**WEBINAR VIDEO TRANSCRIPT**
**Hidden Casualties:**
**The Consequences of the Opioid Epidemic on the Spread of Infectious Diseases (Part 2)**
**March 8, 2018**
**Richard Wolitski, Ph.D., and Corinna Dan**

Corinna Dan: Thank you, Marcella. Good afternoon, everyone. I apologize for the brief delay. We have a lot of people joining and wanted to try to get all of our panelists on in advance, as well as allow other folks the chance to log on and join us today for the Hidden Casualties webinar. This is actually our third event around Hidden Casualties. And we were thrilled with the last webinar, a couple of weeks ago.

But wanted to remind folks that you are in listen-only mode. And that we'll need a signal, if you want to ask a question throughout. You can post questions in the question box on the webinar interface as well as asking them through Twitter. And at the end, we'll open up for question and answer as time allows. We hope there'll be some time at the end. And in that case, you'll have to raise your hand and let the operator unmute you.

That said, if I could go to the next slide, please. Today's audio is via the phone line, not computer. So please make sure you're dialed into the right number. That number has been also entered in the chat box in if you need it again. And it should be showing up on the webinar interface. So want to make sure folks are getting connected. If you are having any trouble, please let us know via the chat function. We have staff here working on that.

Next slide, please. Today we're also working the social media angles. That's such an important part of communications. Eric Cortes is working to tweet, live tweet this session along with our national partners who are joining us for

the webinar today. So, want to thank Eric and all of you who are joining us via social media. Please remember to tag @HHS_ViralHep as well as use the hashtag #OpioidCrisis.

Next slide, please. So today Richard Wolitski and I are joining you here in Washington, D.C., in the Switzer building. And we're just really excited; we had an amazing turnout for today's webinar. And with that, I think we're running short on time. So I'm going to turn it right over to Rich.

Rich Wolitski: Great, thanks, Corinna. Hello, everybody. Pleasure to be today with you and [unintelligible] something that's really, that seems to be catching fire. We're seeing more and more organizations stepping up to address these issues and to solve these problems as experiencing them in their own local communities. I'm going to provide just a little bit of background from the HHS perspective to get us started.

Okay, the first slide. Everyone knows HHS is fully committed to a comprehensive response to the opioid epidemic that's based on the HHS five-point strategy for combating the opioid crisis. The comprehensive approach is evidence-based, targets drivers of the epidemic, and, I think most importantly for today's discussion, it's flexible in responding to emerging threats such as infectious disease consequences of the opioid crisis.

I won't go over all the specific elements. Look to the next slide and talk about the impact that we're seeing and why we're here today. Overall, we know that the opioid crisis has led to dramatic increase in the number of persons who are injecting drugs. And that's what this figure here shows. If you look at the lines in the figure and you see that any opioid injections increased among persons who are 18 to 29 by 622 percent. Among those people between the ages of 30

and 39, we're seeing admissions to opioid injection increased by 83 percent. These are data that come from the CDC.

We see a very strong correlation in the next slide between where the opioid epidemic is occurring, as shown on the left, by drug overdose death rates with the numbers of new hepatitis C infections that are reported across the U.S. On the left, the darkest red represents the largest number of opioid overdose deaths and in the right, we see that the largest number of new HCV infections are represented in the orange colors. And it's a very good correlation between the two. These two things are going hand in hand and fueling each other in some cases.

On the next slide, it gives us, kind of, a brief outline of the approach that we believe is needed to battle both of these co-occurring epidemics. We believe that a Hidden Casualties framework can be beneficial to both the opioid response and to the responses to various infectious diseases that are associated with drug use.

I think first and foremost is a patient-centered model. It's about meeting the needs of the person who's being served. It's designed to address multiple risks and needs of the individual. It's an approach that meets the needs of all people who use drugs with an emphasis on injection drug users but recognizing that people who are not yet injectors, could be in the future. An approach that helps people to achieve the best health outcomes possible for them given the issues and threats to their health that they're experiencing. It's collaborative. It works across programs to achieve synergies across programs by taking advantage of leveraging various funding streams that exist across programs.

And it extends beyond traditional partnership to move various services. In many cases can involve nontraditional partners for public health such as corrections and others. It promotes an approach that integrates services, co-

locates services. If that's not possible, uses facilitated direct referrals to services to facilitate access. It builds on its existing infrastructure. There's no need for a whole new silo here for these responses. And it continues to evolve as the epidemic and as the needs evolve.

If we go to the next slide then, it's really an approach that really, I think Dr. Mermin's going to touch on this as well, emphasizes the need for comprehensive community action. We identify the areas of greatest needs, mobilize the community members including the healthcare providers, law enforcement, and a vast comprehensive approach to prevention including substance use treatment, naloxone, HIV or hepatitis testing, linkage to treatment, and syringe services program.

We all know that syringe services programs have repeatedly been shown to be effective in reducing HIV transmission. Here, we also see that they serve as a gateway to start treatment as well. One city found the syringe services programs were five times more likely to enter drug treatment and three more times likely to stop injecting than were those who had not accessed these programs. And evidence shows that there's value there, there's cost savings. And so they're good in terms of saving our healthcare resources.

And on the next slide, it really, kind of, you know, recognizes that this is an evolving and changing situation. The early opioid response focused on eliminating the supply of drugs and preventing deaths through expanded substance use assorted treatment and naloxone. And it made great progress with that. Many infectious disease programs have not totally integrated key prevention services or partnerships to better serve people who use drugs. So physicians who are seeing people inject drugs are not mentioning and not addressing these issues. And we have huge potential to make a large

difference in the way that our systems work and serve the needs of the people who are coming to our doors and coming to our clinics and our programs.

So today, we're going to view some examples of work that's being done in the field and we're going to want you to answer this question: What is that you can do?

Victor, next slide. Thank you. We were asking the folks at a minimum, take a look at what you're doing. Review your programs, your activities. Just ask how you're addressing the opioid and infectious disease risk and needs in your communities? What are the gaps? What isn't being done that should be done? We want you to think about and identify the opportunities for you to become a part of the response. How can you enhance program serving people at risk of substance abuse disorder? How can you encourage new partners to accept or refer for recommended services? And how can you communicate with leadership and funders about community needs and effective programs?

These are some of the challenges that we want to put to you today. And then finally, I think this is going to be my last slide. I want to make sure that everybody knows about what I think is going to be an incredibly important event that's taking place Monday and Tuesday of next week, here in Washington, D.C. The National Academies of Sciences, Engineering, and Medicine is holding a workshop that focuses on integrating infectious disease consequences with the response to the opioid epidemic. This is a workshop that's being co-sponsored by this office and the Office of Women's Health here in the Office of the Assistant Secretary for Health at HHS. And it's really going to focus on the epidemiology of the co-occurring epidemics. How they interact with each other. What the greatest problems are? And we're going to look at what the opportunities are, as well. What are the things that can be done to better address infectious disease consequences to the opioid crisis?

And this can be a great time for folks to see our new Assistant Secretary for Health. He just started two weeks ago. He's going to be making opening remarks. And for those of you who are not in the Washington, D.C., area, you'll be able to view this live on the webcast. And we've got the URL here for that and also go as always to the hepatitis website on HHS.gov and get additional information about this program. I hope that many of you will be able to join us here, because it really is going to be an important event. That I think sets the foundation for the future. So I'll turn it back to you, Corinna.

Corinna Dan: Sure. Thank you, Rich.

Woman: She just signed in.

Corinna Dan: Would like to now turn the presentation over to Dr. Jonathan Mermin from CDC, National Center of HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. If we can have the next slide, please. Thank you. Dr. Mermin?

Dr. Jonathan Mermin: Great, well, thank you, Corinna and Rich, for some—for organizing the webinar and for some great slides and points. Next slide, please. I wanted to highlight a little bit about the epidemiology of what's going on in the United States with regard to opioids, viral hepatitis, and HIV. And talk about some action steps. Next slide, please.

So first we are dealing with a massive increase in overdose deaths from what is a growing opioid epidemic. Over 500,000 people died from overdoses over the past 15 years. And over 60,000 of those occurred last year alone. No state in the union is unaffected by fatal overdoses. In fact, although there are some states like West Virginia and New Hampshire, Kentucky, Ohio, Pennsylvania, New Mexico that are—that have been most profoundly affected. Every state

has seen an increase in overdose deaths since 2010, and often these have been profound.

We also can see here that deaths due to prescription opioids, in purple, have leveled off since 2011. To some extent because of a response from the nation to try to reduce the overprescribing and reduce access to inappropriate use of prescription opioids. But we've had a dramatic increase in deaths from heroin and synthetic opioids, such as fentanyl, which now make up over 50 percent of all the opioid deaths.

Next slide, please. And what we can see on this map, when it shows up, yes, is that the rate of overdose deaths is actually correlated with the amount of opioid prescribed by clinicians in a state and that varies considerably. So some of the areas in this map prescription rates of opioids are over one prescription per person per year. That would be in the maroon areas. And a rate that's more than twice as frequent as in the yellow states. So harmful opioid use and drug overdoses are associated with how easy it is to get prescription opioids but also increasingly they are associated with nonprescription opioid use.

Next slide, please. Concomitant with this we've seen increases in viral hepatitis as well. And I just wanted to highlight that over 22,000 Americans die of either hepatitis C or hepatitis B each year. And there's been a doubling of the number of pregnant women with hepatitis C. This increase in viral hepatitis is mostly due to injection drug use associated with opioids and other illicit drugs. With regard to transmission to infants, there's been a long history of knowledge about hepatitis B potentially being transmitted to infants and there is a guideline for birth dose vaccination of hepatitis B and then also for providing interventions that can prevent transmission to infants when the mother's known to have hepatitis B infection. Those have been highly effective. Although not reaching everyone who needs it.

But hepatitis C raises quandaries both clinical and scientifically because there are at the current time no treatments for hepatitis C that have been approved for pregnancy or for infants or prophylaxis. About 5 percent to 10 percent of infants born to mothers with hepatitis C will develop the infection.

So we do have the ability to prevent these infections and in the case both to treat them and in hepatitis C case to cure them and in hepatitis B's case to prevent them with a vaccine. But there's a lot more to do.

Next slide, please. So with regard to HIV infections in the US, we've had remarkable success in reducing HIV incidents among people who inject drugs over the past two decades. And in fact you can see here using diagnoses of HIV as the marker, about 6,400 people acquired their HIV presumptively through injection drug use in 2006. And that has deceased steadily until 2015, when we had the first increase in a long time. And that increase was 4 percent, but it would follow a 63 percent decline over the 10 years prior to that. And that's being threatened because of increasing drug injection that is being done by sharing needles or syringes with other people.

Next slide, please. I also just wanted to highlight that there are often sever infectious disease consequences to opioid use particularly injection drug use. So between 2002 and 2012, the hospitalization due to opioid use increased but so did hospitalization due to endocarditis; septic arthritis, which is infection of your joints; epidural abscesses, which are abscessed in, kind of, the spinal column; and then bone infections. And all of those are associated with, kind of, unsterile injection.

And then there are also other health consequences to the opioid epidemic that are not infectious disease related like neonatal abstinence syndrome, which

increased 300 percent from 1999 to 2013 and that alone costs over $1.5 billion per year to the healthcare system.

Next slide. So what can we do? And there's really a lot within the overarching strategic framework that we can do. One is we can prevent the harmful use of opioids and there's a lot of actions. Whether establishing and taking part of the prescription drug monitoring programs in one state to working to with programs for use that prevent use of opioids to helping people who are in chronic pain to reduce their use of opioids so that they don't end up becoming addicted.

The second issue is prevention of HIV and viral hepatitis. There's a lot of ways that we can do that. But particularly for people who inject drugs ensuring that there's access to sterile injection equipment and that people know that they are at risk of these infectious disease consequences and that they can prevent it through certain measures can be very helpful.

Third is treatment of substance use disorder. There's several highly effective medications that help people not use or inject drugs including methadone, buprenorphine, and now probuphine, which is a long-acting buprenorphine derivative. It is an implant that lasts for six months. All of those increase the chance that people will not use drugs and as Rich had mentioned they can be synergistic with other prevention programs. So if one participates in syringe service programs, you are 3.5 times as likely to actually stop using drugs as well.

The other substance use programs can actually screen people for HIV and hepatitis and ensure that people are treated appropriately if they have those infections. And we can also vaccinate people for at least hepatitis B and other vaccine related infections that occur among people who use drugs.

Next slide, please. CDC's response, this slide was originally derived to talk about some of the five pillars that are focuses for CDC to prevent opioid overdoses and opioid related harms. They also related to the infectious disease consequences of opioid use. And really one understands the importance or building the state, local, and tribal capacity. Both to respond quickly if there are outbreaks of infection, but also to work in all the different areas that help us prevent or treat these either opioid use or the infectious diseases associated with it.

We also can support providers' health systems and payers through either our guidelines for prescribing opioids for chronic pain or heath systems can implement coordinated care plans that closely monitor and integrate care for patients on chronic opioid therapy. And then pharmacy benefit plan managers can foster the implementation of guidelines through improvements of coverage.

With regard to public safety, it’s critical for a variety of interventions that there’s a strong engagement with public health and clinical care and law enforcement. And this is important not just for what law enforcement is doing for preventing access to elicit drugs and DA’s high intensity drug trafficking areas. But also to use surveillance to see where there’s the greatest need for inventions and educate the public safety community about opioid use disorder being a chronic disease. And the importance of preventing infections with HIV and hepatitis and other diseases from injection.

We can empower consumers to make safe choices through a treatment awareness campaign, which uses real life testimonials that we're using right now for people who have really, kind of, suffered through this and have the ability of a first-hand experience to share that can really move people to make

changes in their lives. And then we also conduct surveillance and research to make sure we're doing a better job. This is an unprecedented public health threat both from the overdose side and the increase in hepatitis and HIV cases. And we need to do research to be able to make sure that we're doing a good job and we have programs. And then to develop new technologies that will help us do a better job including and ensuring that we have adequate surveillance systems.

Next slide, please. So I just wanted to highlight this. One issue is where could this be going on? Where could be having HIV and hepatitis C and B being transmitted among people who inject drugs? We thought about conducting a mathematical model that would help us learn where there might be counties that are at particular risk. At the same time, congress also asked health departments to submit information to CDC if they thought that they were at risk for or currently experiencing these outbreaks to allow them to use federal funds for syringe service programs. And when we did that, we, kind of, have developed this map. It's a current map. It shows that 44 states and Puerto Rico have areas that are either at risk for or currently experiencing these increases in infections or outbreaks.

There are probably places in every single state where this is a concern. And it involves the local community and the local health departments and the state health departments to look at the information available to then be able to react quickly and to respond effectively and comprehensively to make the differences that we need in preventing new infections.

We also—I have a note here that we're, we soon will be issuing a guide on managing HIV and hepatitis C outbreaks among people who inject drugs. So that state and local health departments can respond most effectively when they see that the need is there.

Next slide, please. And then lastly, it's important to leverage existing services. Community health centers and HIV and STD programs and clinical services exist in all the states. And those programs can screen and refer people to substance use treatment and they also can test and treat for viral hepatitis and HIV. And then viral hepatitis programs, which we support in 46 states, can do enhanced surveillance in the states that at least have some resources, either federally or from the states, to actually look for where we're seeing acute hepatitis C and sometimes hepatitis B cases, they can actually say this is where we need to respond most effectively because it's an indicator of the need for rapid community action.

Next slide, please. So we think we need—the opioid epidemic is increasing infectious disease. The situation is not inevitable, but we really need to think big and act fast. And comprehensive community wide programs can prevent these infections, they can reduce drug use, and they can save lives and ultimately save money as well. Thank you. Next slide.

Corinna Dan: Thank you, Dr. Mermin. I just want to thank you so much for all of your work on these important issues. Your leadership there at Centers for Disease Control and Prevention is really critical as we all work together to respond. So thank you so much. And now I'm pleased to introduce Dr. Judith Steinberg. Dr. Steinberg is at the Health Resources and Services Administration. She's the Chief Medical Officer and she also has a strong background in infectious diseases. So we're very pleased that she's there at the Bureau of Primary Healthcare. And would like to turn it over to Dr. Steinberg.

Dr. Judith Steinberg: Thank you, Corinna. Can you hear me?

Corinna Dan: Yes, we can.

Dr. Judith Steinberg: Good afternoon or good morning, everyone. So the mission of the Health Resources and Services Administration, or HRSA, is to increase access to healthcare for people who are medically underserved or geographically isolated, especially those in our rural communities. And we do this through providing grants and cooperative agreements to more than 3,000 awardees. Our grantees provide direct care and train the workforce for underserved populations.

So just to familiarize yourself a little bit more with HRSA—HRSA administers the community health center program and also the Ryan White HIV/AIDS program. So I'll focus most of my remarks on the health center program.

So this slide shows you the impact that we're having in the health center program. As of 2016, nearly 1,400 health centers, operating over 11,000 sites across the country, served nearly 26 million people. That's 1 in 12 people across the US. Next slide. Health centers use the patient-centered medical home model to deliver comprehensive patient-centered care that integrates behavioral health and primary care. Patient-centered medical homes utilize multidisciplinary teams to delivery proactive, coordinated, and patient-centered care. And 70 percent of our health centers have been recognized as patient-centered medical homes.

Next slide. Given the urgency of the opioid epidemic, HRSA is supporting health centers to utilize that patient-centered medical home model to expand mental health and substance use disorder services, including the provision of medication-assisted treatment and comprehensive addiction services. This to better meet the needs of their communities.

To facilitate this we provided additional funding to health centers to integrate mental health and substance use disorder services into primary care. We're also promoting the use of telehealth through supplemental funding and through technical assistance and training, and by addressing policies that may inadvertently serve as barriers to the implementation of telehealth. We're also providing TA and training to health centers, and I have some links to resources at the end of the presentation.

We're working closely with our partners, our colleagues in the Bureau of Health Workforce at HRSA, to support health centers to be able to recruit and retain the workforce needed to provide these services. Next slide, please. So we've heard about the link between the opioid use—opioid epidemic—and infectious disease complications and that 75 percent of new hepatitis C cases are associated with injection drug use.

So given that, it's important that we not only integrate mental health and substance use disorder services at health centers, but also provide care to patients with hepatitis C and HIV. And again, health centers use the patient-centered medical home model to provide this comprehensive, integrated care. Such integrated care models always begin with screening and prevention, and then linkage to treatment either on site or by referral with good care coordination.

Next slide. Here is some examples of how health centers are providing hepatitis C care. And these are actually models that also are being used for the provision of HIV. And often HIV and hepatitis C care are being provided at health centers. So usually there's a hepatitis C champion, often a primary care provider and team that's been trained to provide Hepatitis C care. They may be supported through virtual consultation with an outside specialist, especially for more complex cases. Or a health center may have an HC—a hepatitis C

specialist onsite or an HIV specialist who does both who works in a team. In either scenario, patients who screen positive are referred by health center primary care providers to the, in this case, HCV team. Or there's a coordinated care with an offsite specialist.

Now using the patient-centered medical home multidisciplinary care team approach, this slide also shows you some examples of staff who may serve on the team. And just a note, many health centers are also Ryan White HIV/AIDS programs clinics.

Next slide. So here are some of the resources that I was mentioning that HRSA is using to support health centers in the provision of integrated mental health, substance use disorder, and HIV/hepatitis C care. First our webpage with hepatitis C resources, then HRSA is also sponsoring an opioid addiction treatment, Project Echo that provides virtual provider to provider consultation—that is specialists to primary care. Also we have a warmline for providers to ask specialists quick questions on substance use disorder treatment. And then lastly, the SAMHSA HRSA center for integrated health solutions. And that provides a wealth of resources to facilitate the integration of behavioral health and primary care.

Next slide. And thank you. Corinna, I'll turn it back to you.

Corinna Dan: Thank you so much. Thank you, Dr. Steinberg. I very much appreciate your taking some time to share some of the resources that HRSA and appreciate the many health center sites who are providing care to people impacted by the opioid epidemic. So now if you could move to the next slide, I'd like to introduce Alysse Wurcel, who is with the Infectious Diseases Society of America. Alysse is going to talk about some of the important work that IDSA along with the HIV Medicine Association is doing to help us understand more

about exactly what those infectious disease consequences are, as well as their recommendations for next steps on addressing those issues. Alysse, are you on the line?

Alysse Wurcel: Yes, can you hear me?

Corinna Dan: Yes. Go ahead.

Alysse Wurcel: I'd like to thank the HHS for giving me the opportunity to speak on behalf of the Infectious Diseases Society of America and the HIV Medicine Association. As an infectious disease clinician, working in the community and the criminal justice system in the greater Boston area, I can attest that there have been dramatic increases in infections in people who use drugs. Can I have the next slide, please?

So there are a lot of different things that we see as clinicians, especially as infectious disease physicians and practitioners. Skin and soft tissue infections include cellulitis, or abscesses and necrotizing fasciitis. And these can result from local trauma to the skin or introduction of bacteria when the needle enters the skin or even injecting drugs that contain impurities. And untreated, these skin and soft tissues infections can go on to very severe infections including infections of the heart valve called endocarditis, osteomyelitis of the bone, and also of the central nervous system in the brain. And we know that across the country there are increases in hospitalizations for people for these devastating downstream infections. The HIV and hepatitis C can be passed through sharing of needle syringes and other items and the preparation of injection of drugs. And we've actually also seen, at least locally, increases in syphilis, chlamydia, and gonorrhea. So we see a lot of the different infections related to use of drugs.

Next slide, please. Intertwined with antibiotics and antiviral medication, management of underlying substance use disorder is key. One of the current options is medication-assisted treatment. There are several other options and so we try, at least in my clinical experience, to engage people in buprenorphine or methadone. Another important part of treatment is management of underlying mental health issues common in people with substance use disorder.

Next slide, please. Recent outbreaks have occurred in Indiana, and Kentucky, and in my state of Massachusetts. I can say personally I've diagnosed and treated about 20 young people with HIV in the clinic and the jails within the past six months. And their main risk factor was injection drug use and we all know that this is only the tip of the iceberg. These are the people who have actually come in and got a test for HIV. But there are a lot of people out there who haven't gotten tested for HIV. And as was mentioned previously, the CDC has analyzed the United States looking for places vulnerable to HIV outbreaks. We do not have a formal monitoring system in place to track real time impact of bacterial infections, like endocarditis. But we know from an MMR report in North Carolina recently, that there is a 12-fold increase in the number of endocarditis cases between 2010 and 2015.

Next slide, please. So for public health interventions, we would like to encourage the CDC and public health partners to integrate interventions aimed at preventing, tracking, and treating infectious disease with broader efforts to address the opioid crisis. We feel that there's a need for increased capacity to allow for state and local health departments to track infections. We need more syringe exchange programs especially in rural areas. We know that—we have increasing data to support safe injection sites as the harm reduction strategy.

We need to encourage people to screen for HIV, hep B, and hep C and additionally with increasing reports of hepatitis B and hep A in marginalized populations. We hope that we can encourage clinicians across the United States to vaccinate for hepatitis A and B. Those are two preventable infections and vaccination is completely worthwhile, especially in people who use drugs.

Next slide, please. As far as surveillance, at the moment the additional surveillance for state and county health departments is needed, especially in rural areas. As unfunded mandates—as the current money is actually not enough to surveil up to what needs to be done, we'd like to suggest potentially increasing surveillance for things like bacterial endocarditis so that we can track longitudinal data for mortality and morbidity from things like endocarditis.

Next slide. Efforts really should be directed, we feel, towards addressing research gaps so that we can refine how we provide care, how we teach about harm reduction, and how we provide treatment interventions. Increased research is needed on the co-management of addiction and infectious diseases. So when someone gets a diagnosis of endocarditis, where do they get their treatment for the endocarditis if they have hep C? Is it a different doctor? And is it a different doctor for the additions team? Is there a way to co-localize those treatment resources to make it easier for the person who is battling with several different chronic diseases? We feel that there should be more funding of implementation research trying to figure out certain things like pre-exposure prophylaxis—also known as PrEP—and how that can be used to prevent HIV.

Next slide. Understanding the epidemiology is key especially with criminal justice involved populations. I can speak to that especially as someone who's providing care in the jails. And then rural areas also don’t have the

infrastructure or medical provider capacity to respond to their local epidemics and yet there are administrative barriers to get them funding due to ethnic demographics.

Next slide. So there—one of the things we hope to understand is how do we transition people throughout the hospital to the clinic, from the jail to the community as they're getting treatment for infectious diseases? So transition and care are key to providing quality healthcare. That can be happening between addictions and inpatient and outpatient providers. It can happen between addiction specialists and infectious diseases positions. Or even for people caring for patients in jail and once the person's released. So how do we facilitate these conversations between clinicians across the spectrum of care?

Next slide. ID workforce capacity is important because we need to train young infectious diseases clinicians how to care for people who have the comorbid illnesses of infections and addiction. Telemedicine had been so helpful for the treatment of hepatitis C and potentially that can be used to diversify to be used for other infections. And we hope that there can be an expanded access to comprehensive coordinated care for opioid addiction and related infections.

Next slide. So just as a summary, the integration of infection diseases, HIV, and addiction medicine is essential to addressing this opioid epidemic. As a clinician with people coming into the hospital for complications of injection drug use, that's my opportunity to engage them into addiction care. We hope that there can be an expand in funding for surveillance and public health interventions; incorporate injection drug use into a federal opioid research priority; increase with research with justice involved populations and rural populations; and fund implementation research on evidence-based interventions. Thank you for your time.

Corinna Dan: Thank you so much, Dr. Wurcel. Really appreciate the leadership of IDSA, of you and your colleagues, and look forward to continuing to learn more about the epidemiology, the specific infections that we should be looking out for and how we can better coordinate efforts. So I'd like to move on to the next slide and introduce Laura Pegram with the National Alliance of State and Territorial AIDS Directors. The Drug User Health Program, which Laura manages, I think, has been around for a number of years in response to some of the trends that we've been seeing for a while. And just want to also note the leadership of NASDAD, her organization, in working with HIV/AIDS directors as well as the hepatitis coordinators in every state that Dr. Mermin mentioned earlier. So excited to hear from Laura. Are you on the line?

Laura Pegram: Yes, I'm here. Can you hear me?

Corinna Dan: Great. Go for it.

Laura Pegram: All right, good afternoon, everyone. And thanks to Corinna and Rich for inviting NASDAD to present and share work and reflections on the state and jurisdictional health department response to the opioid crisis. Go ahead and slide.

All right, so just a little bit about NASDAD. We're a nonprofit, nonpartisan national membership-based organization. We were founded in 1992. We work with all the statewide health departments that administer HIV, hepatitis, and drug user health programs. And like I said, we do that in all 50 states, U.S. territories, and federally funded jurisdictions. Our aim is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions by strengthening domestic and global governmental public health through advocacy, capacity-building, and social justice.

Recognizing inextricable links between people who inject drugs and transmission of HIV and hepatitis, NASDAD has always supported state level efforts that focus on the health of people who use drugs. We've worked with states to develop programs aimed at reducing transmission risks among this group. And this work is scaled up, for obvious reasons, in recent years, as Corinna mentioned. And like she said, I'm the Manager of Drug User Health at NASDAD and I work specifically with state and viral hepatitis programs around their efforts to support people who are using drugs. And who are at this increased risk.

So now when it comes to state-level responses to the opioid crisis, it's important to recognize the incredibly huge diversity we have among all of our states, territories, and jurisdictions. The ways the opioid crisis has hit these different places and regions is as diverse as those places themselves. Additionally, each state and jurisdiction operates in very different social climates and have very different histories and level of engagement of working with people who are actively using drugs. In turn, to adequately meet the needs of these diverse communities, the responses, tactics, and strategies will also have to be incredibly unique and diverse.

Slide. So as NASDAD supports health departments in their efforts to reduce harms and prevent HIV and hepatitis for people using drugs, several themes seem to continually come up in my work. These are things that I hear consistently from state health departments and programs and staff. And they often center on, (1) the need to change the dialogue and also in public perception around who is using drugs; (2) questions about who should be working with these individuals; (3) the best way to reach these individuals; and (4) questions surrounding what are the best ways to respond to this crisis comprehensively?

Now in relation to the opioid epidemic, we often hear only about either, (A) the prevention of use of drugs, or (B) access to treatment as primary strategies. But we all know it's a lot more complex than that. People who are using drugs are first and foremost people. And in that, they're incredibly complex and present with a lot of potential issues that need to be addressed to support their health. These needs can be anything from mental health to housing to infectious disease and overdose prevention. And we're going to have to create programs and services that address this whole range of services in order to comprehensively address the crisis. Put simply, you really can't address infectious disease without addressing overdose. You can't address treatment for substance use disorders without talking about safe recurrent use and personal stability. You can't address overdose without supporting the general health of active drug users, etc. This list could really just go on and on. So all of those things are inextricably connected.

And unfortunately, our responses don’t always reflect that. Often, they remain siloed, especially in the past. So, health department programs working on the infectious disease consequences of the opioid crisis are uniquely situated to address this comprehensive health of people who use drugs since they often need to be focused on just this gray area. The area between prevention of use and treatment for substance use disorders. This is where folks are most at risk for contracting HIV and hepatitis. And this is where health departments have had to increase focus and often refocus their programs.

So in order to do this, these programs have had to adjust what their outreach and infectious diseases prevention efforts look like. This includes working with people who are actively using drugs to identify behavioral risk factors. And helping to provide tools to reduce risks among these individuals. This often includes starting or strengthening syringe access programs and

partnering with community-based harm reduction groups that have been doing this work for a long time and have that expertise already.

Often health departments need to find ways to make their own staff and programs more culturally competent in their work with people who are using drugs. They need to work to reduce stigma surrounding drug use both within their programs and the larger community. And they need to expand services to include education and information about safer drug use that is relevant to their community. This includes learning about the range of drugs that are actually being used in that community. Their transmission risks and how to work with people using drugs to reduce those risks and support health, in a nonjudgmental way.

Slide. Thanks. So now like I mentioned, every state and jurisdiction is totally different in regard to their work with people who use drugs. Some have had programs focused on harm reduction for years. And others are just starting out. And some are just beginning to start thinking about starting out. So like I said, there's a really big range here. And this diversity of states means that there often a lot of challenges in implementing these programs because as we all know there's no one size fits all solution. And there's—that's not going to work for different states. This diversity also means that there are a lot of opportunities to share lessons learned. Basically there's a wealth of knowledge and experience to share between states and every place can learn from the experience of others, regardless of where those programs are at in their progression or development.

It's also important to recognize that there's a lot to be learned from people who are using drugs. These individuals are expert in their own lives and really the most important partner in creating a comprehensive response to the opioid crisis. Health departments have learned they need to meet people who use

drugs where they are in order to effectively address anything. So states are working to create this comprehensive response. Some of the lessons learned that seem to come up a lot often focus on collaboration. I know it sounds really cliché, but collaboration is totally the key to successful programs. And this has been mentioned before here today. But we know that the opioid crisis and infectious disease transmission risks related to it are incredibly complex.

And because of that complexity, the funding and resources to combat this crisis are often spread between agencies. Think about injury and prevention, single state agencies, health and behavioral science services, and infectious disease programs. Each of those agencies has a different piece of that puzzle and are going to have to find ways to work together. States are trying to be really creative around funding. In some places this includes creating an office of drug user health that coordinates statewide efforts and tries to unify that funding. Partnering with other departments to support efforts around this issue and collaborating around services that are offered to better reach this group.

One way we often see that happen—play out between different programs, community-based organizations and departments, is about co-locating services that support drug user health in one place. Several states refer to these programs as syringe service program hubs, either as platforms for services or as implementing say a hub and spoke model where SSP programs are often the primary hub and the services are the spokes.

And like I said before, there's often a wealth of experience among community groups and organizations who already work with people who are using drugs and work to reduce drug-related harms within this community. It's really vital for states to start—starting this work to partners meaningfully with these groups. Often this means helping to fund or support these community-based

programs and finding ways to, again, collaborate not necessarily duplicate efforts.

And of course, it's vital for states to share resources, successful strategies, and effective program models to adequately address this crisis. In my role at NASDAD, and at NASDAD in general, we try to be that bridge for health departments.

Slide. So lastly, I just want to give a really quick rundown of the ways NASDAD can help state and jurisdictional health departments and some of the activities we have been working on. In terms of technical assistance, a big part of my role is about working with states to talk through and assess what's happening on the ground for them. Basically what they're seeing, hearing, feeling in their communities; providing ideas and guidance about program implementation, resources and collaboration; and working to troubleshoot, problem solve, or brainstorm around issues and barriers as they come up.

And NASDAD, in general, works to create resources about effective or innovative programs, policies, and activities that hopefully are useful to other areas based on the experiences of state programs. These are delivered in a variety of formats such as reports, webinars, workgroup calls, learning collaboratives. So if you have questions about any of our resources, including mine, feel free to reach to me or any other NASDAD staff. Or check our website.

We are also part of the CDC capacity-building providers' network. And we create and deliver in-person training for health departments and their community partners who are working with people who use drugs and reducing infectious disease within that group. These trainings can be requested through

state and territorial HIV and hepatitis health department programs and are delivered at no cost.

And lastly, just at the bottom there, I went ahead and included some links to some of our drug user health resources. First the link to our page, our program page; our resource maximizing health, minimizing harm incorporating a drug user health framework; modernizing public health to meet the needs of people using drugs; and our recent call to action for health departments and community stakeholders in support of supervised injection facilities.

Slide. So the last slide is just my contact information. Please feel free to reach out to me at any given point. And I look forward to the questions later. Thank you for your time.

Corinna Dan: Thanks so much, Laura. We really appreciate your work and that of your colleagues at NASDAD. I really appreciate your time today. And so hopefully everybody's caught Laura's invitation to contact her directly for more information and so I'd like to move on then to next set of speakers. We're very happy today to be joined by the National Association of Community Health Centers. Ellen Robinson, who is the Director of Information Resources and Outreach, along with a health center Behavioral Health Manager Kelli Bosak who will make some remarks after Ellen. Ellen, do you want to go ahead?

Ellen Robinson: Great, thank you. Next slide. One more. Great. The National Association of Community Health Centers, we're known by NACHC, is a nonprofit membership organization founded in 1971. Our job is that we work to support all of the health centers out there. And we do that by conducting research-based advocacy, educating the public about the mission and the value of health centers, providing training and technical assistance to both health

center staff and their boards, and we work on areas such as clinical workforce, we create innovation, and aim to improve performance in health centers.

Next slide. As Dr. Steinberg mentioned previously, health centers have a very large reach. We are close to 26 million patients served and we have over 24,000 clinicians. The numbers, as Dr. Steinberg mentioned, are about 1 in 12 people across the United States who get their healthcare from a health center which is why—next slide—it is very important and a NACHC priority to integrate behavioral health with primary care. Given the impact on our patients of opioid use, we've been working on this issue for several years. We've internally formed a workgroup to discuss ways to combat the issue. We have education sessions both at our conferences and as well as other conferences. We conduct webinars, podcasts, and we're privileged to work with CVS Health and the American Academy of Addiction Psychiatry on several projects. And we've also formed some collaborative partnerships with our health centers, primary care associations in the states and health center controlled networks.

Next slide. Our health centers are doing a lot to integrate behavioral health with primary care and work on the substance abuse issue. PCC Community Health Wellness Center in Chicago is one health center who has a comprehensive program. Those comprehensive programs that our health centers do are working with expanded care teams, working with partnerships including medication assistant treatments, pain management through Echo. There's lots of different ways that our health centers work on the issue and each one does it slightly differently according to their patients and their needs.

So with that, I'd like to introduce Kelli Bosak, who is a licensed clinical social worker and one of PCC's behavioral health providers. She'll be discussing

what they are doing in their health center to work with people of substance use disorders.

Kelli Bosak: Good afternoon, everyone. This is Kelli and I'm going to give a little bit of an example from our work here at PCC Community Wellness about managing the opioid crisis in Illinois, and in Cooke County specifically. Next slide. The PCC Community Wellness is a federally qualified health center. We're located on Chicago's west side, in the near west suburbs in Cooke County. Since we were founded in 1980, we have expanded to about 12 different clinics that provide primary care integrated behavioral health, and in the last few years we've integrated medication-assisted treatment across several sites and also in opening a chemical dependency clinic. So we provide a full suite of primary care services as well as behavioral health and other clinicals supports. Our mission is to improve health outcomes through the medically underserved community through the provision of high-quality patient care.

Next slide. So with a little context with the story of in Illinois. The opioid epidemic continues to disproportionately impact African American men. And additionally, African American women and the mortality rates are about three times greater for African Americans and black members of our community than for whites or Caucasians. What we found here on Chicago's west side is that about one in four opioid-related hospitalizations occur within our community. And these are directly our patients who are serving or the community members, neighbors, family members of our patients. This accounts for about 35 percent of the total opioid-related hospitalizations in Chicago, so we're seeing a lot of it here on the west side. And so 83 percent are those who are black or African American, predominantly around the west side.

We're located very close to an expressway that is known as heroin highway. And so it often brings a lot of people to the area to use and also has concentrated a lot of those who have substance use disorders on this side of town. In Illinois, the ability to provide treatment for substance use disorders has decreased in the last 11 years by 52 percent and that's a number one treatment capacity decline in the United States. And so given that, about 61 percent of publicly funded treatment facilities closed down in the Chicago metro area. So what we're seeing is really high rates of use and a really limited ability to provide treatment, especially in communities that were disadvantaged or under-resourced and disproportionately affecting marginalized communities including those who are African American, Hispanic, and Latino.

Next slide. Okay, at PCC we have an integrated model of care and to give you a little timeline of where we started where we've grown, is that in 2007, we started to embed behavioral health into primary care. So we've integrated behavioral health consultants who are usually licensed clinical social workers or professional counselors as well as psychiatric nurse practitioners in the primary care setting. Then about in 2011, four years later, we started to implement, we started to implement medication-assisted treatment at one of our sites, in the Austin community on the west side, which is where the highest rates of substance use and opioid dependence occur. And that was with one prescribing provider, a medical physician, as well as one or two behavioral health consultants providing the care and treatment.

And then over the next three years, we increased the number of patients who we were seeing, but we really found that we needed to expand. Really create a program through additional funding and structure to engage patients when they're coming in through the door as well as support them in their treatment over the long run. With that, we expanded in 2014, to two locations and then

we received grant funding and opened up a chemical dependency clinic at one of our walk-in sites in West Suburban Medical Center in Oak Park, Illinois—just about two blocks away from the Austin clinic. So it's a right bordering Chicago. And since then, since 2016, so almost two years, we've grown from having four prescribers who are able, who had a data waiver to prescribe suboxone to over 10, and even now up to 20 to 23 depending on the time of year and we have our residents here or not.

So in 2016, we had about 100 patients who were receiving medication-assisted treatment. And since then we've grown to 2018 to about 300 to 350. So we opened that clinic, which was, and through that we continue to receive support and more and more people coming through the doors. And we received additional grant funding from the Office of Women's Health and the Chicago Department of Public Health to open a high-risk chemical dependency clinic for women who are currently pregnant or postpartum with a substance use disorder. So we can combine integrated behavioral health, prenatal care, and substance use treatment within one setting.

We have also participated in a learning collaborative through the Chicago Department of Public Health to share the information and resources that we have and the lessons that we've learned in launching this clinic and managing it and supporting our patients with other sites and FQATs in Chicago who are doing this work as well. Now in 2018, we're expanding our medication-assisted treatment then to continuity clinics. So outside of the starting point, which is the chemical dependency clinic, to other sites where they can continue to receive prescriptions and really with the support of NACHC and the CVS Health is to integrate trauma-informed care into the support.

So, next slide. With that model we're seeing we've also helped to shift the culture of PCC to integrate trauma-informed care as well as substance use

screening. Through that we've really just been able to identify a higher rate of problematic substance and other—substance, alcohol-related use disorders as well as mental health concerns through the implementation of universal screenings using SBIRT. So and the AUDIT and DAST, which I'll mention a little bit later as well as the [unintelligible]. So you can see just by screening, we really jumped up in the number of patients who we're identifying with related disorders and we could provide better access to quality treatment for those individuals.

Next slide. Now I'll share a little bit about the integrated pathway to recovery for patients who present and identify an opioid dependence or opioid use disorder, is that we first start off with that universal screening. So we may identify a patient in primary care who shares a use disorder. We engage them in treatment and an ongoing assessment, usually with behavioral health or the medical provider. We also have individuals who self-refer or just start to walk into the chemical dependency clinic. There's a lot of word of mouth that brings individuals in.

When they first come in, they start with induction so that's a process of getting started in the medication. They have a daily integrated appointment with a behavioral health provider as well as a data waiver prescriber. And they attend visits for about one week. We also administer the COWS so that the clinical opioid withdrawal symptoms schedule. So we rate—so we can identify what level of withdrawal they're at to provide the appropriate dosage of the medication.

Then patients, as they complete induction, they engage in treatment. When they're engaging in treatment, they're having integrated behavioral health meetings at every medication-assisted treatment appointment. So it's a coordinate system of care and then we also give a rapid urine screen at each

MAT appointment as well. When patients enter the maintenance phase, we also include them and give options around individual and group counseling. And we have onsite and offsite multiple options for groups and individual work. They still have integrated session at their MAT appointments, rapid Utox, and then we complete ongoing evaluation of their substance use disorders every six months.

Next slide. So some of those tools that we use for clinical consideration are the [unintelligible] or universal screening for alcohol, drug use, as well as nicotine dependence. And then the clinical opiate with withdrawal scale is used during induction.

Next slide. Okay and the medication-assisted treatment options that we're able to offer are the first two, buprenorphine, Suboxone or referred to as Subutex. That is—we're usually using Suboxone when we provide with patients and most of our patients are on suboxone. In addition, we'll also provide the meltroxine vivitrol injection for opioid use disorders as well as for alcohol disorders. And we'll give that injection onsite. And then we do have patients who are on methadone, we don't currently prescribe or administer methadone, but that is an option for some of our patients and we refer out. And it's not currently available for use in FQHC.

Next slide. Okay, some of the wins that we've had is that we've started engaging high-risk OB patients in care. So really starting to deconstruct the stigma around substance use during pregnancy and postpartum periods for mothers. And try and get them in and engaged in treatment so that they can decrease the health risk themselves and to the newborn.

We are also expanding access to group therapy. And we have had open support groups at one of our sites for almost two years. And then we've been

launching that at two other sites so that increase access to that will greatly help to increase social support and decrease isolation for some of our patients. We've also integrated trauma-informed yoga therapy and a group supportive setting through a partnership with a yoga nonprofit. So it's co-facilitated relapse prevention and yoga therapy for our patients with a lot of chronic pain and other ongoing stressors. And we also have smart recovery meetings at our clinics.

In addition, we've expanded partnerships with other substance use disorder treatment facilities including detox programs as well as hospitals who are seeing patients come in to the ER for hospitalizations exacerbated by heroin use or by other infectious diseases. We've increased the licensure of our behavioral health providers to include CADC, so chemical and alcohol dependent counseling. I always forget that acronym. And then increasing the data waivers for a medical provider to include not only MDs and DOs but also EPNs.

We have also been doing a lot to help get the word out in the community and to really increase access to those things via social media and in local newspapers. Next slide. Okay and that's actually it. This is an example of one of our—one of those postcards that we use. So thank you so much.

Corinna Dan: Thank you so much, Kelli. Boy, you all are so busy. I'm surprised that you had time for us today, but I think the program that you've shared today is really comprehensive and that your health center has really worked hard to identify ways to meet the needs of folks in the community. So thank you for sharing all of those great examples. And with that I want to turn it over to the National Viral Hepatitis Roundtable colleagues Tina Broder as well as Louise Vincent. Just want to—before I turn it over, do a really quick time check because we're at 4:11. We've had some great questions coming in on the chat box. So, Tina,

if you and Louise could wrap this up in 9 or 10 minutes, that would be fabulous. And I'm sorry to put time pressure on you, but Tina you want to take it away.

Tina Broder: Thank you, Corinna. And thank you for the opportunity to speak today. NVHR is a national coalition with more than 500 members ranging from volunteer-led grassroot groups to large national advocacy partners. We also build relationships with healthcare providers, state and local health departments, and other government and industry partners to work together to eliminate hepatitis B and C in the United States.

Next slide. A bit about our policy priorities. We work at the state and federal levels to increase access to hepatitis B and C prevention, testing, and treatment. We include a focus on expanding access to hep C treatment in the criminal justice system, which is particularly relevant given the criminalization of drug use. We also advocate for expanded access to syringe and harm reduction services as well as linking people who use drugs to hepatitis screening, hep B vaccination and treatment, and ongoing healthcare. We advocate for increased funding the CDC's division of viral hepatitis which currently receives an inadequate $34 million annually. We recently joined over 90 organizations in calling for an increase of $100 million in additional appropriations to allow NVH to better respond to hepatitis B and C. We work to protect Medicaid and the ACA by providing public comment and action alerts to bring attention to the importance of our healthcare safety net for those living with or at risk for hepatitis B and C.

Next slide. A highlight of NVHR's policy work has been the hepatitis C state of Medicaid access project in partnership with Harvard Law. We provided a comprehensive review of state Medicaid restrictions on access to hep C treatment by looking at policies regarding liver damage, sobriety, and

prescriber requirements. You can find more details including the grades and maps on our interactive website stateofhepC.org.

Some of the major findings. Despite the important public health potential of a cure for hep C and the opportunity to eliminate this disease, many state Medicaid programs continue to limit access. These limitations run counter to clear guidance from CMS and the treatment guidelines of the leading medical societies. We are pleased to note that at least 16 states have lowered their restrictions in the months since the publication of our report. However, these changes have mostly come in the form of dropping disease severity requirements and many of the restrictions related to sobriety and prescriber limitations have remained in place or improved only modestly.

These restrictions are the types most likely to block progress in addressing the hidden casualties of the opioid epidemic. As they bar access to hep C treatment for individuals who are currently or recently using drugs and for those who reside in rural communities with less access to specialty providers. We encourage you to contact us at infor@nvhr.org to join us in advocacy efforts it improves access to hep C treatment in your state.

Next slide. Switching gears now to our program department, we offer capacity building and TA to partner organizations in the community and healthcare providers working to increase routine screening and linkage to care for individuals at risk for or living with hep C. We provide educational webinars on topics such as success of routine hep C screening in emergency department settings and on the recent increases in hep C among pregnant women and infants, which have occurred in parallel to the opioid epidemic.

We also convene working groups for clinicians and publish fact sheets, including a recent series highlighting the variety of hep C related health

conditions that may occur outside the liver. We also offer mini grants to community partners working on the frontlines to address hep C in a variety of settings including homeless services, syringe exchanges, and prisons.

Next slide. Finally I'll say a few words about one of our signature programs working to address barriers to hep C care faced by individuals who use drugs. Our more than tested, cured project has worked with three grassroots partners to engage folks who use drugs to identify the barriers and define the solutions to improve access to hep C care. We've worked directly with drug users to develop appropriate educational materials and worked with syringe exchange programs and local healthcare providers to better understand the barriers to hep C care and develop the solutions to expand access. NVHR is very proud of our work to support community-driven and drug user-led solutions to hep C and we believe our findings will continue to have national implications.

Next slide. Thank you for the opportunity to speak. It's now my pleasure to introduce Louise Vincent, Executive Director of the Urban Survivors Union in North Carolina. She'll share some more information about our work together and her organization's leadership in addressing the healthcare needs of people who use drugs. Thank you.

Louise Vincent: Hello. Thank you, Tina. My name is Louise Vincent and I work with the Urban Survivors Union. We are a community-led group whose mission is to improve the lives of people who use drugs by ensuring respect, dignity, and human rights and social justice for our community. I’m truly grateful to be here today.

Our programs are carried out by people that use drugs. We believe that people who use drugs want to be healthy and have the capacity to be healthy given the proper tools, education, as well as support and a non-stigmatizing

environment. We know that people's rights and health are inextricably connected.

Next slide. So we are a drug user union. We have chapters in Greensboro, North Carolina, Seattle, San Francisco, Charlotte. We're working on developing chapters in West Virginia and a number of other places. So it's very exciting. Drug user unions have about 40 years of history mostly in Europe. And one of the cool things about drug user unions is we're positioned to be reactive, meaning when there's a strong batch of drugs out, we get the information first. We are able to disseminate that information and help people protect themselves. We're pragmatic and highly purposeful. People that are existing in the active drug scene benefit from drug user organization. It gives people passion. They are engaged in their life. They feel part of. It's this idea of moving from a passive recipient of service to an active service provider.

In the Piedmont Chapter, that's the chapter that worked with NVHR on this project, you can see we passed out 435,000 syringes this year. And you can read some of our outcomes. But we also, in all of our chapters, participated in safe injection facility discussions in both Seattle and San Francisco. And we were involved in advocacy-related work, a stimulant user project, smoking as a harm reduction tool, and a naloxone access project. We helped to pass legislation in North Carolina for both syringe access and naloxone access.

Next slide. So basically, working with NVHR on the beyond tested, cured project has been amazing. So one of the things that this project did was it gave us, and I call them grant parents. So NVHR really came in and was able to work with us. They included us as true partners and all of were small, grassroot groups, peer led. And they were able to help us learn the tools of good public health. So logic models, all of, logic models, gannt charts, these

type of, you know, all of the things that are so necessary. They also did the evaluation and helped us get to national conferences and webinars.

So next slide. So basically, you know, we really try to put our money where our mouth is. We pay active drug users. We use team-based systems so that no one person has all of the information. You know, some people are really worried about paying active drug users. But we pay other people for doing jobs and it's really important that we pay people for doing work. You know, there's a lot of considerations and we went—and we found out a lot of things doing this project with NVHR. You know, when you pay people stipends it creates tax liability. And we need to train people. We need to let people know what's going on and help them. We don't want to harm them, you know, we don't want to harm people. We want to help them. So we need to understand where the tax liabilities exist. And what that means for people.

We need to educate and have discussions about what's helpful for people and what they're able to do. Reimbursements are not always helpful for people in the community. You know, we don't have the credit cards often and the credit needed to check into hotels sometimes. And we can't wait months often to be reimbursed. So it's really important that we understand these things working with people that use drugs.

Next slide, please. Sorry about that. Okay, so in order to end the opioid epidemic and all the—and reduce the harms that are associated with this epidemic, we need to make sure adequate funding should be allocated to the groups led by people who use drugs. And this next one, outside organizations should partner with organizations led by people who use drugs. So that's exactly what NVHR did with this project. They worked with people that couldn’t have gotten that funding possibly. And helped us learn how to be good grantees and helped us learn how to participate and be in this process.

Representative from organizations of people who use drugs, we need to be members of national and coordinating bodies. So and we need to address stigma at every level. We need to educate and raise awareness. And when we see it, we need to help people use culturally sensitive language and strategies. And this is one of the main things that drug user unions can do. We can come in and we can do these trainings. We just got through doing a training in West Virginia. We are people that use drugs that are also trained and have the tools and education that can help health departments, that can help community-based organizations practice and use more, you know, more culturally competent language. Learn how to interact with people that use drugs. Those are all really important pieces to this.

Next slide. And then just remembering that people who use drugs need to be involved at every level of health programs all the way from program design, to evaluation. And like I said, being trainers and really making sure that we have low threshold centers. You know, I've visited a lot of syringe exchanges across the United States and one of the things that strikes me, in many of them, is what it takes to get in that door and sometimes we have got way too much sitting there. You know, the jump is way too far. And just remember to support local and national drug user unions. I know the idea of a drug user union sounds strange to people and some people really don't understand it. So if we could talk and share about the importance of drug user led networks and really remind people that people that use drugs need to be treated like human beings. We are people and we need respect and we need to be treated with dignity and we will never be able to improve our health without these things. Thank you.

Corinna Dan: Louise, thank you so much for sharing your important work on the ground with people who use drugs. I really want to express my appreciation for your

perspective and for just sharing, because I think that work is so important. And thank you also Tina and to all the other panelists. I recognize that we have just a few minutes here left in the room. We've already gotten some fabulous questions. So I wanted to respond to some of those right away and then if we have additional time, we'll definitely take more questions.

So is this webinar good for CE requirements? We do not have CEs associated with this program specifically. But in some cases, national associations or states may accept the information about the webinar and the length of time that you participated. And call that continuing education credit. So I would recommend that if you want to do that to follow up with the folks in your state or with our organization and let them know that you participated in this webinar.

I got a question about resources for needle exchange programs specifically in northern Ohio. Wanted to let you know, I wasn't exactly sure what resources you were talking about. But wanted to give credit to the CDC, which has a resource page for syringe services program that may be helpful in terms of information and connecting to other resources. We also have the North American Syringe Exchange Network at Nasen, N-A-S-E-N dot org. They have information about where needle exchanges are located.

We did get a question about available federal funding if the resources that you are asking about were related to funding. And I wanted also to just make sure that people know that CDC, HRSA, and SAMHSA can make existing federal funding available to be used for certain components of syringe exchange programs. There is a process and CDC has been very quick in responding when states or local jurisdictions make the request to use those funds that they're receiving for syringe services programs when the state or jurisdiction has demonstrated the need. So CDC's website had the information about how

to apply to use existing federal funding. At this time I am not aware of new funds that are available from the federal government.

One person asked about the resource that Dr. Mermin mentioned in terms of the guidance, HIV and viral hepatitis outbreaks for people—among people who use drugs. They ask specifically if that guidance will address STDs like syphilis among people who are injecting methamphetamines. Dr. Mermin was able to share that the guidelines do not—for outbreaks do not directly address syphilis. Although it supports linkage to STD clinics and medical services. However, CDC does already have an existing comprehensive health guideline for people who inject drugs, which is available on the website, generally speaking not in the contest of an outbreak.

So one other question that we go that I thought was really great. For people who are working in MAT, or methadone programs, they're asking if generally MAT programs are testing for HIV, hepatitis B, hepatitis C as part of their physical exam. And I would say that from the research, it appears that many MAT programs are not testing. That's a dynamic that we believe should change over time and we have seen an increase in the proportion of methadone programs that are testing for those infectious diseases. But I would encourage people to think about how either from a methadone program perspective they could add testing or add a referral to those testing services. Or from an external person like, I think, the PCC clinic person mentioned that they also collaborate with methadone programs in the neighborhood. So there are a lot of opportunities to get folks referred to testing. And then into health services, short of expanding programs to do everything. Because we know sometimes it's a challenge to do everything well and we want to make sure that we're getting people to the right services, in the right places.

I want to acknowledge that it is 4:29 and all of you who've been with us for the hour and a half have really been patient and great. Really want to appreciate all of the work that's going on in the field that we haven't had a chance to showcase. And, if you could go to the next slide please. Wanted to bring up first off that we are doing an evaluation of today's webinar and we really do use that information to improve the work that we're doing and the future webinars that we're planning. And we are planning future webinars.

Next slide please. And then finally, next Monday, March 12, and Tuesday the 13th, the National Academies of Sciences, Engineering, and Medicine are doing an infectious disease consideration with response to the opioid epidemic. Rich Wolitski mentioned it earlier, but there is still time to register for that webcast. There may still be space in the room if you're in the DC area. And we're excited because we'll be featuring opening remarks by the new Assistant Secretary for Health, Dr. Brett Giroir.

So with that, I think we're out of time. Are we out of slides too? All right, so thank you all so much for your time today.

Rich Wolitski: Thank you so much everybody. It's great to see these examples of good thinking, good work, on the ground and we look forward to continuing our partnership with you to fighting these epidemics. Thank you.

Coordinator: This does conclude today's conference call. Thank you for your participation. Parties may disconnect at this time.

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