid and mortal
- Policies and practices that address these key factors have the potential to reduce HIV, CS, and SBI overall and especially for people who use drugs (all policy is health policy)

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Impact Of COVID-19 On Engaging People Who Inject Drugs & Recovery In Healthcare

9:00 AM - 9:10 AM

Ann Thomas, MD, MPH
Public Health Division
Oregon Health Authority

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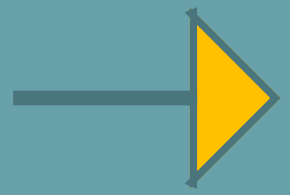
IMPACT OF COVID-19 ON ENGAGING PWID AND RECOVERY IN HEALTHCARE

Ann Thomas, MD, MPH
Public Health Division

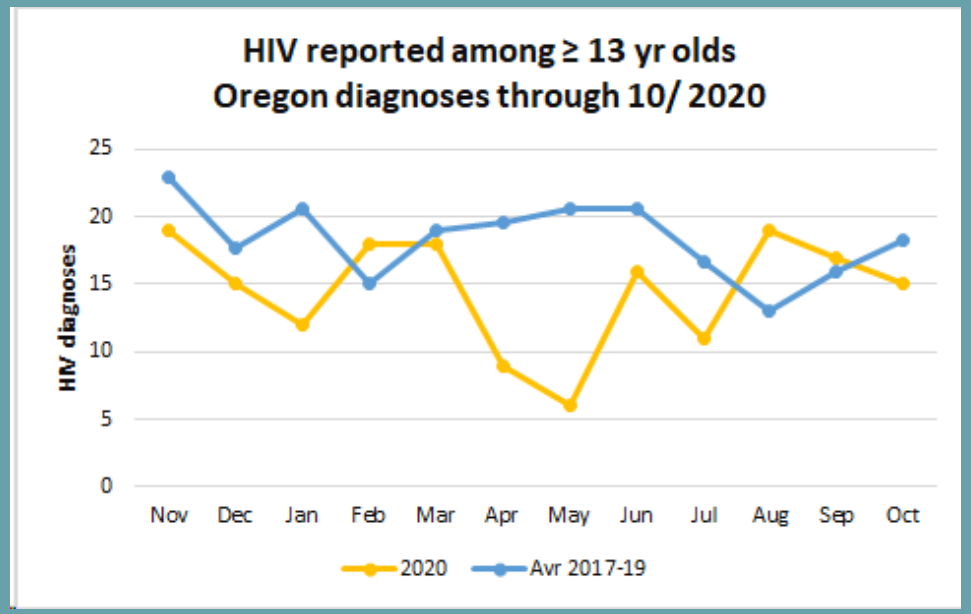
Challenges posed by COVID-19 to PWIDs

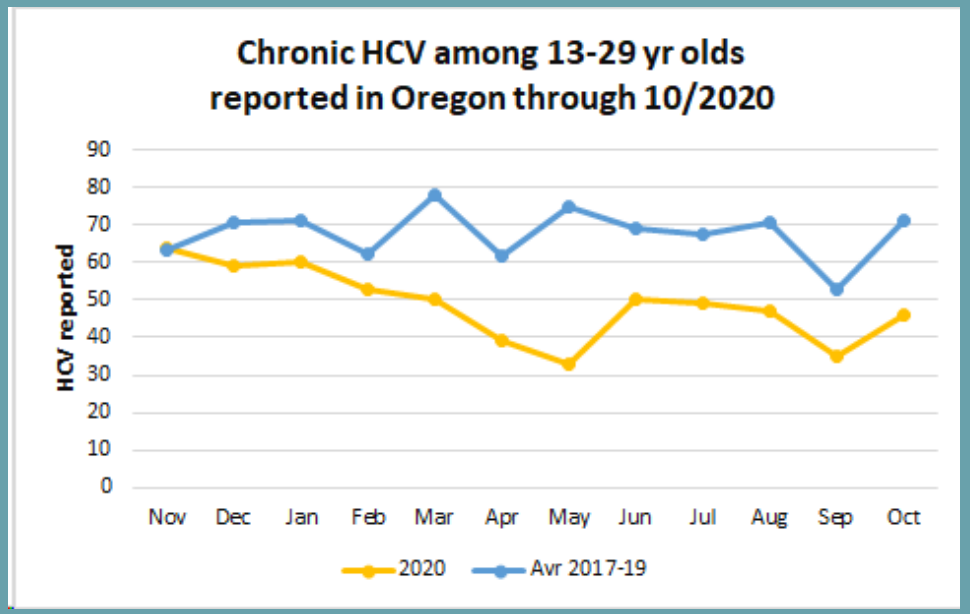
- High prevalence of comorbidities
- Unsanitary and crowded living situations
- Stigmatization, incarceration
- Homelessness and difficulty adhering to physical distancing, quarantine and isolation recommendations
- Less access to essential PWID services (SSP, MAT)



- Homelessness
- Overdoses
- Unsafe injection practices
- Unsafe sex

Vasyleva, et al. JIAS https://doi.org/10.1002/jia2.25583





IMPACT OF COVID IN OREGON: SCREENING FOR HIV AND HCV

Impact of COVID in Oregon: Overdose Deaths

- Most commonly due to fentanyl and heroine
- In May alone, 40% of deaths due to fentanyl alone

Pandemic Exacerbates Oregon's Addiction Crisis: Overdose Deaths Rise 70%

By: Ben Botkin

Overdose deaths spiked nearly 70% in April and May in Oregon, which already has the fourth-highest addiction rate in the country.

The dramatic rise confirmed the fears of advocates and providers that COVID-19 would worsen the addiction crisis in the state.

Impact of COVID in Oregon: responses from OHA community engagement meetings, 3/26 and 4/9

- COVID-19 disruptions have
  - *Increased risk of overdoes, relapse, and infections*
  - *Decreased access to SUD detox, inpatient and outpatient treatment, and long-term recovery supports*

Harm Reduction, SUD Treatment and Recovery Support Programs Recommendations

- **Prevent overdose:** Increase naloxone distribution immediately to people at risk of overdose
- **Prevent infectious diseases:** Harm reduction and Syringe Service Programs need guidance to adapt services safely and provide adequate amounts of supplies to distribute to prevent infections.
- **Support access to care:** Recovery support and substance use treatment programs need guidance to adapt activities to protect staff and clients from COVID-19 infection.
- **Maintain recovery support programs:** Substance use disorder recovery support programs need guidance and support to legally adapt protocols and procedures to protect staff and clients from COVID-19 infection and maintain program services.

What OHA Can Offer

- Oregon Harm Reduction Clearinghouse
- Harm Reduction and SSP Manual
  - *https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/Pages/harm-reduction-library.aspx*
- COVID-19 Homeless Shelter Guidance https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2256.pdf

***Video Featuring*:**

Sean Mahoney, PWS, CRM

Peer Manager

EVOLVE Peer Delivered Services

Mental Health and Addiction Association of Oregon (MHAAO)

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Brief Overview: Harm Reduction Principles

9:10 AM - 9:30 AM

Dayna K. Morrison, MPH
Program Manager, Oregon AIDS Education & Training Center

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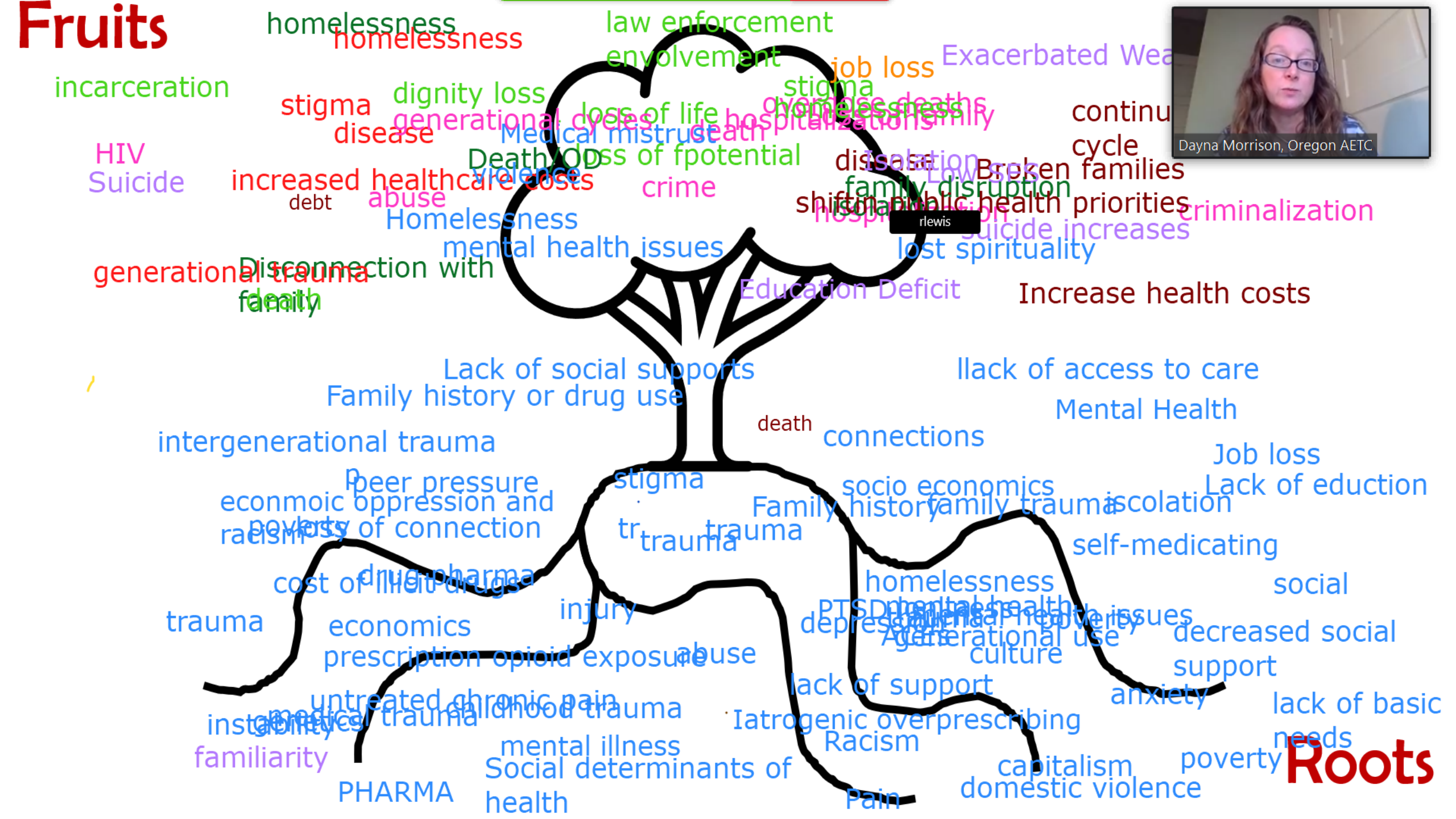
Fruits
homelessness
homelessness
law enforcement
envolvement
job loss
Exacerbated Wea
incarceration
stigma
dignity loss
stigma
generational cycles
loss of life
hospitalizations
family
continu
cycle
disease
Medical mistrust
death
HIV
Death/OD
loss of fpotential
Suicide
increased healthcare costs
violence
crime
Broken families
family disruption
debt
abuse
Homelessness
criminalization
mental health issues
lost spirituality
generational trauma
Disconnection with
family
Education Deficit
Increase health costs
Lack of social supports
llack of access to care
Family history or drug use
Mental Health
intergenerational trauma
death
connections
Job loss
peer pressure
stigma
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childhood trauma
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Iatrogenic overprescribing
Racism
mental illness
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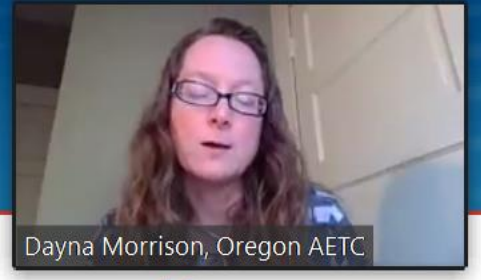
Social determinants of
health
PHARMA
capitalism
poverty
domestic violence
Pain
Roots
Dayna Morrison, Oregon AETC
rlewis

What Comes to Mind When You Hear Harm Reduction?



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Harm Reduction Examples

AETC AIDS Education & Training Center
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Embracing Positive Change

"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

- Dan Biggs

Source: Harm Reduction Coalition

SAMHSA
Substance Abuse and Mental Health Services Administration

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Harm Reduction is a *Compassionate Philosophy*

Recognizing Substance use:

- **Has pros and cons**
- **Is here to stay**
- **Is complex**
- **Exists in social context**
- **Is not the person**

Source 2019 UW HaRRT Center

Harm Reduction is a *Practical Approach*

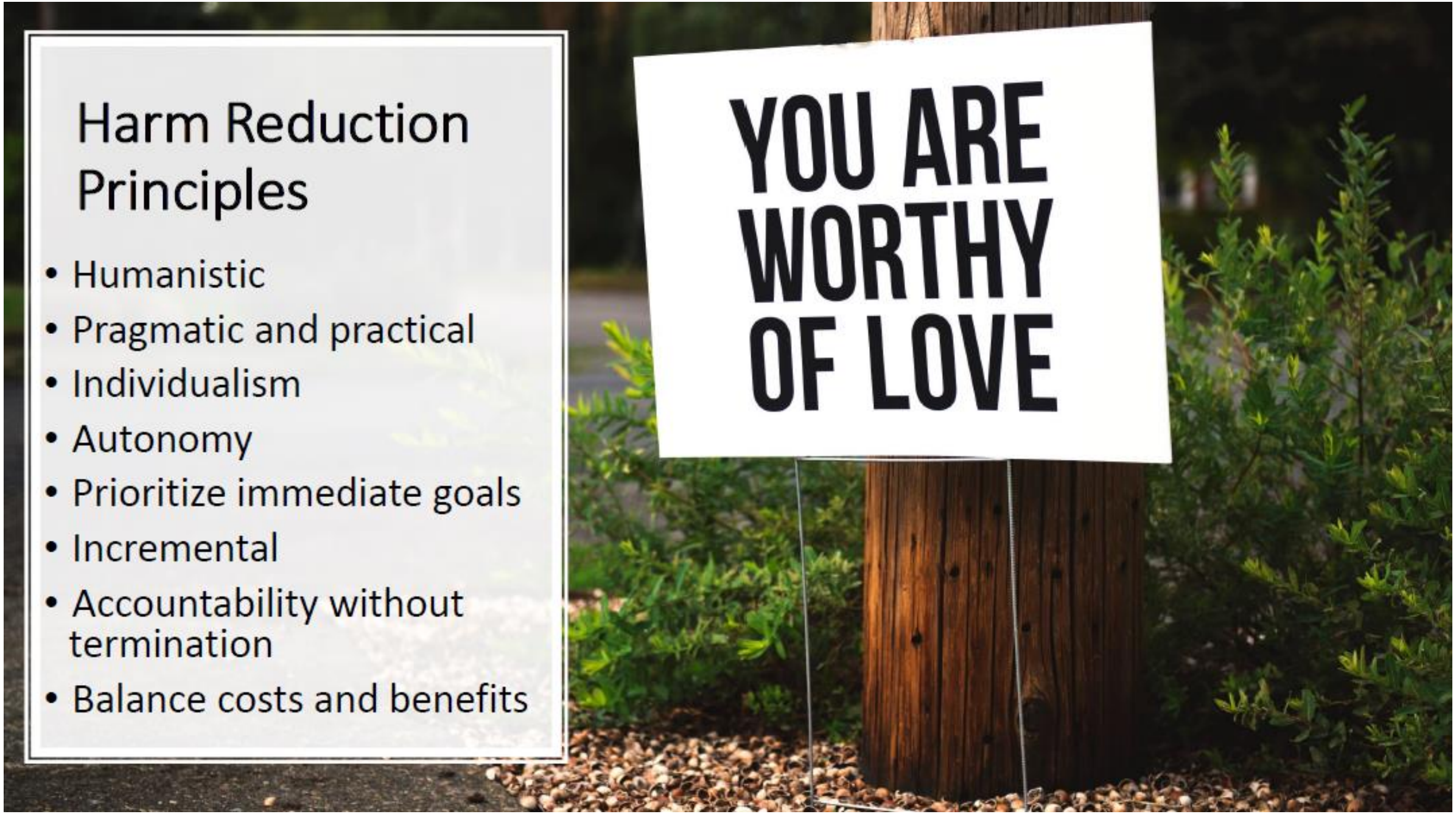
- **Client Driven**
- **Quality of Life Focus**
- **Any Positive Change**
- **Advocates for Social Justice and Racial Equity**
- **Safer Use**

Source 2019 UW HaRRT Center

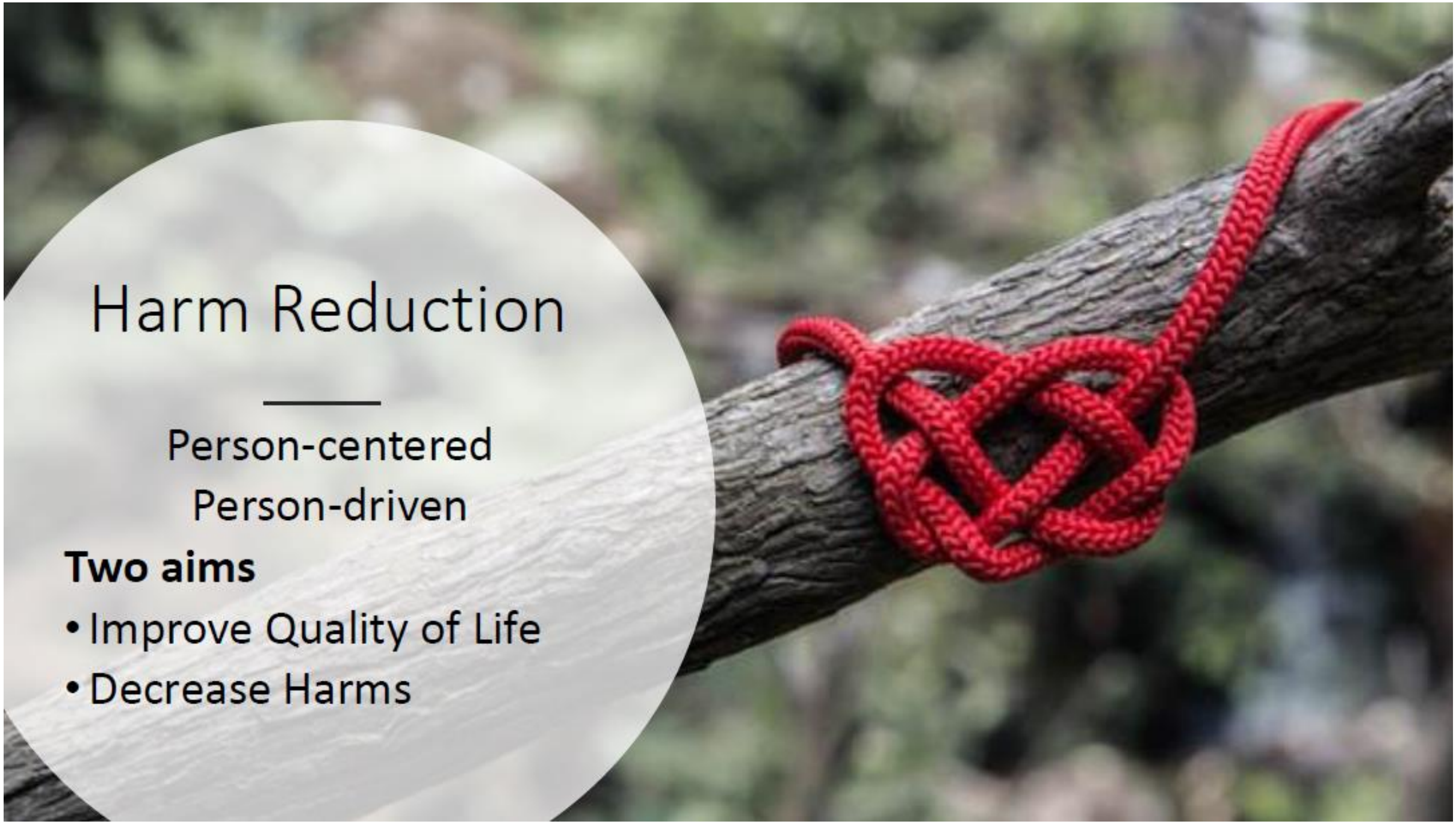
Harm Reduction can be described as a set of strategies

Harm reduction is a grass-roots and “user-driven” set of compassionate and pragmatic approaches to reducing the substance-related harm and improving quality of life **without requiring abstinence or use reduction.**

HaRRT Center Collins et al (2011); Marlatt (1998)



Source: Jude Leahy, Oregon Health Authority



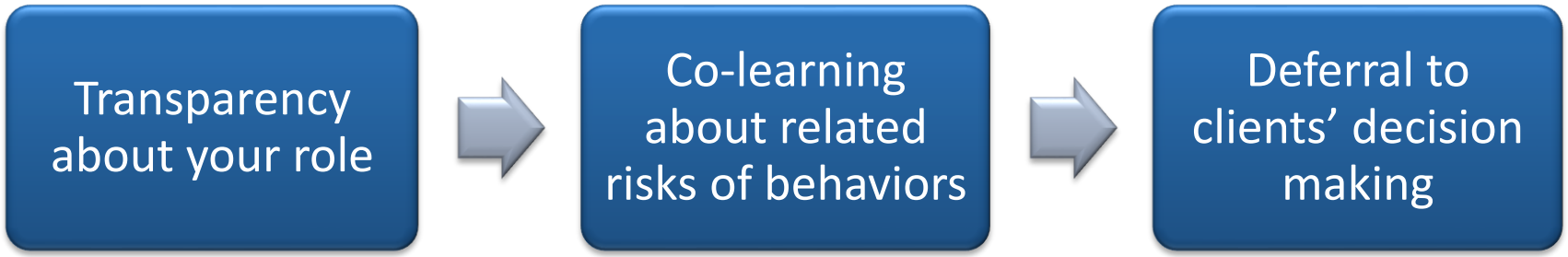
Source: Jude Leahy, Oregon Health Authority

For example…
Use Reduction vs. Harm Reduction

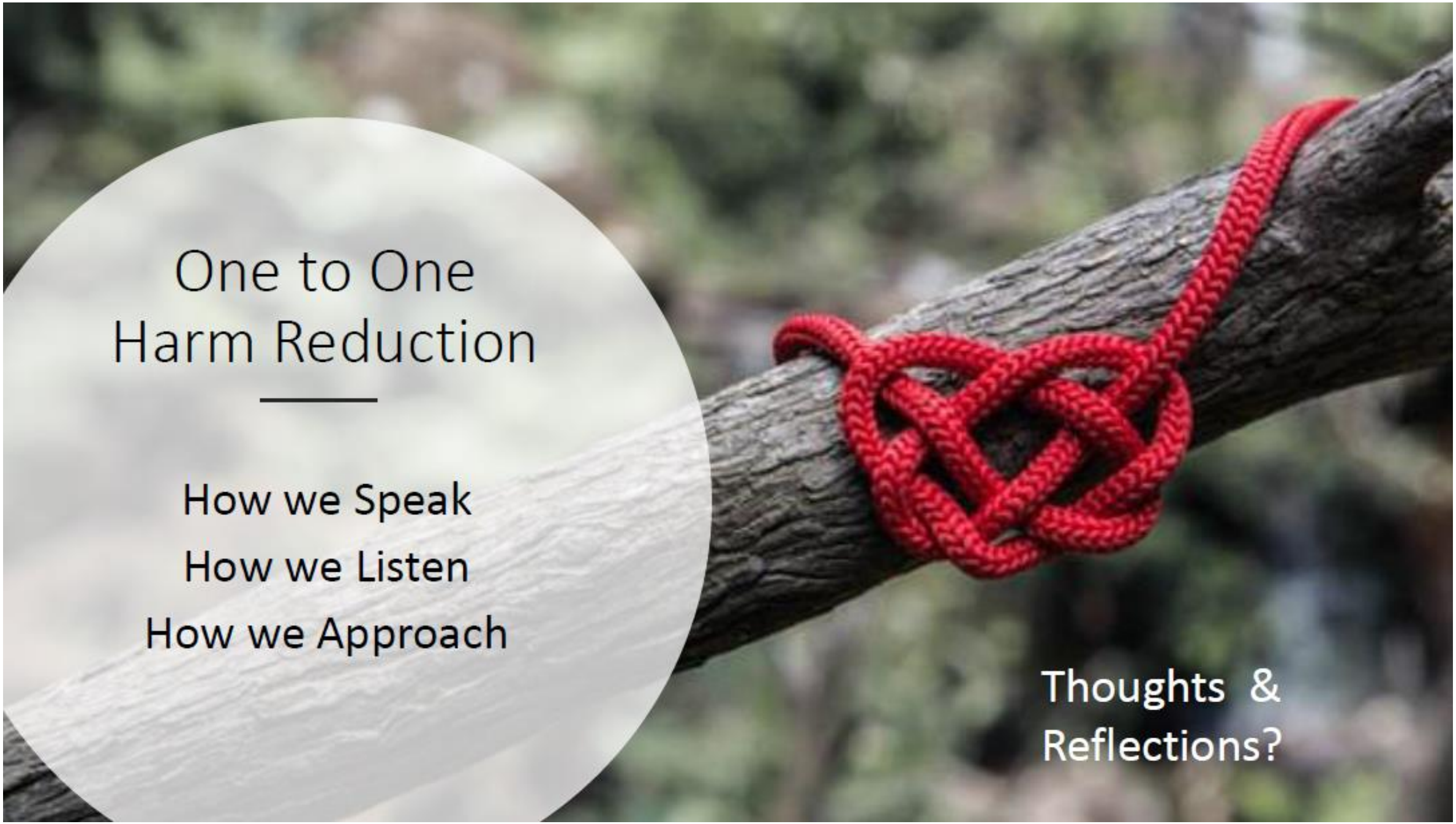
Use Reduction	Harm Reduction
• Ultimate goal is abstinence	• Goal is to reduce harm
• Use and problems are in 1:1 agreement	• Risk of problem is variable and individually based
• Prescriptive: professional "prescribes" treatment	• Predictive: helping client assess their risk for harm
• **Professional knows best!**	• **Client knows better!**

Source 2019 UW HaRRT Center

How to Convey a Harm Reduction Mindset



Source 2019 UW HaRRT Center



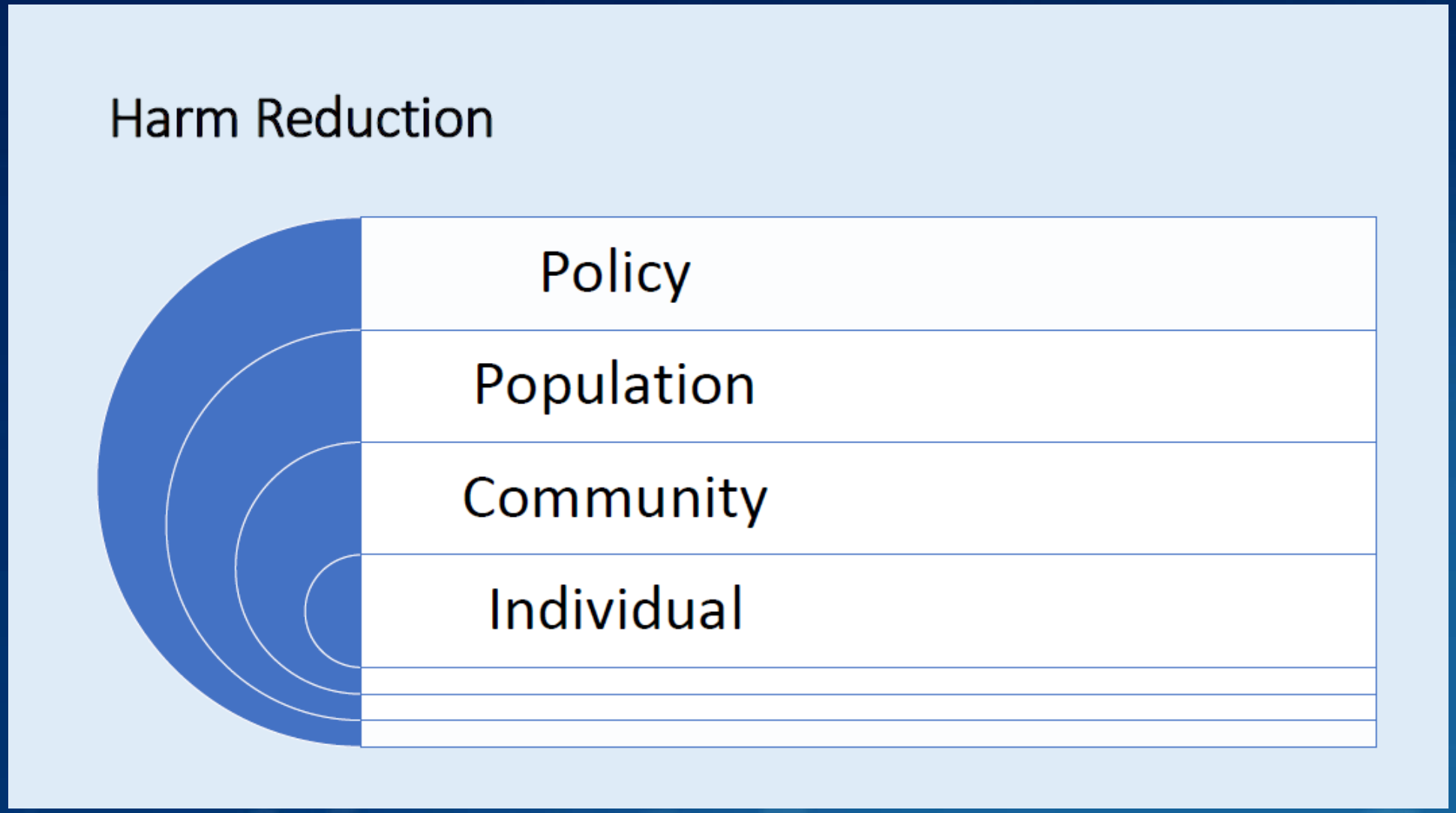
Source: Jude Leahy, Oregon Health Authority

Harm Reduction principles: Opening the Door

One-to-One Harm Reduction work begins with…

- Honoring the patient
  - *I am really glad to see you today*
  - *How was it getting here for you?*
    - listen for ways the clinic/hospital can support them to engage in the future
- Addressing Acute Need
- Inviting a conversation about substance use
  - *I would like to ask about substance use, is that okay?*
  - *Tell me a bit about how/what you are using*
  - *Do you have any questions you about your use today?*
  - *What would you like to see happen for you with regards to [patient's priority]?*

Harm Reduction Approach



PWID Service Update: Harm Reduction In The Field

9:30 AM – 10:10 AM

- OHA Update: CCO 2.0 & Measure 110, **Sam Byers MPA**
- Addiction Toolkit, **John Nusser MD MS**
- Addiction Technology Transfer Center Network (ATTC), **Jan Schnellman MEd**
- Syringe Service Programs, **Jude Leahy MPH**
- Prime+ Peer Program, **Hannah Roy & Sabrina Garcia**

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Oregon Health Authority Update: CCO 2.0 & Measure 110

Samantha Byers, MPA
Opioid Rapid Response Project Manager
Health Systems Division, Oregon Health Authority

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Oregon Health Authority Update: CCO 2.0

- Requires the following:
  - CCO full responsibility of the behavioral health benefit
  - Behavioral health benefit to be part of the global budget
  - Integration of physical and behavioral healthcare
  - Requires CCOs to address SDOH
  - Comprehensive behavioral health plan developed with the LMHA (Local Mental Health Authority), community stakeholders and partners

Oregon Health Authority Update: Measure 110

- **Measure 110**
  - Decriminalizes small possession charges
  - Fee associated with citation can be waived with participation in a comprehensive behavioral health screening
  - Centers peer work to engage and support individuals needing behavioral health services

Implementation currently in development
Likelihood of disclosure about use history without fear of incarceration

Addiction Toolkit

John Nusser, MD, MS, FAAFP
PeaceHealth

MWAETC

John Nusser's addiction tool kit

- Rehab / AA&NA / Counseling / Church
- Harm reduction
- Meds for alcohol
- Meds for meth
- Meds for opioid use disorder (MOUD):
  naltrexone, methadone,

  buprenorphine/naloxone

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Zoom polling for clinicians

Are you:

- Not interested in getting waivered for buprenorphine
- Waivered but not prescribing
- Prescribing a bit
- Prescribing with ease

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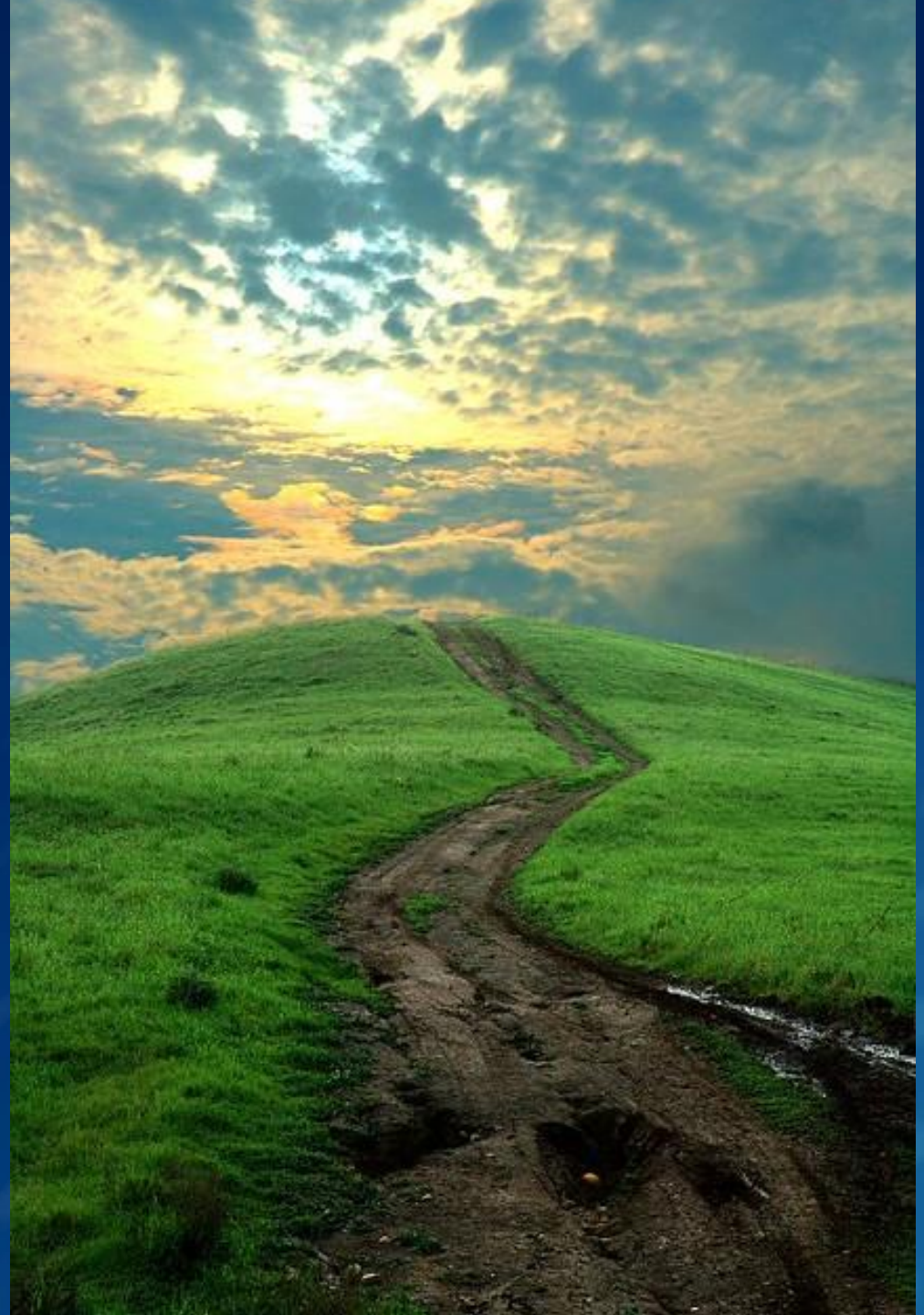

Addiction Technology Transfer Center Network (ATTC)

Jan Schnellman, MEd
Technology Transfer Specialist, ATTC

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ATTC

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  - 44th Annual Alaska School on Addictions and Behavioral Health 05/07/2018 - 05/09/2018
  - Oregon 2018 Conference on Opioids, Pain & Addiction Treatment 05/17/2018 - 05/19/2018
  - 34th Annual Idaho Conference on Alcohol and Drug Dependence 05/22/2018 - 05/24/2018

Northwest Addiction Technology Transfer Center

The Northwest Addiction Technology Transfer Center (NWATTC) provides services to develop and strengthen the substance use disorder treatment and recovery workforce in Alaska, Idaho, Oregon, and Washington.

Located at the University of Washington's Alcohol & Drug Abuse Institute as of October 2017, the NWATTC seeks to accelerate community-based implementation of evidence-based practices (EBPs) for treatment and recovery by:

- Sponsoring training online and in-person to enhance clinical knowledge and skills, and adoption of EBPs,
- Providing intensive technical assistance to support systems change and organizational efforts to implement EBPs,
- Offering consultation for systems-level change in the emerging new landscape for behavioral health care,
- Disseminating science-based information on EBPs, cultural competence, and more.

Areas of EBP Expertise:

- Motivational Interviewing/Motivational Enhancement Therapy
- Screening, Brief Interventions, and Referral to Treatment (SBIRT)
- Healing of the Canoe
- Co-occurring Disorders Treatment
- Contingency Management/Motivational Incentives
- Cognitive Behavioral Therapy
- Recovery-Oriented Systems of Care

Take Our Workforce Survey!

We want to know **what content and processes YOU prefer** in educational events. Take our **short survey** to help us assess the workforce needs in our region!

Find the survey here!

Please feel free to **share the link with your colleagues**; the more information we can collect, the better we can help you help others!

http://attcnetwork.org/northwest

Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.

- The ORN accepts requests for education and training.

- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Working with communities to address the opioid crisis

- To ask questions or submit a technical assistance request:
  - Visit www.OpioidResponseNetwork.org
  - Email str-ta@aaap.org
  - Call 401-270-5900
- Jan Schnellman, TTS
  - WA/OR/AK
  - janeric@uw.edu

- SAMHSA's State Targeted Response Technical Assistance (STR-TA) grant created the *Opioid Response Network* to assist STR grantees, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis .
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Syringe Service Programs (SSPs)

Judith Leahy, MPH
Viral Hepatitis Coordinator
Public Health Division, Oregon Health Authority

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The continuum of care

Harm Reduction is not the only solution—but is a critical element to support hope, healing and health.

Harm Reduction
Syringe Access & Syringe Service Programs

Late 1980s

1987: Oregon's drug paraphernalia law excludes syringes (deregulation)

1988: The US Congress enacted a prohibition on the use of federal funds for SSPs through section 300ee-5 of the Public Health and Welfare Act.

Public Health and Welfare Act permitted lift of federal prohibition in the future if the Surgeon General determined SSPs were effective.

1989: Outside In opens its Syringe Exchange

Early 1990's

Emerging scientific evidence that syringes distributed could prevent HIV transmission among persons who injected drugs.

Disability Activism in US "Nothing About Us Without Us"

1993: Harm Reduction Working Group meets in San Francisco. This starts the Harm Reduction Coalition

1995: Institute of Medicine (IOM) panel reviewed HIV Prevention evidence and recommended that the US Government lift syringe funding restriction.

1995: CDC review of SSPs scientific evidence

Late 1990's

1997: Congress passed Public Law 105-78; allowing federal funding for SSPs if the Secretary of HHS endorsed the scientific evidence.

1997: Secretary of HHS Dr. Donna Shalala endorsed SSP evidence.

However, the funding restriction was not repealed.

1998: National Community Health Advisor Study identifies CHW core roles, competencies

2000's

2001-2009: Federal syringe prohibition in place.

Multnomah County establishes Community Capacitation Center to provide training for CHWs

CDC funds Poder de Salud/Power for Health

Bureau of Labor Statistics assigns CHW's an occupation code

Early 2010's

2010: The FY2010 Consolidated Appropriations Act prohibition of the use of federal funds to purchase syringes.

2010: CDC and states developed guidance documents for SSPs

2011 OCHWA founded

2012: Syringe funding ban reinstated in the Labor-HHS spending bill for US programs Consolidated Appropriations Act of 2012

Late 2010's

2015- CDC Community Health Worker Brief

2016-2018: Federal appropriations language allows DHHS to fund, under certain circumstances, SSPs, except for syringes or needles.

CDC consultation required to determine if a jurisdiction is experiencing or at-risk of significant Increases in hepatitis or HIV infections.

2017: Oregon successfully completes CDC consultation process.

2017-2018 Oregon CHW needs assessment

2019: Oregon HB 2257 Provides affirmative defense to unlawful possession of controlled substance for employee or volunteer of syringe services program.

2020's

Center for Health Care Strategies Policy Brief on how CHW workforce contributes to the health care system

2020: ORS 475.757 Syringe service program as affirmative defense to unlawful possession of controlled substance

2020: Oregon voters pass Measure 110

HR, SSPs, CHW and Peer Support have important roles in the COVID-19 Response for people with lived experience of substance use

Judith.m.leahy@dhsoha.state.or.us

Harm Reduction

Providing **naloxone to lay persons reduces overdose deaths and is safe and cost effective**.

People who use drugs perform most bystander overdose reversals. Organizations that provide naloxone kits to people who use drugs can reach large numbers of potential overdose bystanders.

People who use syringe service programs are **five times more likely to enter drug treatment** and **three times more likely to stop using drugs** than those who do not use syringe exchange programs.

Harm reduction programs, such as syringe service programs, are proven to **reduce HIV and HCV infection rates by 50%.**

When syringe service programs are combined with medications that treat opioid dependence, **HIV and HCV transmission are reduced by more than two-thirds**.

COVID-19 Basic Prevention Kit

Item #	Description	Price	UOM	Qty per kit	
1111746-bx	Hand Sanitizer w/Aloe 0.9 Gram Ethyl Alcohol Gel, Individual Packet (144/box)	$ 11.69	144	7	$ 0.57
461752-cs	Hand Sanitizer with Aloe Purell, 2oz. Alcohol (Ethyl) Gel Bottle (24/case)	$ 25.61	24	1	$ 1.07
119925-cs	Dial antibacterial soap, 2.5 oz individually wrapped bar (200/case)	$ 64.47	200	1	$ 0.32
1162051-cs	Procedure Mask McKesson Pleated Ear Loops - One size fits most BLUE (36BX/CS) (1,800 masks)	$ 807.57	1,800	7	$ 3.14
911643	zip close bag	$ 28.27	1,000	1	$ 0.03
					$ 5.13

Harm Reduction Supply Kit

Item #	Description	Price	UOM	Qty per kit	
942669-bx	28g 0.5" 1mL syringe	$ 7.69	100	10	$ 0.77
464713-bx	tourniquet	$ 20.90	250	10	$ 0.84
466878-bx	adhesive bandage	$ 2.64	100	10	$ 0.26
191089-cs	alcohol wipe	$ 29.70	4000	10	$ 0.07
2001-cs	cooker	$ 263.00	5000	10	$ 0.53
1002-bx	cotton pellet filter	$ 21.00	15,500	20	$ 0.03
3003-pk	twist tie	$ 22.00	2,000	1	$ 0.01
957784	zip close bag	$ 21.07	1000	1	$ 0.02
					$ 2.53

To Go Kit Costs

Wound Care [tape] kit	$ 1.07
Fentanyl Test Strip kit	$ 1.01
Injectable Naloxone kit	$32.33
Nasal Naloxone kit	$106.42

Harm Reduction and Syringe Service Programs

Region	Harm Reduction or Syringe Service Programs in Oregon
Benton	Benton County Public Health
Clackamas	Outside In
Clatsop	Clatsop County Public Health
Curry	HIV Alliance
Deschutes	Deschutes County Needle Exchange Program
Douglas	HIV Alliance
Harney	Harney County Syringe Exchange Program
Jackson	Jackson County Syringe Exchange Program
Josephine	HIV Alliance
Lane	HIV Alliance
Linn*	Linn County Public Health
Lincoln	Lincoln County Harm Reduction Program
Malheur	Malheur County Health Department
Marion	HIV Alliance
Multnomah	Outside In
Multnomah	Multnomah County Syringe Exchange
Multnomah	Portland People's Outreach Project
Confederated Tribe of Siletz Indians*	Tribal Healthcare Services
Washington	HIV Alliance
Yamhill	Provoking Hope
Umatilla	Eastern Oregon Center for Independent Living

Essential tasks to tackle

Improve the process for community-based organizations to order and distribute naloxone to people at risk of overdose.

Increase community and provider understanding of the evidence-based interventions that are part of the continuum of care for substance use disorder.

Change the narrative around substance use disorder to one of equity, resilience, recovery and hope.

Secure funding to expand Harm Reduction and Syringe Service Programs and breadth of the harm reduction supplies identified by our community stakeholders needed to save lives in Oregon.

Prime+ Peer Program

Sabrina Garcia
Peer Support Specialist
Transformation Wellness Center, Klamath Falls

Hannah Roy
Certified Recovery Mentor/ Health Specialist
Malheur County Health Department

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Prime+ Peer Program

PRIME+ peers can

- Provide naloxone, the overdose reversal drug
- Provide information about overdose prevention and safer use strategies
- Help you figure out your needs and work with you on the steps to meet them
- Assist you with Oregon health plan (OHP) sign-up
- Go to medical, housing, counseling, and other types of appointments with you
- Connect you with substance use counseling and treatment
- Connect you to hepatitis C testing and treatment

Peers from Coos Bay

Discussion

Break

10:10 AM – 10:25 AM

Naloxone TED talk:
What? Why? Who? How?

John Nusser, MD, MS, FAAFP
PeaceHealth
Oregon AIDS Education and Training Center (AETC)

Reverse Overdose Oregon

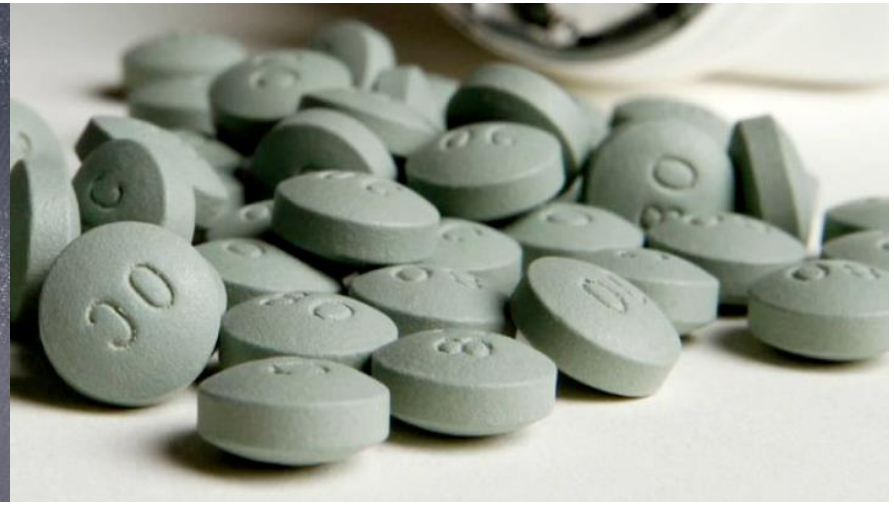
Last Updated: November 2020

The Oregon HOPE Series

What? Naloxone reverses overdoses

Why?

- Overdose: The leading cause of injury death in US
- Opioids are associated with 80% of these deaths
- Every 12 minutes, a person in the US ODs & dies



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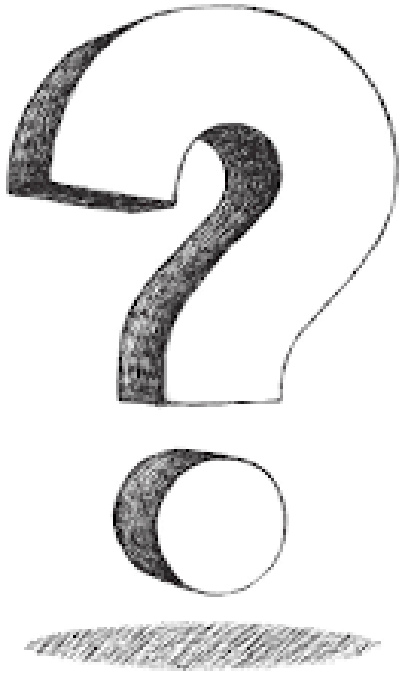
Why are we here?

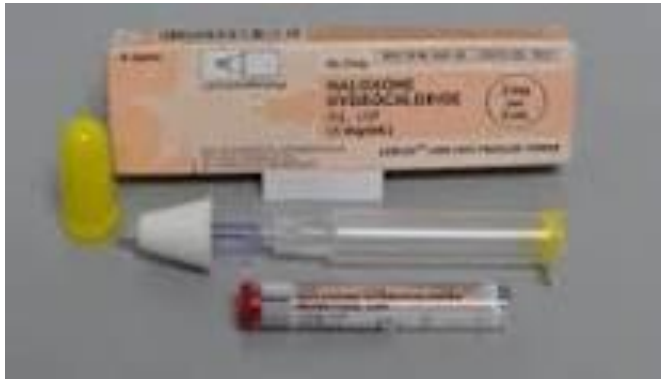


Let’s chat.

Primary care people: How often do your colleagues prescribe naloxone? For whom?

Peers & non-clinic folks: Would your community benefit from greater access to naloxone?

Everyone: How do we increase access?



Walley BMJ 2013

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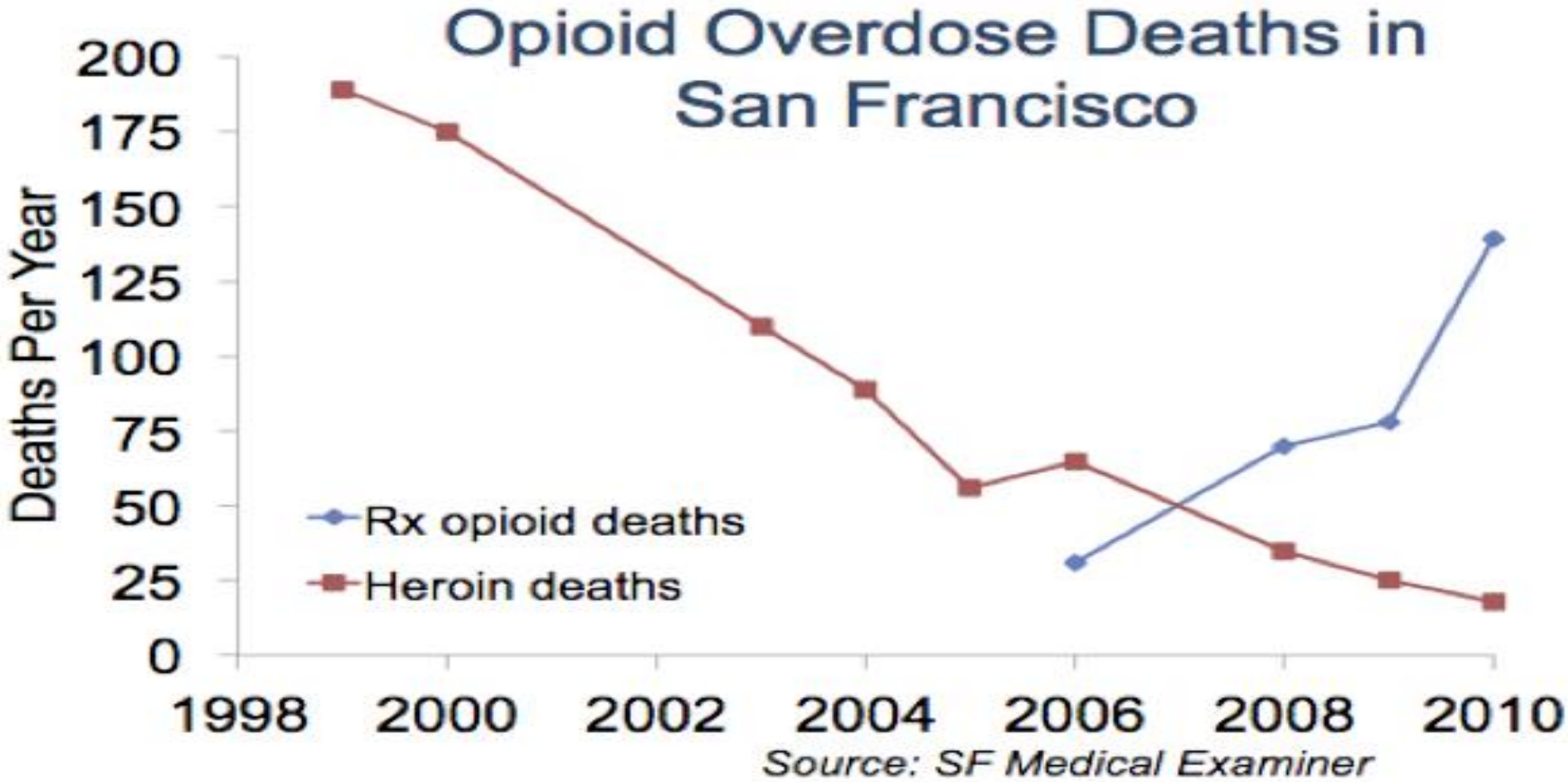
Why naloxone?



Overdose fatality rates are lower in counties with higher naloxone implementation[1]

Who?

CDC Guidelines for Managing Chronic Pain[8]

- Consider offering naloxone when factors that increase risk of overdose are present. e.g.
  - History of overdose
  - History of substance use disorder
  - ≥50 MME/day
  - concurrent benzodiazepine use

Slides thanks to Diana Coffa,UCSF

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My ask of clinicians:

Recommend naloxone for:

all your patients

taking chronic opioids,

suboxone,

or IV drugs.

How: Discussing naloxone with patients who are prescribed opioids

- Normalize –

"These medicines can be very strong and it's easy to have a bad reaction to them. So I give all of my patients this antidote in case that happens."

- Avoid the word "overdose"
  - –Patients equate it with heroin, addiction, and illicit use
  - –Many do not identify as being at risk for overdose.

Slides thanks to Diana Coffa,UCSF

How?

- Naloxone 4mg/nasal spray. May repeat in 2 min #2, Refill 1
- Many insurances have no co-pay
- Cash price $30-$50.
- Free at many syringe exchanges

How?: Who should initiate?

- Providers
- Templates
- Panel management
- Counselors
- Pharmacists
- Employers
- Patients
- Public

No Rx required

Portland Business Journal 11/18/2019

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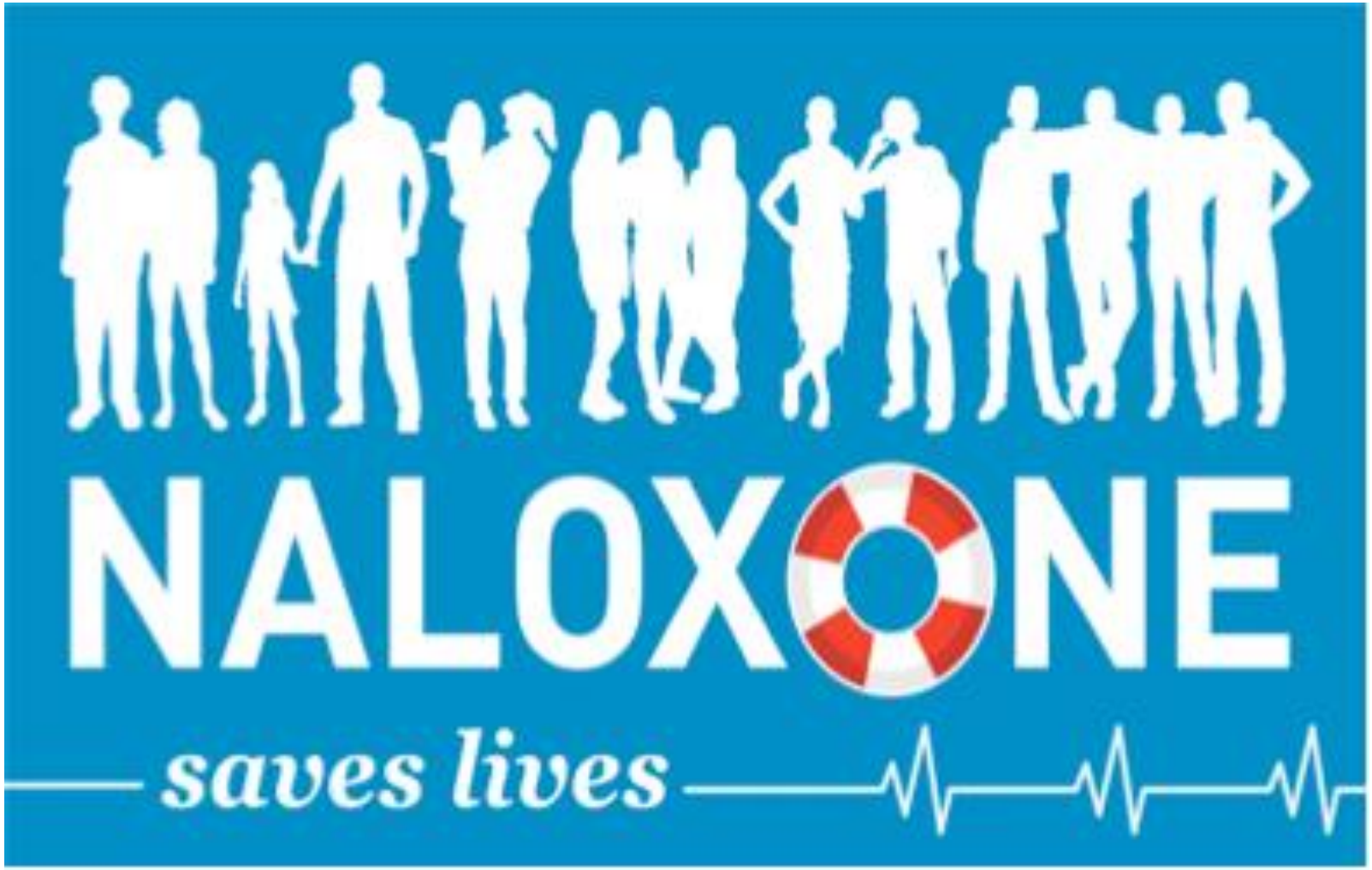
Let’s chat! How do we do this better together?



https://www.fda.gov/consumers/consumer-updates/having-naloxone-hand-can-save-life-during-opioid-overdose

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Break-Out Sessions by Region

10:30 AM – 11:00 AM

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Instructions

- Use the chat to introduce yourself and your role in working with people who inject drugs
- The Note Taker will put the Case Up for everyone to read and think about their role.
- Describe the case and steps you would take to assess how this patient interacts with the healthcare system, during and following the visit.
- Think about the collaborative ways you can leverage resources in your community to serve this population.

Miguel

Miguel's friend dropped him off at the emergency room in a rural community due to a painful abscess. He had tried cut it open and drain the pus two days prior. The triage nurse records the following:

- 38 year old, white male with an abscess of concern on his left shoulder
- Temp: 99.5
- HR: 80
- BP: 132/87

1. Who will this person interact with during and after this healthcare visit?

2. How could a harm reduction approach be used by each member of the team to support this person?

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If you decide to order labs/ask more…

Other things about Miguel: Identifies as a cisgender man, reports sex with cisgender women; currently sleeps on a friend's couch – dependent on friend for transportation; has traded sex for drugs in the past (receptive anal intercourse)

- Urine Drug Screen (UDS) – positive for amphetamines
- No past record of screening for viral hepatitis/HIV
- HIV 4th generation sent to lab (blood draw) – 3 days later results negative
- Viral hepatitis panel sent to lab (blood draw) – 3 days later results positive for HCV
- Wound culture – positive for *Staphylococcus aureus* – Results available 24 hours later
- Syphilis screening – 3 days later positive RPR
- Gonorrhea and Chlamydia – 3 days later results negative

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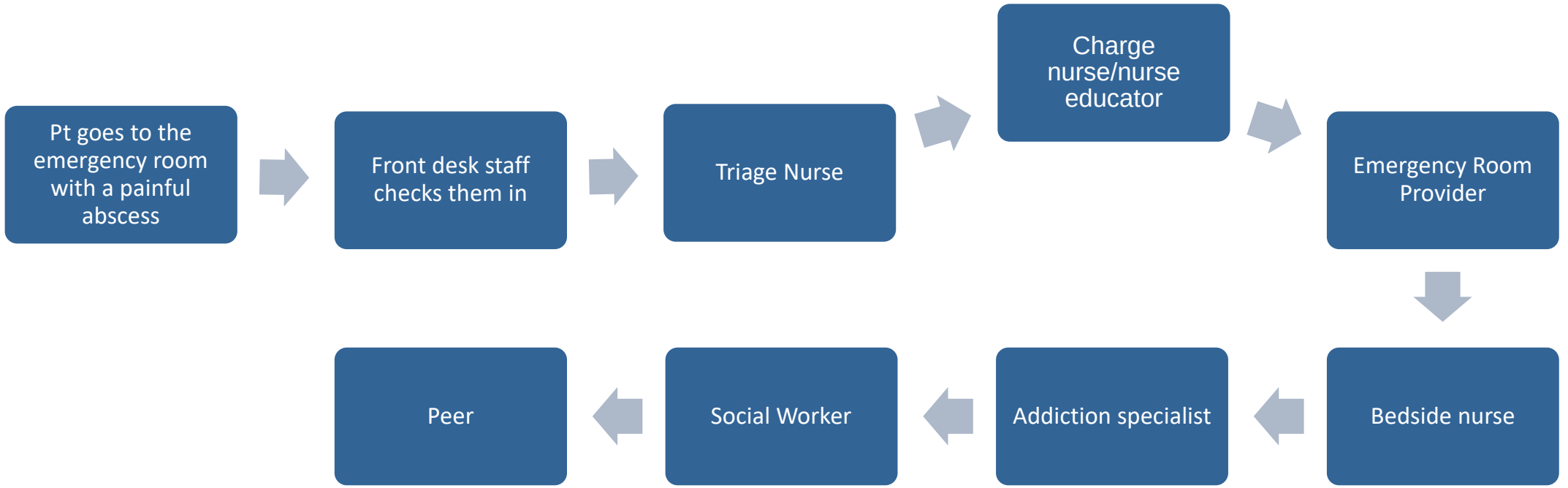
Who does Miguel interact with in **Southern Oregon**

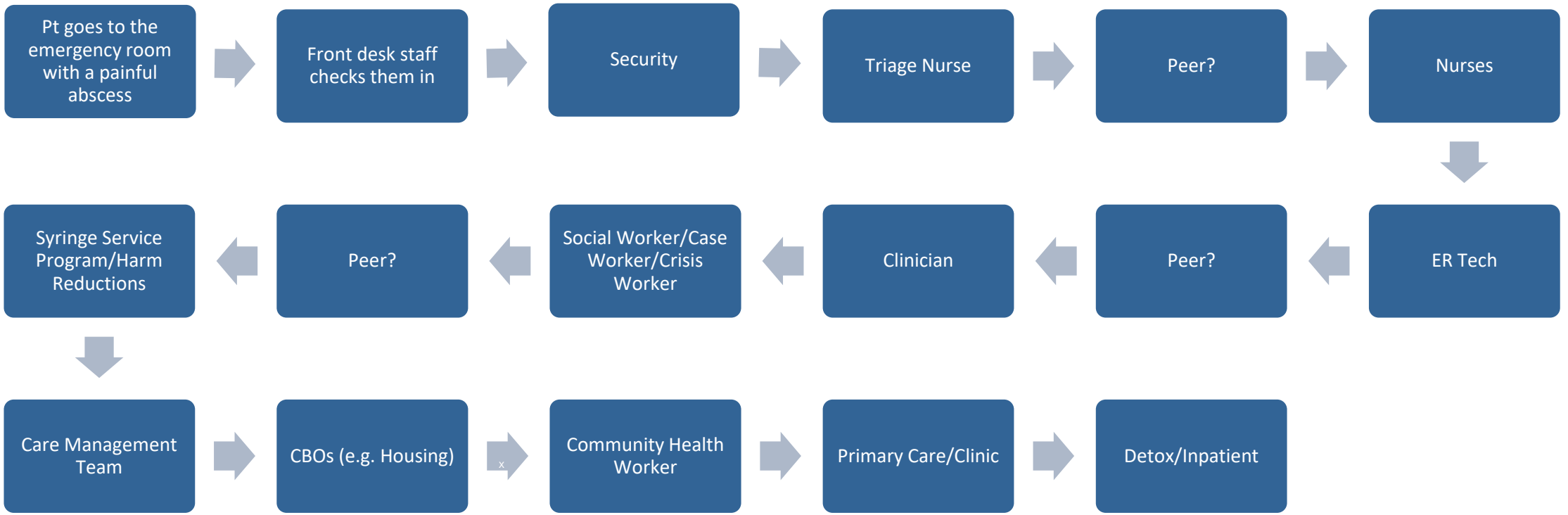


How can a harm reduction approach improve the patient's experience within the healthcare system – **Southern Oregon**

Remove judgement from all roles. All roles should incorporate naloxone prescribing, referral to syringe services, assessing risk for STIs, identify individuals who could benefit from these services

Waiting Room	Front Desk staff	Triage Nurse	ER Provider	Bedside Nurse	Addiction Specialist	Social worker	Peer
	Ask questions about risk without judgement to identify opportunities						

Who does Miguel interact with in **Central/Eastern Oregon**



How can a harm reduction approach improve the patient's experience within the healthcare system - **Central/Eastern Oregon**

List examples of how harm reduction can be used by the different roles in your patient's experience.

Waiting Room	Triage Nurse	Provider/Nurse	Social Worker/Nurse?	Provider/Peers/SSP	Care Management Team
Approach to asking people about Masks (being trauma informed) Offer a shield/alternative if possible)		Informing on wound care – CO-LEARNING	Ideal to leave with sterile syringes and/or how to get them in the future	Access to naloxone/naloxone boxes – actual kit	Priorities during the pandemic – providers in Eastern Oregon are traveling and don't always know local resources, how to utilize nurses or consistent staff
				Give peers naloxone kits to hand out in the community	

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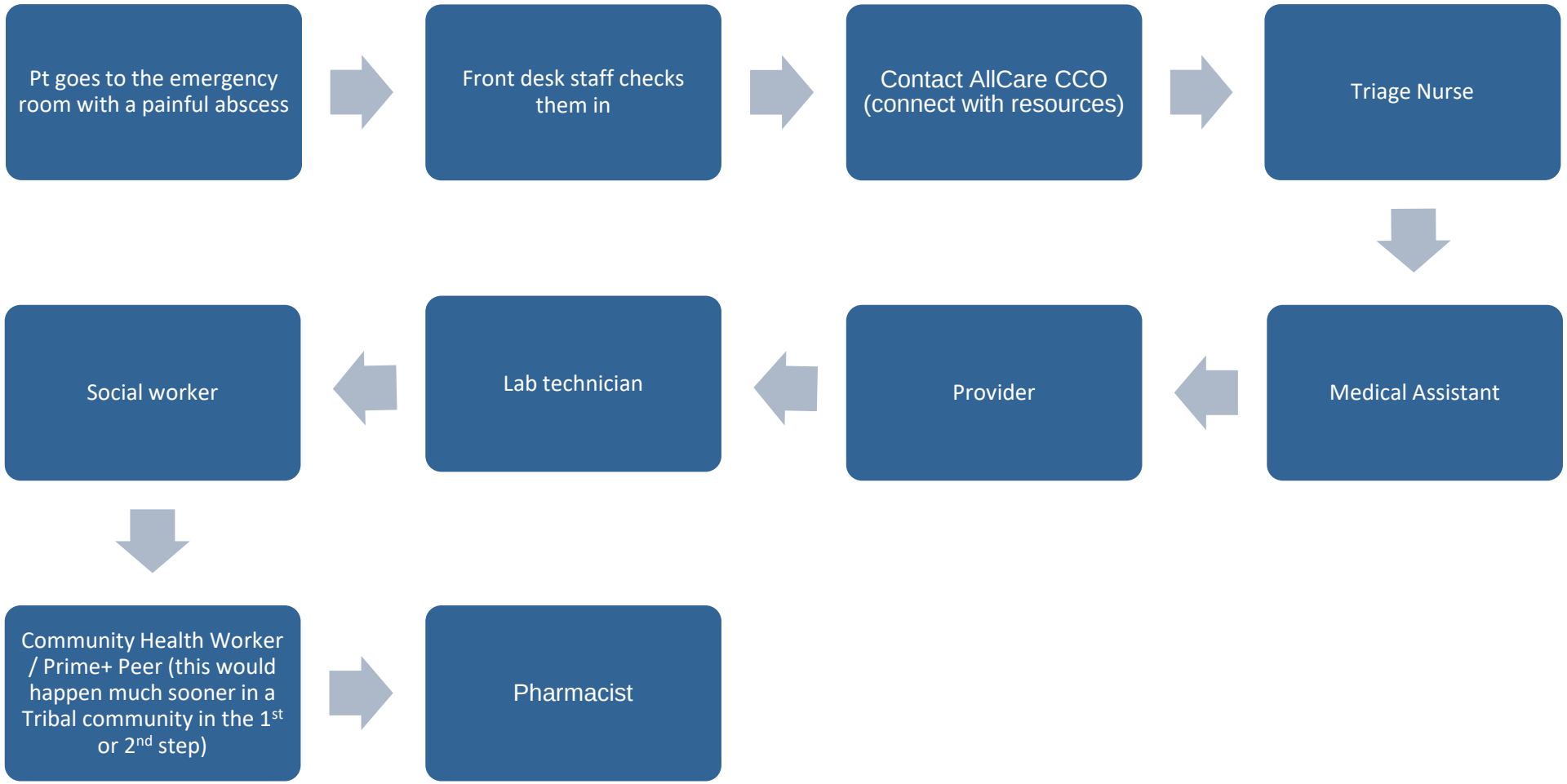
Who does Miguel interact with in **Lincoln/Linn/ Benton/ Lane counties**



How can a harm reduction approach improve the patient's experience within the healthcare system – **Lincoln/Linn/Benton/Lane counties**

List examples of how harm reduction can be used by the different roles in your patient's experience.

Waiting Room	All CAre	Triage Nurse	Medical Assistant	Provider	Peer/CHW
How they react to the person; body language/being judgmental or not; checking biases			More compassion	More compassion	Convincing them that they need care
Being treated with empathy				Discuss why he's there to start with	Advocating for what works the individual patient
				Risk reduction	Focusing on what the patient needs or wants
				Hygiene?	Picking up meds
				Get waivered	Building relationship with them
				Refer to out-patient	
				Narcan	

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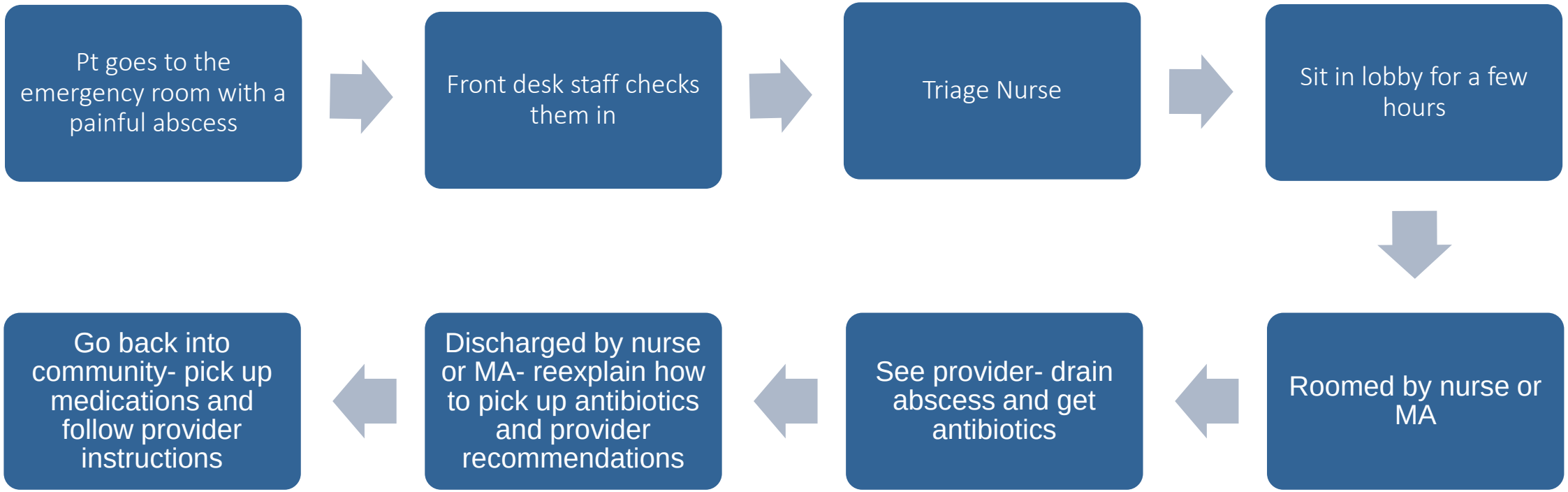
Who does Miguel interact with in **Washington/Clackamas/Yamhill counties**

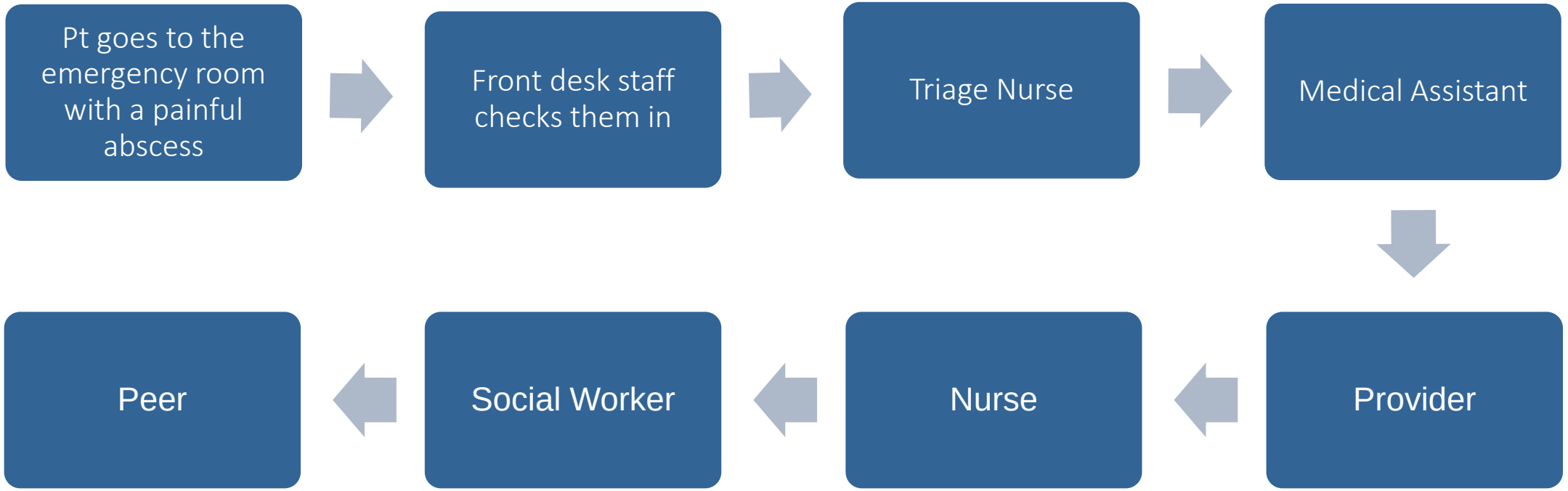


How can a harm reduction approach improve the patient's experience within the healthcare system in **Washington/Clackamas/Yamhill counties**

List examples of how harm reduction can be used by the different roles in your patient's experience.

Waiting Room	Triage Nurse	Sit in lobby for a few hours	**Roomed by nurse or MA**	**See provider- drain abscess and get antibiotics**	**Discharged by nurse or MA- reexplain how to pick up antibiotics and provider recommendations**	**Go back into community- pick up medications and follow provider instructions**
Create a safe place waiting space by adding Posters- "recovery is hope" "ask us" "we care" etc.	Inform patient why they are receiving a drug screen and what will be done with the information- hospital will not call probation officer for example	Similar to waiting room	Tell patient they are glad they are there receiving services- provide encouragement even though it may be hard and painful for the patient to access care	Providers can talk about drug use in a non-stigmatizing way. Providers need to confront these issues, regardless of if they are uncomfortable about it or not		
Behavioral health can be integrated here- peers can sit with them while they are waiting						

Who does Miguel interact with in **Multnomah County**



How can a harm reduction approach improve the patient's experience within the healthcare system in **Multnomah County**

List examples of how harm reduction can be used by the different roles in your patient's experience.

Waiting Room	Triage Nurse	Medical Assistant	Provider	Nurse	Social Worker
Images on Television, advertisements, images of people displayed on art, trauma informed lens. Trauma informed Oregon has an assessment that could help	Could ask if person needs Naloxone	Using non-stigmatizing and inclusive language Cultural inclusivity as well.	Using non-stigmatizing and inclusive language Cultural inclusivity as well.	Using non-stigmatizing and inclusive language Cultural inclusivity as well.	Using non-stigmatizing and inclusive language Cultural inclusivity as well.
Clear signage	Using non-stigmatizing and inclusive language	Awareness in talking about what is a 'safe place' for everyone. Safe might differ for clients.	Referring to services that might work best for patient. For instance, needle exchange.	Education about withdrawal, cravings, substance use disorder (harm reduction approaches) important. Nurse can be first point of contact with patient, with multiple interactions.	
Peer specialist to welcome patient at check in. A peer could meet someone in the waiting room and walk through the whole process with the patient. Or could check in at different points of time in visit.	**Staff with lived experience at all levels**	Training for all staff on appropriate language about Harm Reduction and what it means. Specifically nursing staff.	Provider to patient experience: "what is on your list of things to do today?"		
Vending machines with Naloxone					

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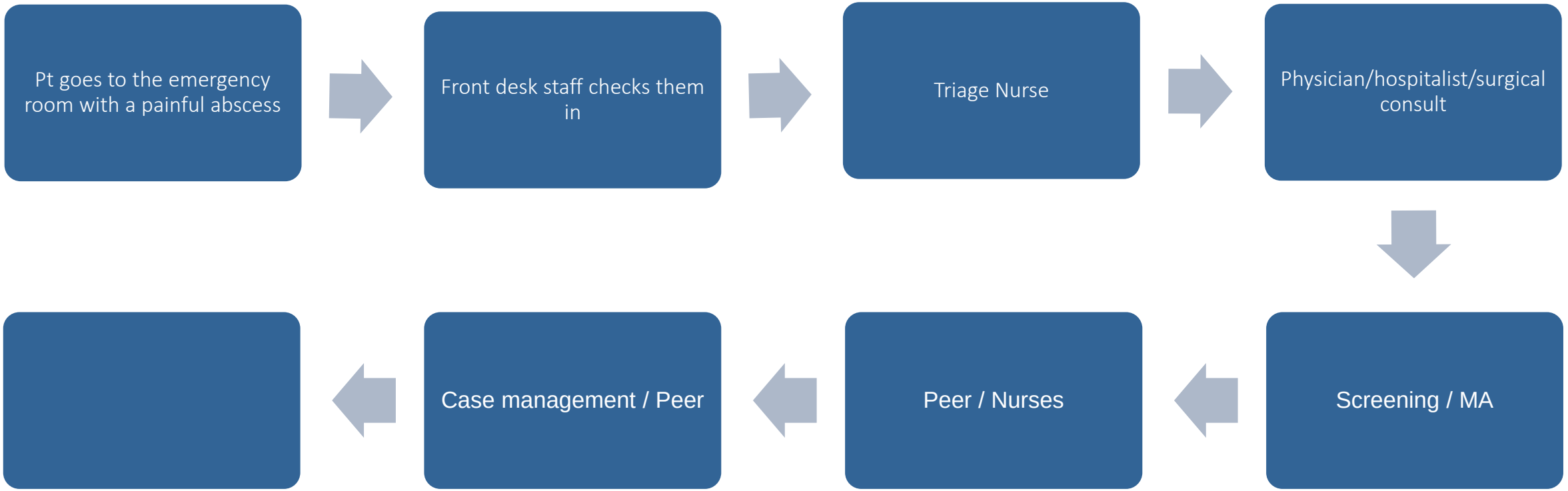
Who does Miguel interact with in **Outside of Oregon**



How can a harm reduction approach improve the patient's experience within the healthcare system in **Outside of Oregon**

List examples of how harm reduction can be used by the different roles in your patient's experience.

Waiting Room	Front Desk	Triage Nurse	Provider	Case Manager
	Insurance eligibility	Screening / MA	hospitalist	Peer support
			Plastics consult	Patient educator
				Connect with recovery coach

Miguel

In this case the abscess is treated and bandaged; the patient is given a prescription for antibiotics and discharged. Miguel sits down and falls asleep in the lobby.

Who does this person interact with in the hospital prior to discharge?

Were there missed opportunities?

- Who does this person interact with following discharge?

Were there missed opportunities?

- If the patient was hospitalized instead, what other healthcare providers would the patient interact with and how can harm reduction be used in inpatient care.

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Report Back

11:00 AM – 11:15 AM

Report Back

- Briefly review 3 regional maps with the larger group
  - What similarities and differences to you notice by region?
- What harm reduction strategies inspired and/or resonated with you in your discussion?

Next Steps…

- What would an ideal scenario look like
- What things are in place now that allow this scenario to happen, what are the barriers to the “ideal scenario” for this patient?

Video Featuring:

Jessica Gregg, MD, PhD

Addiction Medicine Specialist

Oregon Health & Science University

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Primary Care for People Who Inject Drugs

11:15 AM – 12:00 PM

Sean Mahoney, PWS, CRM
John Nusser, MD, MS

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Primary Care in People Who Inject Drugs

John Nusser, MD, MS, FAAFP
PeaceHealth
Oregon AIDS Education and Training Center (AETC)

Sean Mahoney, PWS, CRM
Peer Manager
EVOLVE Peer Delivered Services at the Mental Health and Addiction Association of Oregon (MHAAO)

MHAAO is an inclusive peer-run organization dedicated to self-direction honoring the voice of lived experience.

The Oregon HOPE Series

Objectives

- Describe how to reduce infections in people who inject drugs
- Discuss screening & treating patients for STIs, Hep C & HIV
- Be introduced to Pre-Exposure Prophylaxis (PrEP)
- Observe harm reduction & write down one technique you'll try

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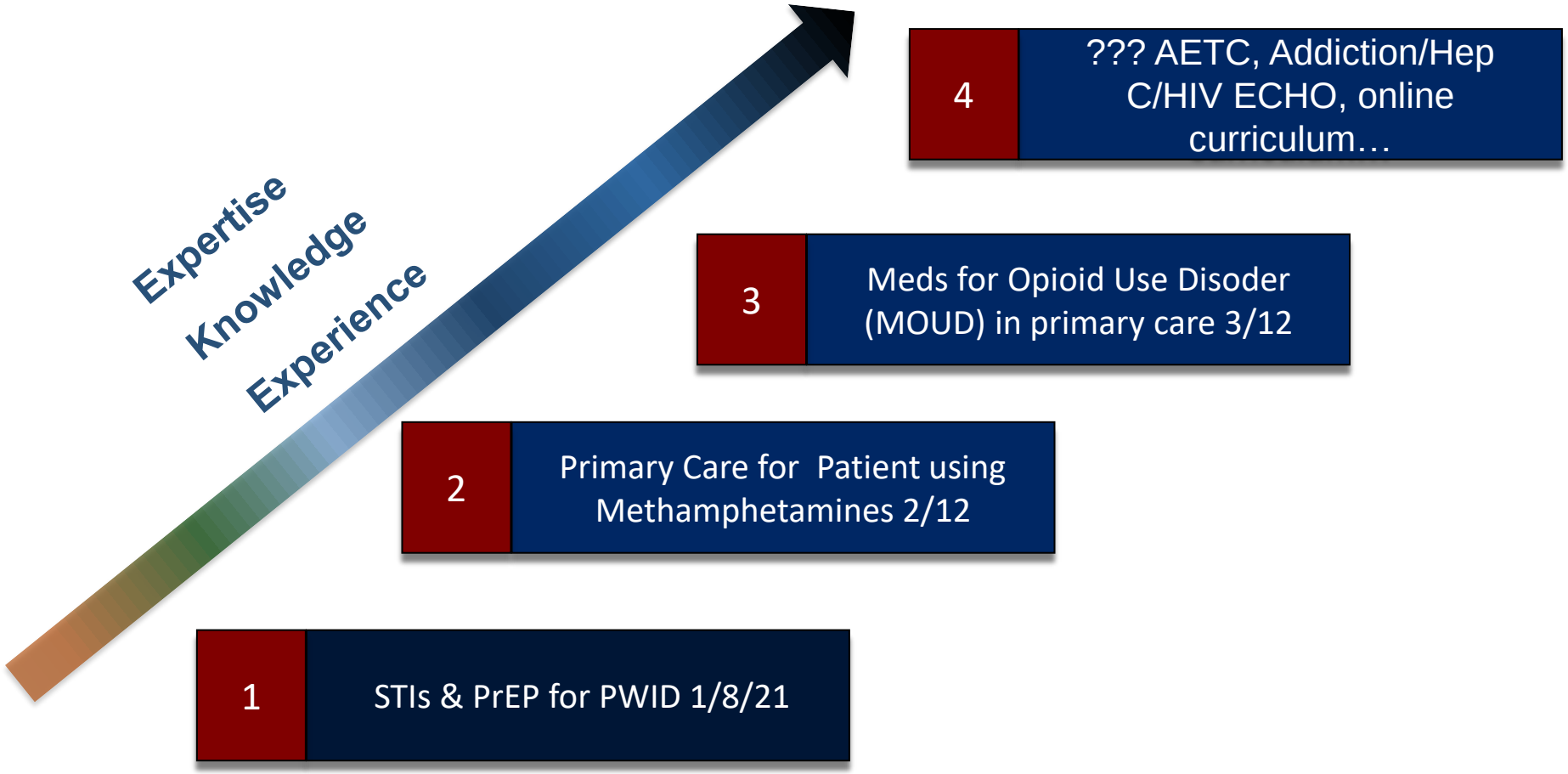
Free Education Opportunities



REDUCING INFECTIONS IN PEOPLE WHO USE IV DRUGS

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Mary

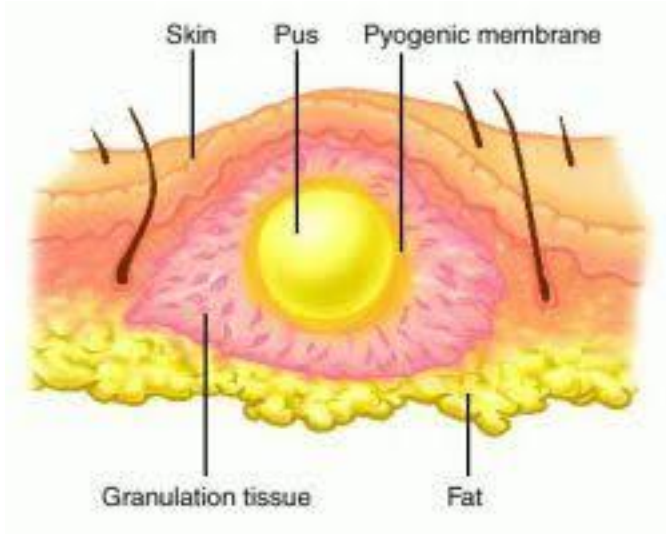
- Mary is a 25 yo woman who has been using meth and occasionally heroin. She usually uses IV. She recently tried skin popping heroin.
- She now presents with a painful 3 centimeter fluctuant area on her left mid thigh. She is afebrile. She wants the pain to go away.

- What do you recommend?

MRSA abscess (methocilin-resistant Staph Aureus)

Basic abscess care:

- Do your best with lidocaine
- Open the lesion, break up loculations, wash.
- Leave opening larger to avoid excessive packing



- Antibiotics not needed for abscess < 2cm per RCT
- If antibiotics are used, bactrim (TMP-S) 1 pill po bid rec'd
- If sulfa-allergic, clinda can be useful.
- Harm reduction is key. What does this look like?

IDSA guidelines Clin Infect Dis. 2014;59(2):147. N Engl J Med. 2016;374(9):823.

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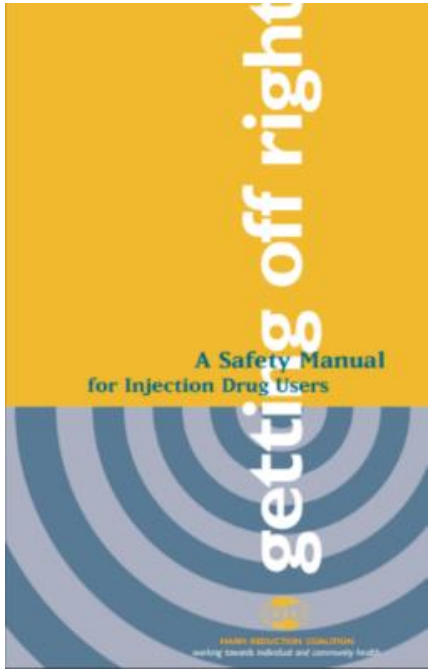
Harm Reduction Can Be:

- Improving abscess care
- Using more safely
- Avoiding skin popping or muscling
- Minimizing sharing works or needles
- Avoiding IV
- Naloxone
- Getting more regular health &/or MH care
- PrEP
- Getting on bup (suboxone) or methadone
- Using less or quitting



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HEP C, STI, & HIV SCREENING

USPSTF, CDC, AASLD/IDSA say screen once:

- Baby boomers (born between 1945-1965)
- *Or anyone with these risk factors:*
- Past use of IV drugs (or intranasal)
- Tattoos done in an unregulated setting
- Prison time
- Hemodialysis
- Elevated liver enzymes

SCREEN ANNUALLY: CURRENT PWID & MEN WHO HAVE SEX WITH MEN (MSM)

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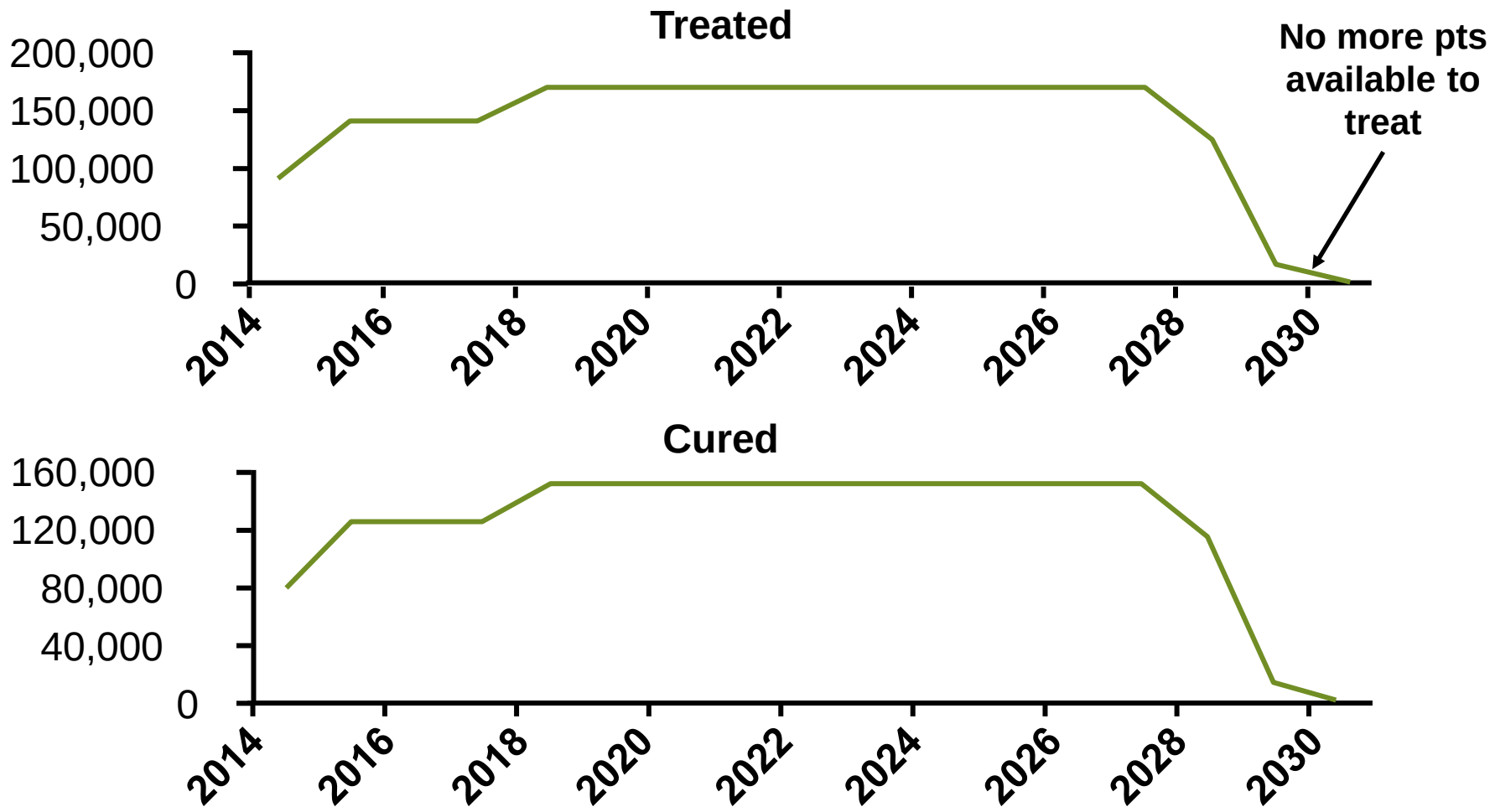
Increasing Use of Effective Therapy Could Eliminate HCV in the US by 2029



Razavir H, et al. Hepatology. 2013;57:2164-2170.

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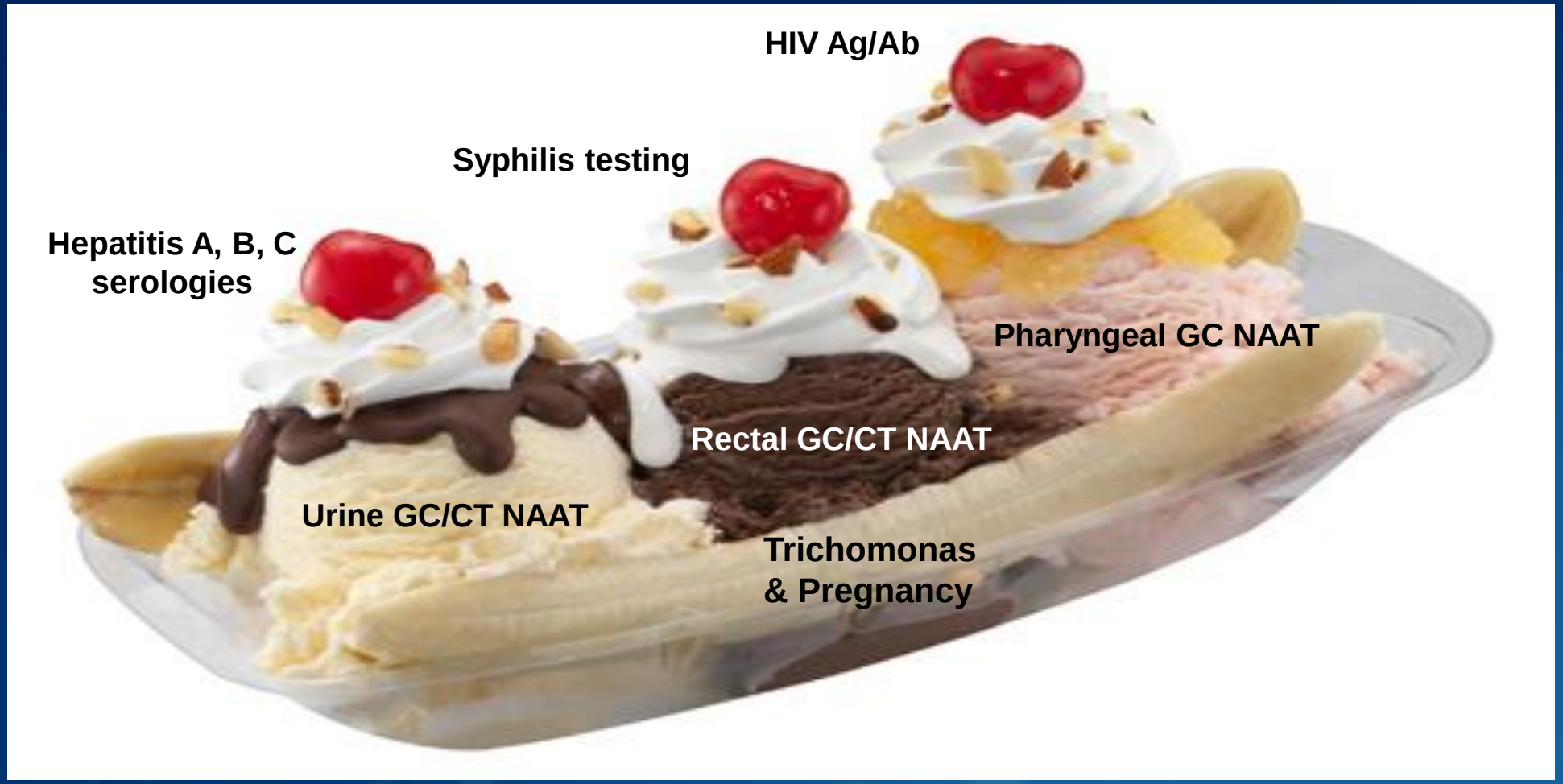
Mary

- Mary's back a few weeks later. She hasn't skin popped anymore.
- Her partner had an "STD", and so she wants to be screened for everything. She is asymptomatic.

- What do you screen her for?

STI/STD Screening options



Taking a Sexual Health History

- Establish a good rapport
- Make no assumptions
- Put it in context (sexual health is part of health)
- Assure confidentiality

Follow with Open Ended Questions:

- How would you describe your intimate relationships?
- Are you currently sexually active?
- Who are your partners?

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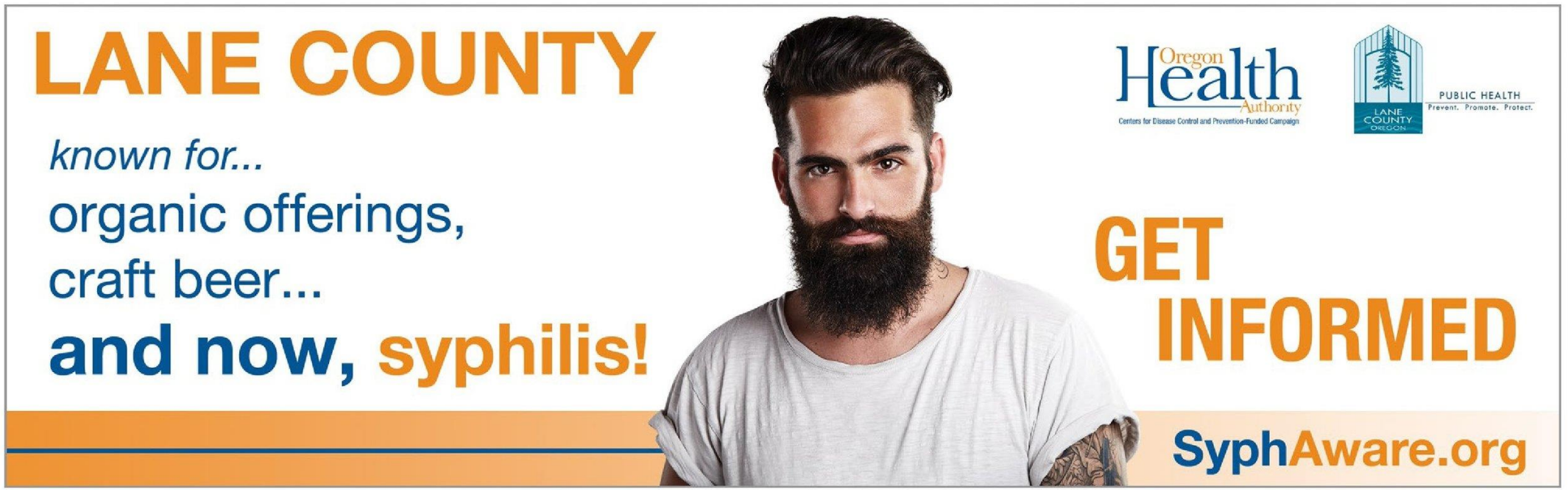
www.syphaware.org



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CDC Treatment Guidelines

CDC STD Tx app

http://www.cdc.gov/std/tg2015/chlamydia.htm

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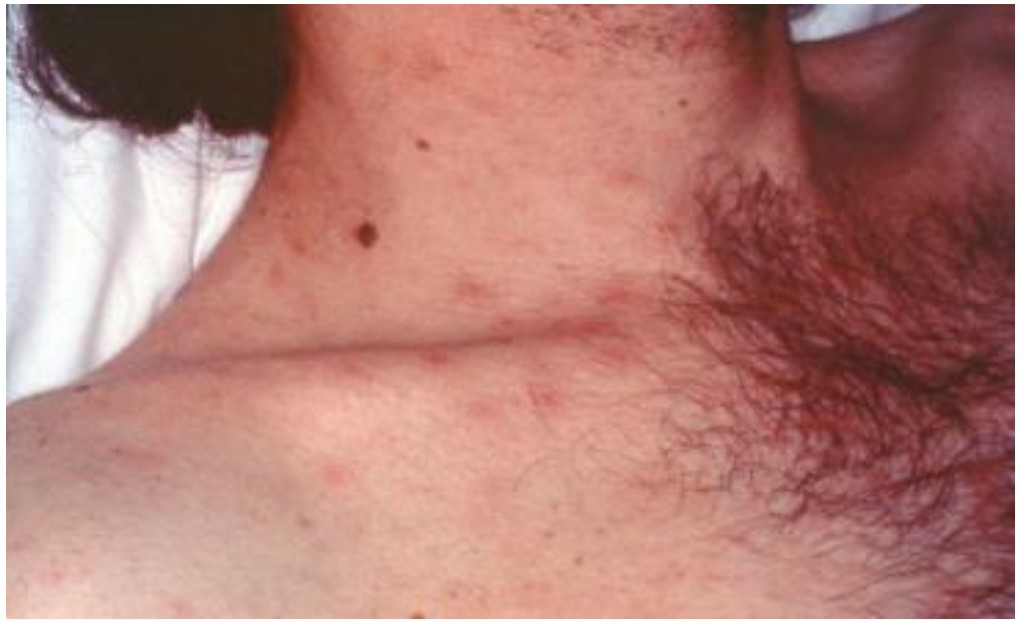
Flu-like symptoms?

Symptoms begin 2-6 weeks & last 2-4 weeks.

- Fever
- Fatigue
- Myalgia
- Skin rash
- Headache
- Pharyngitis
- Cervical Lymphadenopathy
- Arthralgia
- Night sweats
- Diarrhea



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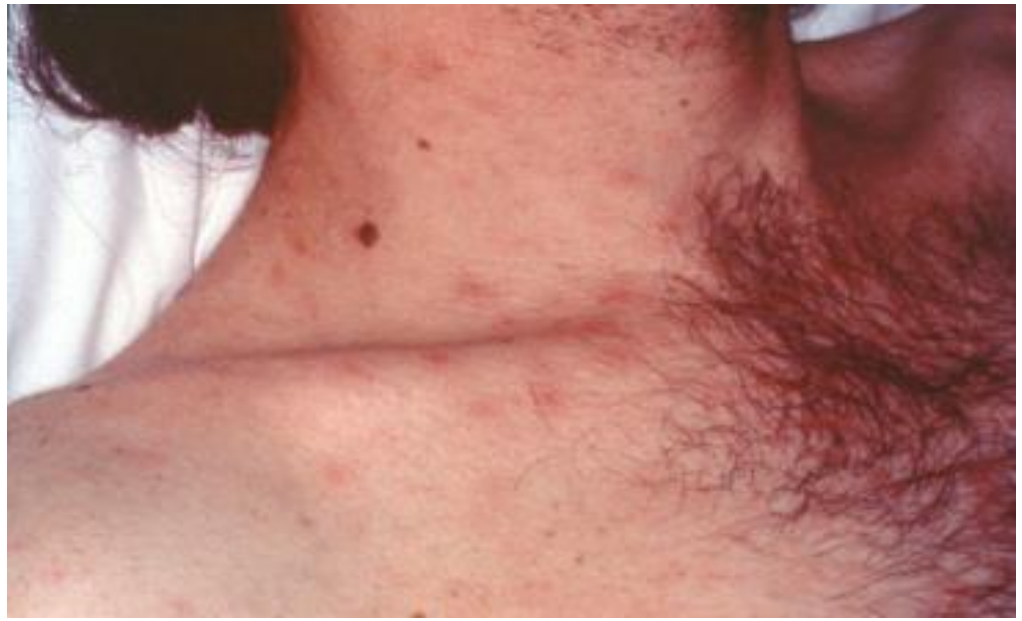
Flu-like symptoms? Think acute HIV.

Symptoms begin 2-6 weeks & last 2-4 weeks.

- Fever
- Fatigue
- Myalgia
- Skin rash
- Headache
- Pharyngitis
- Cervical Lymphadenopathy
- Arthralgia
- Night sweats
- Diarrhea



Daar ES, Pilcher CD, Hecht FM. Curr Opin HIV AIDS. 2008;3(1):10-15. www.depts.washington.edu

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Routine HIV Screening in Oregon

- USPTF: Screen everyone. Yearly if high risk!
- Oregon permits “opt-out” testing without written consent
- >60% of Oregonians have never been tested for HIV
- 1,230 Oregonians live with undiagnosed HIV infection

Oregon BRFSS,2015, CDC

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CDC:
HIV Undetectable = HIV Untransmissible

https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

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PREP TO PREVENT HIV

PrEP (Pre-exposure prophylaxis to prevent HIV)

Mary has returned after couch-surfing in Portland for a few months. She is off meth mostly, but is using heroin daily. She rarely shares needles. She has a gay friend who is on PrEP, and she'd like some.

- Would you prescribe PrEP?

http://www.hopkins_aids.edu

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PrEP = Truvada* = tenofovir plus emtricitabine

Who Should be Offered PrEP?

Consider offering PrEP if HIV neg & in the last 6 months:

- **Shared needles/equipment or**
- **Had a bacterial STI (gonorrhea/chlamydia/syphilis) or**
- Had condomless anal or vaginal sex with a partner at substantial risk of HIV or
- Had survival/transactional sex

People having receptive anal sex benefit the most

USPHS PrEP Guideline 2017

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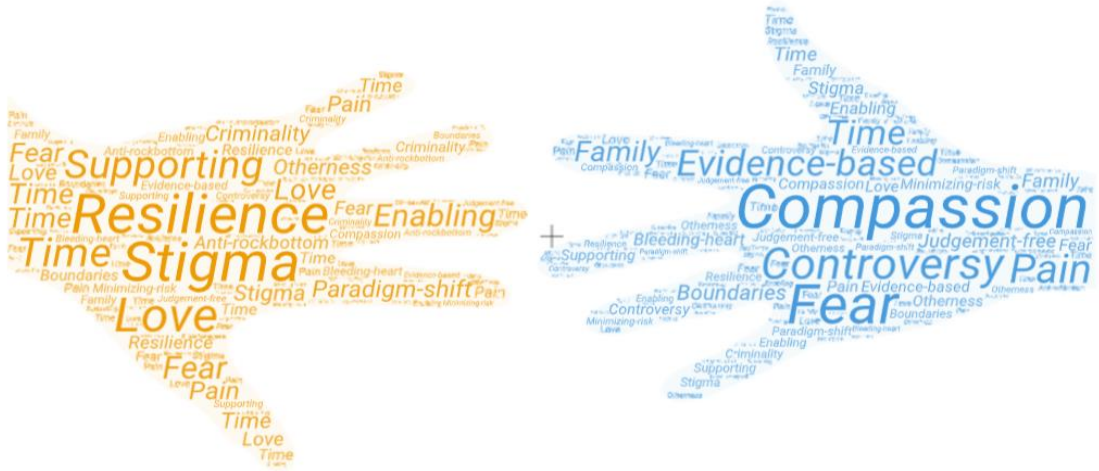
Primary Care & Harm Reduction

- While observing this scenario,
- Write down at least one thing you'd like to try and type in chat
- Note what went well and what could be better…



- Frank is 25 y.o. man who presents for follow up @ urgent care 2 days after drainage of his arm abscess. His arm is improving.

REDUCTION OF INFECTIONS IN PEOPLE WHO USE IV DRUGS (CONTINUED)

Harm reduction (continued)

Mary usually uses IV heroin & meth, and she wants to "get clean". She's used some suboxone (bup/naloxone) from a friend, and she wants to get some from you.

What do you do?

Buprenorphine/naloxone
(4:1 combination)

Partial opioid agonist

- Decreased overdose risk

Naloxone inactive unless injected –then precipitates withdrawal

- Decreased abuse risk

2mg/0.5mg

Sublingual, once daily

- Safe for flexible dosing

8mg/2mg

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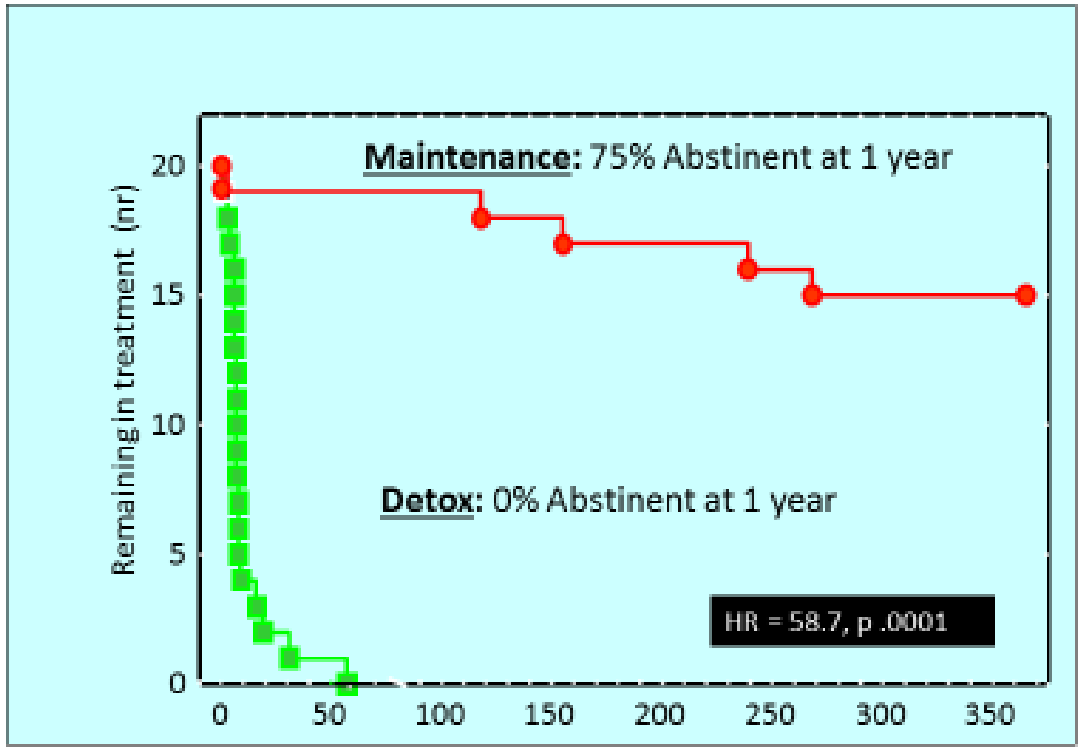
Bup Maintenance is Effective… Detox Is Not

Treatment Retention:
Buprenorphine Detox vs. Maintenance



Kakko, Lancet 2003

Success?

- Mary is delighted. The daily dose of 16mg (8,4,4) works well. She is not craving nor using heroin.
- However, she still uses meth every few days. Her POCT UDS is positive for bup and meth.

What is success? Who defines it?

What is success? Who defines it?

- Do not judge treatment progress and success on the amount of medication a patient needs or how long treatment is required.
- Rather, gauge treatment progress and success based on patients' achievement of specific goals that were agreed on in a shared decision-making and treatment planning process.

SAMHSA, *Medications for Opioid Use Disorder.* Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC

Closing Equity Statement

12:00 PM – 12:15 PM

Ruby Moon

Community Health Director, Siletz Tribe

Opioid Response Network STR-TA

NAHEWD National Alliance for HIV Education and Workforce Development

any Positive change PRIME+ Peer Program

Special Thanks

Jude Leahy
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Jan Schnellman
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Andy Seaman
Jessica Gregg
Linda Drach
Alicia Knapp
Jill Kesler
Laura Martell
Steve Kokes
Lance Heisler

Oregon Health Authority

END HIV

AETC AIDS Education & Training Center Oregon AETC

Resources from Today's Event

- IdeaBoardz
- HaRRT Center Resources for Safer Drug Use:
  - Stimulants/Uppers
  - Depressants/Downers
- Oregon Health Authority's Inject Drug Use-Related Vulnerability Assessment
- Prime+ Peer Program: Site Locations in Oregon
- Lane County's SyphAware.org
- Opioid Response Network
- Journal of the International AIDS Society: "Challenges posed by COVID-19 to people who inject drugs and lessons from other outbreaks"

Additional Resources

- For clinical q's about substance use, Hep C, HIV, & PrEP: Call the UCSF Warmline at **1-855-300-3595**
- **Winter Webinar Series** - first session on 1/8/20
- **STI and PrEP monthly Zoom forum (with Sugat Patel, MD)**
  - Email Ashley@oraetc.org for more information
- **ECHO: addiction, Hep C, HIV**
- Suboxone training
- Health Department, syringe exchanges, HIV Alliance
- Patients & Peers
- Harm Reduction Coalition: Getting Off Right – A Safety Manual for Injection Drug Users
- Email Jnusser@peacehealth.org for more information about engaging people who inject drugs in healthcare

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Don’t Forget!

- Complete the post-training evaluation survey and request your CME certificate: https://www.surveymonkey.com/r/PWID124

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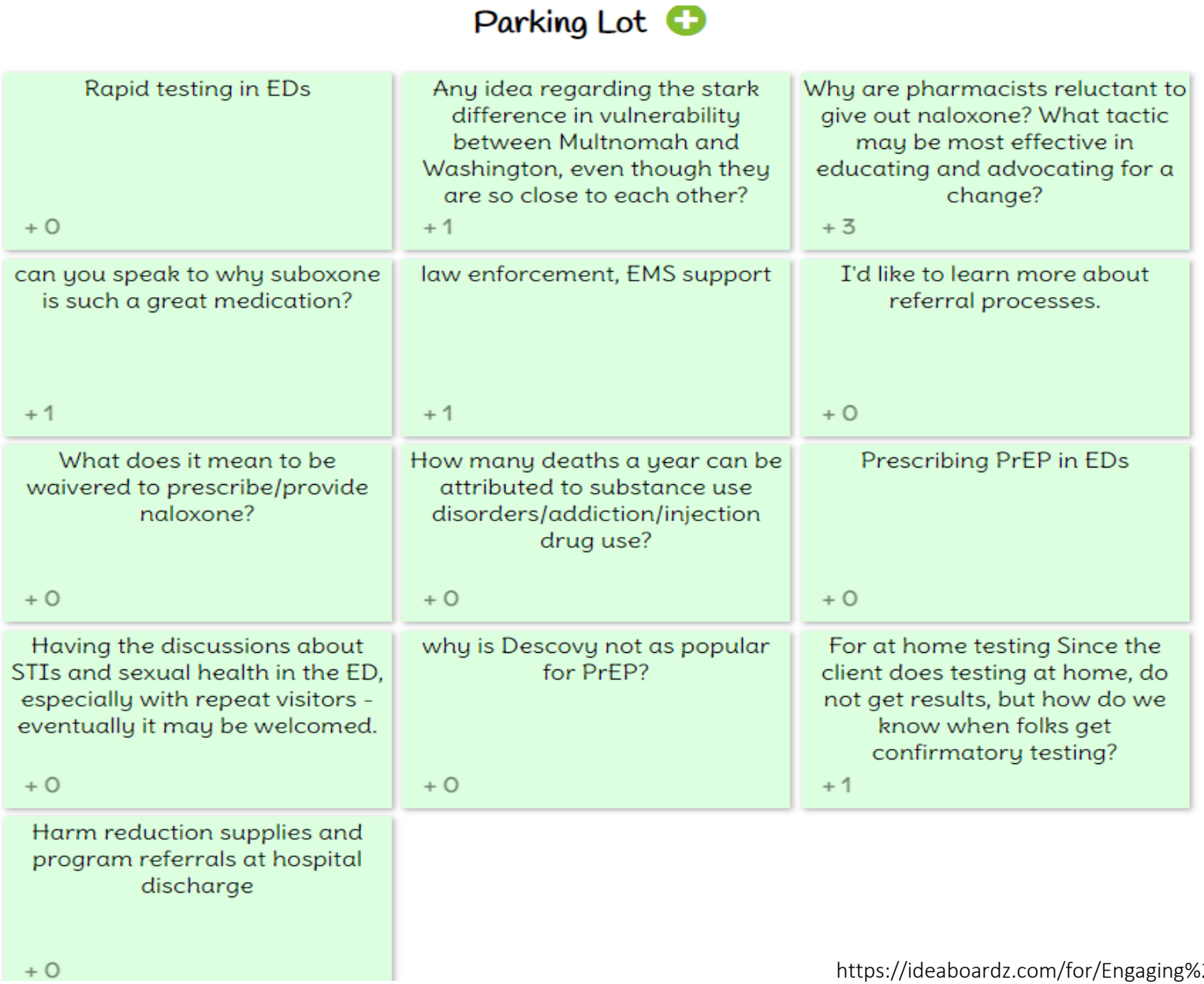
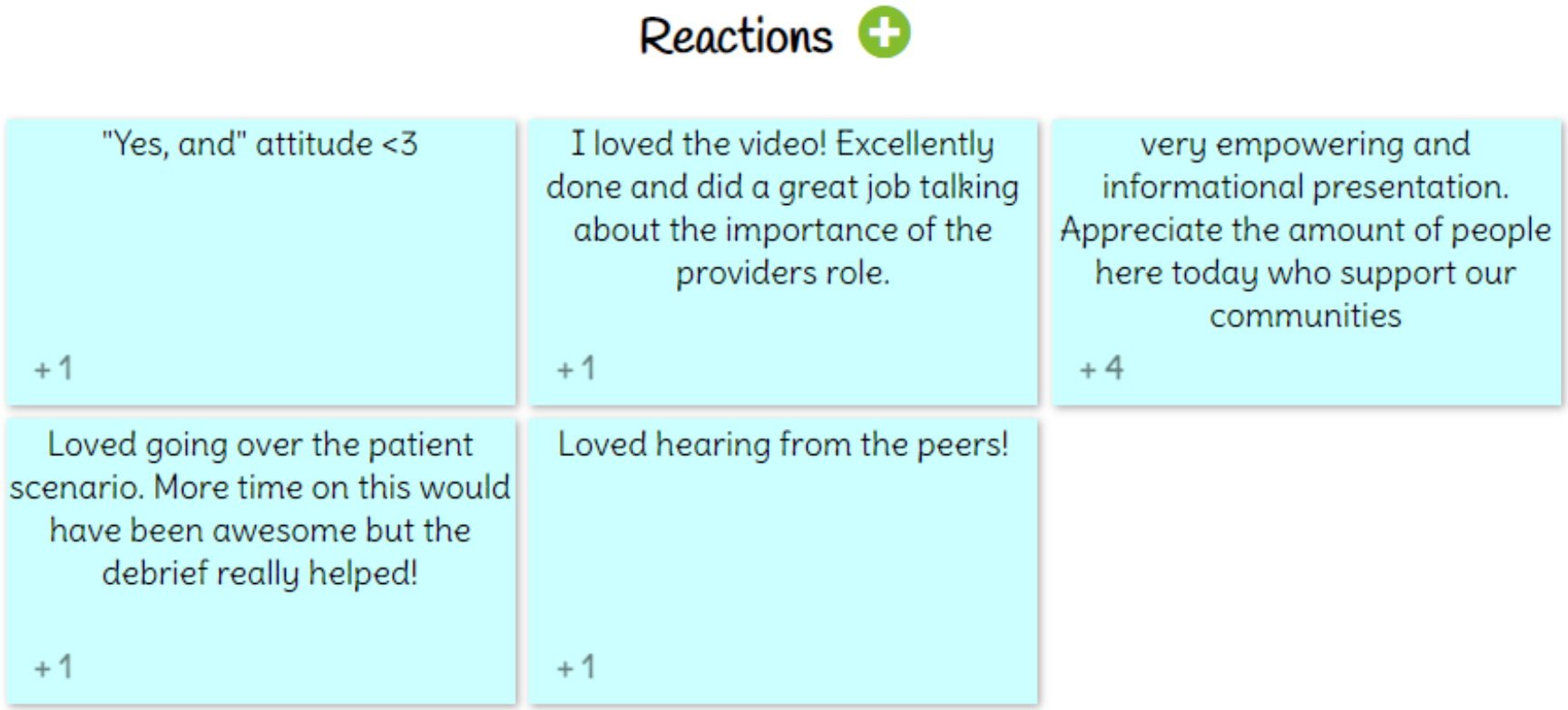
IdeaBoardz – Parking Lot Items



https://ideaboardz.com/for/Engaging%20PWID%20-%20Parking%20Lot/3560244

IdeaBoardz – Reactions



https://ideaboardz.com/for/Engaging%20PWID%20-%20Parking%20Lot/3560244

Acknowledgment

This Mountain West AIDS Education and Training (MWAETC) program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,911,844 with 0% financed with non-governmental sources.

AETC AIDS Education & Training Center Program Mountain West