Standing Advisory Committee
Opioid-Associated Disease Prevention and Outreach Programs
December 10, 2021
10:00 AM – 12:00 PM

Attendance list

Committee Members Present	**Others**	
Andrea López	Allison Thomson	Jack Latchford
Deanna Dunn	Andrea Shearer	Jason Bienert
Robin Rickard	Anita Ray	Jeff Beeson
Dr. Jinlene Chan	Amy Higgins	Jerah Griffith
Dr. Gregory Branch	Anjana Rao	Jessica Ellis
Terry Prochnow	Arron Hall	Jessie Dunleavy
Victoria Sterling	Barbara Allen	Kelci Reiss
Zachary Kosinski	Brandi Cahn	Kyle Kenny
Dr. Sarah Kattakuzhy	Caitlin Hall	LaTasha Brickhouse-Frazier
Harriet Smith	Chelsea Simms	Leah Osae
Katie Carroll	Chris Grapes	Leslie Evans
Cam Kerr	Christine Marshall	Lisa Morrell
Dr. Malik Burnett	David Washington	Marie Stratton
	Cola Anderson	Melissa Clark
Committee Members Absent	Dennis Rivera	Mike Massuli
Freedom Diamond	Doug Fuller	Patrice Blackwell
Dr. Patrick Chaulk	Elizabeth Murphy	Patricia Tichnell
	Emily Winkelstein	Peter DeMartino
	Emily Heinlein	Romonda Gould
	Eric McCullin	Ryan Devine
	Erin Russell	Sherry Soto
	Erin Woodie	Sohail Qarni
	Gregory Frailey	Tiffany Cox
	Haley Detrich	Tarsha Moore
	Himani Byregowda	Tolu Arowolo
	Howie Newton	Tonya Green-Pyles
	Izelle Van Zuylen	Zoe Renfro

I. Welcome

Jinlene Chan, MD, MPH, FAAP
Deputy Secretary, Public Health Services

Erin Russell, MPH
Chief, Center for Harm Reduction Services
Introduction of new committee members, Robin Rickard and Andrea Lopez. Introduction of committee members.

Dr. Chan: Department of health has been impacted by the network security incident. Local health departments may also be impacted directly or indirectly.

As leadership overseeing covid-19, COVID impacts everyone. No corner of our community that hasn't been impacted. To give you a sense of where we are with that. If you've been watching the news, a new variant has come into play with Omicron, and a number of cases have been identified in the state. Not unexpected. Once we heard about it, we knew it would be here in the US and Maryland. Cases are rising, seeing more community transmission. More people are being hospitalized for COVID-19. It's putting a stress on our hospitals across the state. Vaccination remains the most important tool to protect against disease. In all the settings you work in, continue to practice precautions, vaccination, and masking. If you have any questions, the state stands ready to help and facilitate that. We're going into year three of addressing and continuing to respond to this COVID-19 pandemic. It still is front and center at the Maryland department of health. Because of widespread impacts on all communities, I want this group that's focused on preventing harm regardless of the community to be aware of covid-19. As we move forward, we'll hear updates on our SSP activities from partners over the past quarter. Erin and her team launched a new pilot to test drugs in communities, we'll provide an update on that later. We've made strides on the discussion of the last meeting in talking about the structure of the committee. Hoping for good discussion about creation of a vice chair role on this committee to support work we have and the expansion of our work.

Dr. Sarah Kattakuzhy [chat]: I did just want to say that vaccine hesitancy is real and affects our communities for a number of reasons, and is something all of us can address and help combat. If anyone has questions about how to address vaccine hesitancy, please contact me! I've had lots of heart to heart discussions in the last several months. skattakuzhy@ihv.umaryland.edu

II. Advisory Committee Actions

- ***Approval of meeting minutes from September 2021***
  Dr. Gregory Branch: Motion to approve.

  Victoria Sterling: Second

  Dr. Chan: All members in favor say "aye.

  [Multiple]: Aye.

- ***New SSP application:***
  Erin Russell: MDH received an application from an existing SSP for operation in an additional jurisdiction. Request for volunteers to serve on the subcommittee for application review. Existing subcommittee members have reviewed five or six applications. Looking for new volunteers. Who has time over the next few weeks.
  Volunteers: Victoria Sterling, Dr. Sarah Kattakuzhy, Harriet Smith, Cam Kerr, Deanna Dunn, Katie Carroll.

- ***Vice Chair update***

Vice Chair discussion

Dr. Chan: Talked about an additional position in prior meetings. Did follow up after the meeting and talked to the assistant attorney general office and office of boards and commissions to get guidance. Next step is we understand that there would need to be changes to the legislation to change the positions and to appoint a co-chair. We are able to do a vice chair via bylaws. Nominating from the existing membership. Authorities are delegated by the chair. In order to create a new position, we would have to make adjustments to the state statute that created this committee. Had been discussing community co chair over the past meetings. Can instead establish a vice chair.

Erin Russell:
Review of position proposed duties:

- Support development of each meeting's agenda by connecting in advance with the Center for Harm Reduction Services, reviewing the proposed agenda, and offering feedback;
- Lead meetings in the absence of the Chair;
- Facilitate Committee business by calling to vote during meetings and discussing changes and updates with members in between meetings
- Propose reorganization of the committee as necessary to meet its duties (establishing new subcommittees, etc.);
- Chair subcommittees as needed; and
- Recruit and support members.

Bylaws language:

1. Will serve a two-year term, renewable by vote;
2. Supports the onboarding of the next Vice Chair throughout the term;
3. Leads Committee meetings in the absence of the Chair;
4. Serves as Chair of subcommittee as needed;
5. Serves in other supportive capacities as requested by he Chair or Committee;
6. Participates in the development of each Committee meeting agenda;
7. Facilitates Committee business by motioning for vote during a meeting;
8. Advises the Department on individuals to serve as members of the Committee; and
9. Communicates with Committee members as needed in between meetings.

Challenges and opportunities that led to this proposal:
We have people with lived experience on the committee and have the opportunity to identify people that have the experience that the committee wants. The vice chair can be someone with lived experience, that's up to the members. The vice chair can help support the center in building a more inclusive committee. Connecting to the community that we serve--we need to do more capacity-building as a committee. Vice chair can help with that.
Another challenge to having a co chair--everyone has raised the issue of compensation. We're not able to compensate people for time on the committee, we can only compensate for travel. That's important, especially for asking someone to serve in this capacity. That's a barrier that's difficult to overcome.
Go back to the bylaws to see if there are any edits or adjustments, then we'll jump to the slide about opportunities. There are opportunities for us to build that capacity. We can discuss that today as well. Thoughts or feedback?

Dr. Sarah Kattakuzhy [chat]: I support the bylaws language as is written

Dr. Gregory Branch: Motion to accept as written

[Multiple]: Second.

Dr. Chan: No further discussion before moving to vote. For the bylaws, let's do a roll call vote.

Record of vote:
Andrea López: Yes
Deanna Dunn: Yes
Robin Rickard: Yes

Dr. Gregory Branch: Yes
Terry Prochnow: Yes
Victoria Sterling: Yes
Zachary Kosinski: Yes
Dr. Sarah Kattakuzhy: Yes
Harriet Smith: Yes
Katie Carroll: Yes
Cam Kerr: Yes
Dr. Malik Burnett: Yes
3 committee members absent for vote

Dr. Chan: Bylaw has been approved, thanks to the committee for reviewing and approving. WIll be able to elect a vice chair. Suggest entertaining nominations at the next meeting. Among the members, consider whether you're interested in putting your name in the hat for vice chair.
Idea and concept of inclusion of people with lived experience in our conversations is front and center. We should not make decisions without input of people with lived experience who are using the services that we're providing. Our goal is to improve people's lives, so that's important to us. Interested in thoughts the group has about how we can do that. Zach, you had ideas on moving that forward. Can you talk a little about that and get feedback from the larger group.

Zach Kosinski: We were talking about challenges and expectations of serving on this committee. Those requirements are things we don't set people up for success for--people don't have access to email, ability to respond to it, reading the language, participating in a virtual meeting. Everyone on the current committee had some knowledge. If we just bring someone into this role, it could be setting people up for failure. More formal ways for people to get access to those skills and find out if they'd be interested in pursuing.

Dr. Chan: Hoping to create a small workgroup to think through this. Beyond another position, are there other ways we can integrate that perspective into the committee? A community advisory component to it? Those are things I'd like to explore more--if there is interest in taking that a little further to perhaps put some proposals together for the larger committee to entertain.

*Zach Kosinski:*I'm happy to continue participating in those discussions. I think it's important to create pathways for people to be successful. There is a distinction between creating a separate mechanism for people who are active participants at SSP to participate in the state--that looks different than creating pathways for people to gain the skills to participate in a committee like this, and then decide whether they want to be on a committee like this.

Cam Kerr: There should be a subcommittee that has this conversation. Multiple reasons--one is that the only reason I have the ability to be here relatively on time with a laptop with knowledge of how to raise my hand and communicate in this space is because I work at BHRC. I was brought on to this--it took me until 3 months ago to remember the name of this position, let alone--I didn't answer emails, didn't get support from this committee. Support came from the space I worked in. The conversation needs to be a little bit broad--we need to make it broader and deeper than how can we support--whatever we can give is not going to be enough. If we're talking about people who don't have regular access to things and don't have space they can continue to open up those--it took me a long time to start answering emails. There should be deeper conversations so we can actually be supportive instead of harmful.

Harriet Smith: Just to add--I fully support what Zach and Cam have been saying. Wanted to uplift

that it's important to continue to try to have representation from people who have received Syringe services in maryland. We have a broad understanding of what lived experience means. For this group, it seems important to have that type of lived experience--received services, or used injection drugs in maryland.

Dr. Chan: Propose taking this discussion offline--not permanent subcommittee, but a workgroup to come back with further discussion and proposals. How we can incorporate their feedback and use it as a tool to improve or expand services--that would be my suggestion.

Harriet Smith [chat]: Workgroup sounds great!

Cam Kerr [chat]: 100 percent, I can't provide that type of lived experience in this space, which is why I love that uplift Harriet thank you

Harriet Smith [chat]: I nominate Zach to be in the workgroup

Dr. Sarah Kattakuzhy [chat]: Agree with a workgroup!

Andrea Lopez [chat]: I would also be interested in this work group

Erin Russell: In the chat, there is support for the workgroup comment.

Dr. Chan: Zach proposed to lead the committee.

Zach Kosinski Yes.

Dr. Chan: Before the next meeting, pull together a subgroup from the committee to talk about what that means and help define it. Have a touchpoint with you to frame this in a way and come back with tangible, actionable steps that the committee could consider.

Zach Kosinski: Will send an email out to everyone to assess interest and identify a time that works.

Erin Russell: Center can provide administrative support.

III. Maryland Department of Health Updates

Erin Russell:

New Center for Harm Reduction Services Staff
Patrice Blackwell, MSW
Harm Reduction Programs Manager

Patrice has experience doing direct care, is familiar with Ryan White, doing case management, and working with the Maryland AIDS Drug Assistance Program, that's a gap in knowledge we've had. She'll support grant monitoring. Keep an eye out for her name, you may hear from her soon. Welcome PAtrice.

Allison Thomson:

Syringe Service Program's Fiscal Year 2022, Quarter 1 Data
Allison Thomson, MPH, Center for Harm Reduction Services

Program development--no changes since last shared map except now have one pending application. That is an organization hoping to expand into an additional county. We have 19 approved SSPs and the Baltimore City needle exchange program. 8 out of 20 are CBOs, and we have 2 voucher programs in Wicomico and Frederick counties.
At the beginning of this fiscal year--we usually operate under state fiscal year with data collection--implemented changes to collect satellite data separately. Coming from the same program, but operating under authorization and agreement with existing programs. Programs use these to expand and meet people at different touch points. Authorized programs provide training, support, and supplies, and allow these organizations to register participants. They then report who they're reaching to authorized entities.
Quick list of programs using satellite services. The Baltimore county health department recently established an agreement with the Torsch Foundation. BHRC has built capacity in multiple programs across the city. Two current satellite sites. Charm City Care COnnection also in Baltimore city.
SFY22, Quarter 1 Program data presentation: July 1, 2021 - September 30, 2021.
All programs registered 2,726 new participants. 34% increase from same quarter last year. 6,699 total participants served. Following slides have separated by local health departments and community based organizations. LHDs registered 828 new participants and served 2,358. CBOs registered 1898 and served 4343 total participants. All programs have adjusted and modified services and have grown in the past year--they've expanded, implemented delivery. It's amazing what they've done over the past two years. LHDs specifically are experiencing issues retaining and finding Peers and having limitations on building closures. Local health departments; programs seeing a lot of returning participants.

Dr. Chan: Is this about who is participating in the local health department, or where the people say they live?

Allison Thomson: This is each program name, shortened.

Dr. Chan: There's a need for these services, people will travel to where they can get services. I'm interested in understanding better where people live, if we know who seeks these services. That may signal to us that we need to expand services that are more accessible closer to where people live.

Allison Thomson: We do collect top zip codes where people live--we don't collect all zip codes. Most common zip codes are in the jurisdiction. Anecdotally we hear about people coming from out of state and coming from different counties. For example, Calvert is a new program, there may still be people from that county going to St. Mary's.

Dr. Chan: I understand some people may go to a program out of county because they don't want to go locally for fear of being recognized.

Allison Thomson: With CBOs, programs have taken this year to increase the feedback they're receiving--both formally and informally, and satisfaction with programs. The orange bars for total participants served here are evidence of relationship building.
Participants served; 48.9 percent as Black/African American, and 48.4 as WHite. Age less than 1% are under 18, 12.5% as 18-24, over 50% were 25-44. 34.6% were over age 45. Gender: still working to finalize gender options list to be more comprehensive and appropriate. As of right now, this is the list we have. 56.2% reported as male, 42.5% as female. 1.2% as Other. Drugs used reported: most common reported. 100% reported heroin,

80% as cocaine, 68.4% fentanyl, 10.5% opioid pills, 15.8% speed/crystal methamphetamine. Total encounters: a total of 22,090 encounters occurred during this quarter. 100.3% increase compared to last year's same quarter. 7 programs had over 2,000 encounters each. Local health departments account for 28.1% of these encounters and CBOs 71.9% of these encounters. Baltimore city has the highest number of encounters out of LHDs, most of the CBOs have over 2000 encounters. 1.38 million syringes were distributed in this quarter, a 41.3% increase from last year's quarter 1. 206 average per participant. 538,794 collected, 46.5% increase from last year's quarter 1. 38.9% collection rate. Collection rates: Baltimore county has 294% collection rate as a result of syringe kiosks--most are located outside of the local health department building. Lastly, referrals and linkages to care: these consist of active or passive referrals, services onsite and also provided through referral protocol. 10,678 referrals or linkages during this quarter. 74.8% increase from last year's same quarter. Overdose education and naloxone is always the highest referral.

Dr. Chan: What about other vaccinations?

Allison Thomson: I believe some programs are providing Hep B, flu vaccines, and having wellness availability at programs and onsite. Some programs collaborate especially within Baltimore City with SPOT van for example to bring them onsite or to the same area.

Dr. Branch: In Baltimore county, we do wound checks and we do tetanus and other vaccines. Because some of them are coming into the health center for the needle exchange itself. We provide all those other services. Doing Hep A as well.

Dr. Chan: Not sure how we're asking or collecting--would be interested in collecting better numbers on vaccines, whether tetanus, wound care, flu or vaccines. Adults as a whole don't get their vaccines. For people seeking services in our programs, we want to be sure to the extent we can--this may be the only health care service they access unless they're really sick. Just want to provide as many preventive services as possible.

Dr. Branch: Excellent idea. From a practical perspective, it is difficult but not impossible. When you provide certain services, it's the same location but a completely different program. SSP, won't know necessarily what the medical stuff that person is getting, because that would be confidential. So in Baltimore County, we're providing the service to the individual, but who's providing the service may be 3 or 4 different program.s those programs know to refer to each other and bring clients to each other, but don't necessarily know what happened after.

Dr. Chan: I understand that there are logistic and program challenges. We're combatting a lot of different potential health impacts.

Dr. Branch: It's do-able, but communication of all the information for the individual person is not necessarily in one report. If you go to an STI clinic and you're getting needle exchange, you may get those on the same day and at the same location, but each program doesn't know the other program that worked with that program or what the person got there. Issue is the communication of all of that information to come up with the data.

Dr. Chan: Maybe that's something we could figure out, accessing some of CRISP and immunet. One of the goals I have is that when we talk about harm reduction, it's

understanding that people access services in so many different ways and have different needs. First and foremost is understanding the numbers and the barriers.

Howie Newton: Good morning. I was thinking when you were talking about numbers regarding HIV testing--wondering if there could be some disconnect with how it's being promoted and presented. It was mentioned that numbers were low because of covid. Type of interactions taking place in regard to interactions with SSP participants, it doesn't take that much more time to conduct an HIV test. Wondering if there were some issues with how it was being promoted?

Dr. Chan: If we were able to distribute 1.3 million syringes in the past quarter, there were a lot of interactions, despite covid, which is good. But this means people are still at risk.

Harriet Smith: To add another perspective, we refer people all the time to HIV testing, to primary care, which should include HIV testing. Those are soft referrals often--ex. Including flyers. We don't count those. We're trying to get education about different services and topics, like rising syphilis rates, in conversation, and through general education--flyers, signs, etc. So this is capturing something and not capturing everything. Don't want to believe that there's a real dearth of conversation when this is the solid referrals when I think about what we report.

Dr. Chan: Do you know how many referrals are connected

Harriet Smith: Those are the ones we count--how are you going to get there, have you been there before. Don't count flyers.

Dr. Chan: Have you considered providing HIV tests?

Harriet Smith: Yes, we're partnering with the Baltimore City SPOT team to do that. Took months but the MOUs have been signed. Hepatitis C, HIV testing, and vaccinations when available through the Baltimore City Health Department and primary care for those things as well.

Dr. Chan: Looking at how we can expand onsite services so they don't get away with just a piece of paper, but a test result in hand. Knowledge is power.

Deanna Dunn: I was just thinking that not all our programs do provide the testing in house. If we're wanting to be a one-stop shop for people, we consider encouraging our programs to develop that practice. For vaccination, there's been comments about vaccine hesitancy in the community. It would be anecdotal if we know that clients are more resistant to vaccines and if we can encourage vaccination in general at our centers.

Robin Rickard: At these sites, does anyone help individuals get signed up to Medicaid so they can go see a primary care provider?

Allison Thomson: There is some insurance navigation onsite or connection to a person who can do that. When someone enrolls, asking if they have active insurance and if we can help them enroll. Absolutely that's occurring. Programs do a lot to ensure they can be a one-stop shop and bring services onsite and limit barriers.

Dr. Branch: In Baltimore County, we also assist them in getting other benefits, like food stamps. We try to present a lot of those things in a system and apply for all those programs.

Allison Thomson: Those referrals and linkages to care broken down here compared to previous fiscal year. Each linkage has grown exponentially since last fiscal year. HIV, viral hepatitis, and STIs haven't grown as much but exceptional growth in the midst of covid.

IV. Rapid Analysis of Drugs (RAD) Pilot Project

Center for Harm Reduction Services, Maryland Department of Health
Ryan Devine and Jason Bienert will provide additional information.

Erin Russell: We have launched a pilot project to test routine paraphernalia that is returned to a syringe service program. We started out with 8 sites, all received training by Maryland State Police and National Institute of Standards and Technology (NIST). Paraphernalia does not have to be transported to the lab for testing, and gets swabbed. Using a DART mass spectrometer. Swabs go into this machine, within a few minutes, we have results of everything in this sample. On the envelope there is a case number, results are uploaded to align with the case number. Programs have access to results and case numbers to share results with participants who provided the sample. Observed gap in our understanding of what's contributing to overdose in Maryland. This is a way we can systematically obtain new information about drugs being used and see the landscape across the state. Fills the gap we have in understanding what's causing overdose deaths. This information is not just for us at the state level. It's for partners contributing and for people using drugs in Maryland to understand what's in their sample and what other people in their community are seeing in the drug supply. This is critical information. Samples being sent to the lab takes one to two weeks to turn around, slower at the start of this project. Different testing programs have smaller machines on site--other states where testing has been done have taken that approach. We're trying out a centralized testing approach so we can use DART, but hope to explore different options over the long term. State level approach benefits local testing because it fits into the context of what's happening statewide. We're communicating with other states doing this testing. Hope it helps us understand cross state drug trafficking links. Has been a strong movement towards drug checking across the country in recent years. To make this happen, looked at legal authority to do so. Syringe service program legislation allows for collection of paraphernalia, those providing it and those handling it at the program. Strong support at the department to pursue this, talked to a number of other stakeholders.

Jason Bienert: At Voices, when the idea first came across, we started working with participants in the field directly. We told them we could test their drug supply and give them a better idea of what they're injecting. Everyone knows it's not heroin and they actually care what they're putting into their body. At that point we gave it some publicity, assured them it would be anonymous. Told them a month turnaround. This is something we could use to help. In cecil we have a huge issue--initially we thought just xylazine. Coming out of Baltimore, we have an issue with levamisole--that's what I thought I was seeing. Now that samples are returning, it's validation. Wounds are unique, treated totally differently. Luckily I had experience with them, but participants are much more assured that the information they're getting is better and it's real and we can squash rumors that this has--whatever everyone is saying on the street. Reality is that much is the same, probably coming from the same source. Another interesting part is that nothing travels over the Susquehanna river--it seems like a natural border--I don't know if people don't want to pay for it or tracking

scares them. But we haven't seen anything cross over. That's about it. When we're in the field--doing wound care gets us deeper than SSP. If I see anything testable, I just ask for it. If the participant is someone we regularly see and the team is out, give them a personal sharps container and they hand it to the SSP team and tell them, this is for Jason. Because I've been handling all the testing--easier to have it centralized, because if somethings wrong, I can fix it. Cecil branches into eastern shore and there's a different drug supply--everything different, stamps, different sources. Interesting to see as the results come in. because wounds down there are slightly different from what you see in Cecil county.
Anita Ray: Ryan was on the phone but he's off today. He thought we may have been able to share earlier. I will say it has been a great experience for us in Calvert County. LIke was shared earlier, participants are interested in what they're using. We've seen from data you shared--we've had a pattern of everyone having fentanyl in their drugs. We go to people's houses--we've had a huge success with giving covid vaccinations, flu vaccinations, HIV testing, Hep C testing. We're 100% mobile, we go into recovery houses, we have a huge homeless population. We've given double doses to people. As far as testing, people welcome it, they want to know what they've been using. They don't have to bring anything to us, we're mobiel so we go to them. Ryan has been a key component of our success with getting testing done. With PHQ4 to interviews to see if they have any kind of behavioral health issues. That has gone extremely well and we've opened up primary care--that ties into trust and continuity of care.

Chelsea Simms: A few programs were having issues getting buy-in from participants. At Calvert, it's been great. Participants are interested in the program and are eager to participate. Our HRT team did reach 10,000 syringes distributed, we're really proud of them.

Anita Ray: We thought 10,000 would be what we do in 12 months, we did it in less than 6 months. The program has taken off. You all have been an incredible support system, we thank you too.

Erin Russell: We are partnering with JHU to evaluate our harm reduction programs, that team will be providing some support to evaluate how this goes for programs, as well as the Overdose Data to Action grant that is support evaluation as well to see how results can fit into Maryland strategy more broadly.

Anita Ray: One of things we are hopeful about is that this is something we can continue to help us with having a more data-driven perspective. If you want feedback from our population about this project, we are more than willing to share.

Robin Rickard: DC has the same type of program. The chemist found the same type of thing, such great information to have. They do the same thing you're doing with RAD, it was a swab of syringe, found this new type of drug. They're then able to get information out that you may need more than one or two naloxone to bring someone back. Because it's much more powerful. Excited we have this program here.

Erin Russell: Through testing programs of syringes in DC, they identified nitazine. I have spoken to SSPs there and they've increased outreach directly to communities where those results came from. I think we can do similar direct action if we see a new substance. Thanks for highlighting that. Partners at Baltimore Washington HIDTA drafted a helpful analysis of nitazine, what it means, what it is--bringing in those resources to understand these new

substances has been helpful too.

Deanna Dunn: I had the opportunity to play with mass spec in this capacity. It was one of the most exciting experiences to get real-time proof of what was being used. I think it's great that Maryland is implementing this and we're in the beginning steps. How can we make this into a prevention service to prevent our participants from having to use the drug prior to testing--that would be the most valuable thing for them. So far it's valuable for us, and we're giving tips to manage repercussions of using the drug. But I hope it continues to evolve towards that goal.

Erin Russell: That would be the advantage of point of care testing--the smaller test machine--onesite at a program--as well as swabs to get a general sense.

Lisa Morrell: I know we all heard the great news about the program in New York opening the same injection site. There was a little clip last night on NBC news about it. It went inside and was eye-opening to see it, made a great point of the public health approach and how powerful it is. Recommend everyone to see it.

Erin Russell: This [grant opportunity referred to in chat] is part of the American rescue plan, 30 million set aside for harm reduction, SAMHSA is putting some of that out. Established an unprecedented harm reduction grant--400,000 a year for 3 years. It's what we have all been asking for from our federal partners--open to any organization--a local health department, state health department, nonprofit organization, etc. It's a step in the next direction, we need more federal money directly for these services, especially nonprofit organizations. Sent around an email yesterday--we're just getting started working on it. We want to talk to our harm reduction community and partners and obtain some input on what the best approach is for Maryland, if the state should apply, and if others will apply. To be determined on how we approach that for our state.

Cam Kerr: It's two sites that have been opened--Overdose Prevention Centers--one in Washington Heights and one in East Harlem. They opened last Tuesday. The last number I heard this week was 15 people who had been saved from overdose in those spaces. Kind of what Erin said earlier--that bittersweetness. They are having tours of the facilities and so there is a sign-up sheet to reach out to them. Some members of BHRC are going and others are enroute. Definitely highlight that it would be great for us to be next. Need to do the work of educating those around us and hope that the legislature can be bold. They don't even have to be bold, they can just follow what New York has done.

V. Public Comment

Jessie Dunleavy: Is there any data regarding SSP programs and incidents of HIV in the counties so there's incentive for expanding the programs into other counties.

Allison Thomson: That's a goal we're working on this year to evaluate using our Hopkins partners to look at rates and prevalence of Hep C to evaluate our program's effectiveness.

Peter DeMartino: We are working towards integration of all programs. SSPs have a longstanding history of frontline HIV prevention and linkage to treatment and care. We are definitely looking at that with our partners at Hopkins and utilizing available HIV surveillance data. I will note first that the pandemic has impacted HIV testing and the

diagnosis of people living with HIV. it varies from jurisdiction to jurisdiction. We definitely have jurisdictions that are home to the larger proportion of the epidemic in the state. Tend to be in central Maryland, using that broadly. Diagnoses are overall low, so we need to work with partners including harm reduction programs to make sure people are receiving the care they need when they need it, including screening for infectious disease. There are jurisdictions where their reality is 1 in 4 people being diagnosed with HIV are within 3 months of an AIDS diagnosis because it is a late diagnosis. There's still that public health mandate for routine HIV and not just HIV but routine emphasis of sexual health and drug user health overall that includes HIV screening everywhere. So we can definitely do a much better job of screening people for HIV. Our harm reduction partners have been exceptional at providing that service and linking marylanders to that service.

Jessie Dunleavy: With regard to counties that haven't implemented SSP yet, do you just leave it up to the county to show an interest and go through the process, or is there an attempt to sell them on the idea?

Erin Russell: At this stage, we're not actively pushing or engaging counties or health departments. Since the center has been established, harm reduction is much more present in the conversation. Our ACCESS harm reduction awards are offered to all local health departments--many receive the awards but do not have SSPs. Even through the application process, they're being educated on SSP and the goals we expect our grantees to work towards. Anytime there's interest, we provide presentations, I've had one-on-ones with health officers. Our conferences have been another great resource--we held events that engaged partners from across the state and talked about harm reduction and brought SSP to the table in a new way for a lot of health departments. A combination of a lot of the work of the center and harm reduction being a lot more present in the state's response to the overdose crisis. We've seen more interest, as DR. CHan says, there's so many considerations. Those who aren't doing it yet, there are things that need to be ironed out before a launch would be successful.

Deanna Dunn: Follow that with a burning comment--so proud to be a part of this committee. The more I'm involved in this work, the more I'm impressed with what Maryland is doing. Wanting to maximize what we're doing in our state, knowing COVID has made it clear that we don't operate in a vacuum. A lot of states that could benefit from this are having worse crises. How can we help facilitate more people to experience what we are accomplishing in maryland--the data really helps. People listen to the numbers. I wonder if we couldn't have maybe a newsletter or something. All the data I've seen in this meeting, I can go share with people. How can we replicate or have some easy handouts for people that can help expand what we're doing? We see other great things happening in other states. The fact that we have a state run committee is very unique.

Dr. Chan: Are you suggesting an annual report that outlines accomplishments? A report could be very long. But it could be a start.

Deanna Dunn: How can we make that more accessible in general?

Erin Russell: We can do a better job of that at the center, we're building staff capacity and MDH shifted to a new website platform, we've all been trained and able to make more updates to the website now. We have more opportunities to post public information.

Dr. Chan: [referring to comments in the chat regarding information about Hepatitis, HIV, PeP, and PrEP]. Interest from committee members, important for all SSPs. Don't want to pigeonhole a person into one category as someone who accesses Syringe Services PRogram; striving to take a whole person look and meet them where they are for their whole health needs. If they can trust the syringe service program or primary care, we want to provide as much as we can in those locations. If there are programs we can highlight at that next meeting that are providing PeP and PrEP, that program-level experience would be helpful to provide.

Deanna Dunn: The Maryland Regrounding Our Response curriculum was a part of our presentation at the USCHA conference last week for HIV/AIDS. We presented on the rewrite we did for WEst Virginia, we're having the official launch of the West Virginia RoR curriculum in January. I'll share the registration link in case anyone is interested.

Lisa Morrell: I saw an article about PrEP and put it in the chat.

VI. Closing