Maryland
DEPARTMENT OF HEALTH

Standing Advisory Committee
Opioid-Associated Prevention and Outreach Programs
June 11, 2021
10:00 AM – 12:00 PM

I. Welcome – Erin Russell, Chief, Center for Harm Reduction Services

Standing Advisory Committee Roll Call

In attendance:

Gregory Branch
Victoria Sterling
Katie Carroll
Dr. Malik Burnett
Dr. Sarah Kattakuzhy
Lt. Joshua McCauley
Dr. Deanna Dunn
Cam Kerr
Dr. Patrick Chaulk
Dr. Susan Sherman
Harriet Smith

Others Present:

Allison Thomson
Erin Russell
Dana Heilman
Kyle Kenny
Wende Huang
Patrecia Williams
Colleen Lamont
Amanda Walton
David Washington
Elizabeth Murphy
Tonya Green-Pyles
Katie Evans
Rondi Suit
Alicia Nelson
Derrick Hunt
Jeff Beeson
Trisha Tichnell
Peter DeMartino
Lisa Morrell
Lyra Cooper
Caitlin Hall
Zoe Renfro
Jenna Harrison
Arron Hall
Himani Byregowda
Jacqueline Burrier
Kelly Drummond
Leah Osae
Melissa Clark
Romona Gould
Tiffany Cox
Talia Pettway
Melvina Hall
Cola Anderson
Chelsea Simms
Christine Marshall
Tasha Jamison
Tammy Hubbert
Primett Jones
Crystal Phillips
Seun Falade
Marianne Gibson
Amy Hecht-Zizes
Augusta Gribetz
Erin Woodie
Gregory Frailey
Jordan Strieter
Leslie Evans
Lisa Pollard
Mark Robinson
Rae Elkasabany
Harriet Smith
Holly Luther
Mike Massuli

Mia Williams	Sohail Qarni	Howie Newtown
Ben Stevenson	Catie Brenneman	Izelle Van Zuylen
Anna Corselius	Jessica Ellis	
Emily Clouse	Chris Ora	

Welcome

Dr. Peter DeMartino, Director, Bureau of Infectious Disease Prevention and Health Services

I'm here on behalf of Dr. Jinlene Chan, Welcome. Dr. Chan now has the permanent placement as Deputy Secretary for Public Health. Thank you for participating in the SSP Standing Advisory Committee. Thanks to the committee members, Dr. Chan, and Center for Harm Reduction Services, and members of the public. Lots of challenges this year. I want to personally and professionally recognize the dedication to people who use drugs. SSPs have been exemplary in never wavering in providing services to the population that we serve. Advisory committee meetings bring us together to discuss state of syringe services in Maryland, acknowledge what we're doing well, where they are opportunities for improvement in systems of care. Overdose deaths are higher than ever. Maryland is one of three states with a dedicated center for harm reduction services.

II. Introduction of new Standing Advisory Committee Members

Erin Russell, Chief, Center for Harm Reduction Services

Vicki Sterling is Director of Behavioral Health at Washington County. She is the representative for the Maryland Association of Counties on the committee.

Vicki Sterling: I'm excited and honored to be on the advisory committee as representative of MACO. We've modeled meeting people where they are at Washington County harm reduction program. We're always there, my team goes above and beyond. I'm excited to hear what other jurisdictions are doing and share things we're doing.

III. Introduction of New Syringe Service Programs

Power Inside

Cola Anderson, Harm Reduction Programs Manager

Power inside is a holistic harm reduction organization that's been around for 20 years. We're excited to expand in this way. We provide a myriad of services for women, we're looking forward to being a part of the SSP community. We plan to launch our program July 1st. We're happy to be starting these services, they're definitely needed.

Family and Medical Counseling Service, Inc.

Mark Robinson, Regional SSP Coordinator

We really appreciate the opportunity to expand our services in Maryland through MDH. We've already been operating under the Prince George's Health Department and have made great inroads in that community and meeting people where they are and helping save people's lives through SSP and harm reduction efforts and initiatives, to meet people right where they are without judgment and without stigmatizing their lifestyles. We've seen the program making a huge impact in reducing infectious disease transmission and connecting people with primacy care, behavioral health care, other treatment services. FMCS has been in existence since 1976, operating in Washington DC and has a long history of doing what we now call harm reduction within disenfranchised communities, dealing with people who have been marginalized for decades. The solution is trusting relationships and helping people transition through their issues. We look forward to the opportunity to expand our services, it's a great mission, I'm glad to have support and knowledge with these other entities.

IV. MDH Updates

ACCESS Maryland Harm Reduction Conference

Erin Russell, Chief, Center for Harm Reduction Services

We will have a conference on August 5th—it's all virtual, there's an opportunity to have speakers to be in person and then we'll stream their presentation. Attendance will be all virtual. The link is in the chat box. I encourage you to register early, because you'll get a package in the mail of the swag you'd get when you show up to a conference. We are working on engaging measures such as watch parties. Please check out our website, register. Conference theme is building healthy harm reduction communities. We came up with this theme before COVID. Now that theme and content is more critical than ever. We're looking forward to honoring that for our harm reduction community, talk about how we're there for each other.

Maryland Harm Reduction Landscape and Needs Assessment Solicitation

Erin Russell, Chief, Center for Harm Reduction Services

We're launching a housing initiative, we have an open request for application (RFA). We're looking for 1-2 partners who can do a landscape and needs assessment about what housing options are available. It will coincide with a harm reduction housing workgroup that will review outcomes and results and brainstorm about how to put them into action. Thanks to everyone who has already signed up. We want to make you aware this is something we're working on, if you know an organization that's a good partner.

ACCESS Telehealth Update

Dr. Sean Falade-Nwulia, Johns Hopkins School of Medicine

I'm a physician at Hopkins where I provide infectious disease and SUD care. I spend a lot of time thinking about how to improve access to care. I'm working with a group of providers who have provided care to patients with SUD in Maryland for over 15 years. I'm excited by this initiative that has been put forth by CHRS where we're working in collaboration with MDH and SSPs to improve access to OUD and Hep C care. Our mission like many on this call is promote healthy outcomes for PWUD. The vision of this program is to make treatment for OUD and viral hepatitis universally accessible for PWUD. This audience is familiar with this data. SUD is a big problem nationally, opioid use in Maryland. We are seeing increases in overdose morbidity and mortality and in hepatitis C virus infection. It's critical to develop strategies to mitigate prevalence. The lighter colors [on this graph] are lower prevalence and darker colors are higher. The areas of Maryland with the highest number of cases are in Washington county, Baltimore city, and Somerset county. The challenge is that in these regions that suffer the brunt, there are fewer providers available. Which makes the opportunity to provide care in these regions via telemedicine very exciting. In addition to the benefits that individual patients get from treatment and cure for hep c, we have evidence to show that if we treat people who use drugs for Hep C. The proportion of people infected with HCV went down, because more patients were getting treated, patients treated and cured less likely to transmit, and Hep C was controlled. Medications for opioid use disorder—still some concerns in our communities. People are hesitant and concerned that treatment OUD with medications is replacing one drug with another.

Patients receiving buprenorphine and methadone, drug use dropped significantly. The fact that you get buprenorphine or methadone doesn't mean you stop drug use necessarily. Important to understand. These medications reduce the risk of acquiring hepatitis c. Multiple studies look at what happened to patients who got MAT. Overall, patients who received MAT had 50% reduction in likelihood of acquiring HCV. MOUD also serve us as overdose prevention. The introduction of buprenorphine made a difference in reducing overdose death. Data from patients who had one overdose (overdose is a sentinel event that increases future risk of overdose). Patients that got methadone or buprenorphine were less likely to die. From clinician perspective, think about addressing health needs of PWUD. SUD is a treatable chronic medical disease that involves complex interactions—brain circuits, genetics, life experiences, and the environment. Cure for OUD is not instant, patients require ongoing support and treatment. Cure for HCV is simple. Medications patients take for 8-12 weeks and they are cured—can you imagine how positive an experience that is to receive treatment and be cured for a stigmatized disease? This treatment needs to be stigma free, language matters.

With ACCESS telehealth, we're working with MDH and SSPs to assess available telemedicine infrastructure at SSPs. We will leverage expertise of the Johns Hopkins office of telemedicine to implement the telemedicine infrastructure. Then develop strategy to

implement opioid use and viral hepatitis treatment at SSPs via telemedicine. We'll ensure that OUD and HCV services fit into the SSP workflow for other service provision.

The goal is to provide patient centered care grounded in best practices of addiction medicine. Motivational interviewing, patient identifies their goals, use their goals to keep patients engaged. Harm reduction is key part of everything we do. Encouraging engagement in services provided at SSP. Prescribe buprenorphine to treat OUD, prescribe HCV treatment medications. Patients have opportunity to be evaluated for mental and behavioral health concerns. The goal to work collaboratively with SSPs and MDH partners. Make sure we're meeting needs of patients.

We have had integrated programs at partner practices for a couple of years. This slide is sharing some perspectives of patients. Comprehensive care located at one site is better for patients. Here are some quotes.

"It felt like things were going to be okay"

Harriet Smith [chat box]: Are there efforts to get more providers to consider offering the cure to people who are homeless, using drugs, trading sex, and / or other elements of life that typically get patients denial of the medication?

Sarah Thomas [chat box]: Harriet I'm part of a group that is petitioning Maryland Medicaid to remove any questions about drugs and adherence (which are a set up for discrimination) from the Hep C approval process. For the first time we are getting traction, so hopefully this will help with provider hesitation.

Dr. Seun Falade-Nwulia: I think we have a lot of experience connecting patients to drugs. We will leverage that to ensure every patient that presents for care gets access to that care. Like DR. Thomas has alluded to, sometimes that involves writing lots of appeal letters, getting on the phone with insurance. Sometimes involves being able to explore other avenues for access to drugs, including patient assistance programs. We will be leveraging that experience providing care to this population to ensure that every patient that presents is connected. It may take a little longer, but we always find a way to make it happen.

Chris Ora: People Encouraging People in Baltimore city is leading overdose prevention on street outreach. In terms of the reduction in disease, is there any relationship that's been tracked in conjunction with addressing the other life issues, especially because I'm excited about housing being talked about. When you're talking about cure, there's a cure and then there's relapse. How does that sustain the cure in the longer trajectory?

Dr. Seun Falade-Nwulia: Excellent point, one of the key things is that our care provision in this population has to be comprehensive. A key part is addressing the social determinants. One thing we work on with individual sites is to understand what services are available locally so that we can connect patients to those services. In our program in Baltimore, it's key part of what we do—help people connect to work programs, housing, food, transportation. These are things we are working with the individual sites to understand

what services are available. Bigger discussion is trying to understand what services and opportunities are available in MD as a whole, so patients are connected to social services they require to engage in their recovery.

Harriet Smith: Sorry, another question. Are there efforts to get buprenorphine and methadone providers to offer Hep C treatment at the same site? I'm especially thinking of the CBO providers.

Erin Russell: There may be additional efforts led by the Center for Hepatitis within our Bureau, I can follow up on that. Shout out to the OOCC who's funding supported the launch of this project. They have been supportive funding for our harm reduction work. Although there are lots of funds for SAMHSA to support treatment expansion, they are not the best funding for a harm reduction treatment program. SAMHSA required evaluation requires a lengthy survey of each patient, which immediately makes the program high threshold. We're grateful to the OOCC, which means we can run this program in a harm reduction manner.

Maryland Harm Reduction Training Institute (MaHRTI), Syringe Service Program Academy

Rae Elkasabany, MaHRTI Coordinator

I'm with the Maryland Harm Reduction Training Institute. We are in Behavioral Health Systems Baltimore (BHSB). Our goal and mission are to provide training and technical assistance (TA) to a variety of audiences throughout Maryland, including peers, PWUD, all ACCESS grantees, SSPs, and ORPs. We provide trainings for staff of these programs, we also offer TA. If you all run into any issues that you need help with, we're happy to assist. You can find the TA request form on our website. In the past we've done core trainings in person, last fall we did it virtually for the first time. This is the latest evolution of our training process. This will be an online learning platform like taking online courses, which will be on demand. Which means when programs get new staff, they don't have to wait 6 months until the next live training to be trained on these important skills. We're also going to incorporate live online courses and practice sessions, which we feel are really important, because we can tell you how to do things, but practicing is important. This is a new way for us to do this, will not be perfect. As folks go through this, we're open to feedback to improve it for everyone and make it as effective as possible. It's going to be hybrid live and online format. Mandatory on demand courses for new staff so they can be trained much sooner, hopefully within a month of them becoming new staff, that includes volunteers as well, anyone who will provide outreach. We are also doing live online courses through zoom, these are also mandatory. Wanted to do these live because data is changing, practices changing, laws changing—makes sure information is most up-to-date, gives room for discussion and questions. People providing outreach are the experts, want to provide room to talk to each other and problem solve together and build community. We're also doing practice sessions, which are optional, they will be live. And we're going to facilitate

them but give attendees the opportunity to work together on a variety of skills. For anyone providing direct care or service to SSP participants, unless they've already completed training before through MaHRTI. This is also for staff of programs that are applying to operate as an SSP in the next 6 months, so even if it's still in process, you're encouraged to participate. It's launching at the end of June, this is when registration will open, programs will receive a link so that staff can register. We will make course material available in mid-July so there's a buffer. Once we make on demand material available, we encourage people to complete it as soon as possible so you can space out the different components rather than doing it all at once. The live sessions and practice sessions will run from end of July through mid-September. We space them out to give everyone room to work on at reasonable pace, we know everyone is busy and doing a lot. Wanted to make sure programs have opportunity to work through materials, digest it, implement it. By the end of September-October, want the materials completed, there is a deadline. So, people are trained and then you'll receive a certificate. These are the mandatory courses. These are the mandatory courses, we've broken them down into different sections, people are going to do foundational work in harm reduction 101, SSP 101, then talk about stigma which will lead into outreach, how to deal with conflict, and some more technical skills like basic wound care. We are in addition to that, although not at same time, offering a more advanced wound care training but it's not included in the SSP academy. It will end with SSPs in Maryland. The laws, requirements, and SSP staff panel. There are optional practice sessions, we've picked three topics that people in the past said they'd like more practice on—outreach and conflict management, motivational interviewing, and technical skills. These are optional but complement the on-demand courses. Registration process will go smoothly and be streamlined. Programs will receive a link that they can provide to previously untrained staff to register.

Two live sessions will be recorded and attendees will be prompted to consent when entering the session. We have recorded these in the past to make these available. We do need people's consent.

Erin Russell: Previously we relied so much on National HRC, bringing in external experts, now MaHRTI has all of that in-house here in Maryland.

Cam Kerr: Knowledge is what is needed. Moving beyond that, what kind of validity does this have on a resume. Do you get a certificate, do you say you went to the training?

Rae Elkasabany: We plan to provide a certificate. At the moment, it doesn't hold as much weight as a degree. But it's still really important to say I've been through this, I have this core foundational knowledge. You can put it under special skills. I would definitely put it on a resume.

Melvina Hall: We went through 6-week course for SSP. They didn't have any CEUs for peers, and I'm a certified peer and I work with peers. In order to get our recertification, want to be able to say we hot 6 or 7 CEUs for this SSP course. We have to keep our recertification up every two years.

Rae Elkasabany: Some of our courses are CEU certified for peers, not all of them. I'm not sure if it's in this online format, we haven't figured out whether you can do it. But we are planning on putting the post test on here. Our goal is to make that a route where you can get the CEUs. I don't want to give definitive answer, because we don't know yet, but that is our goal.

Melvina Hall: When we first started, we came in the first class, they gave us a certificate of completion.

Katie Carroll [chat box]: I think it would be very beneficial to the peer credential to have harm reduction be offered as a specialist credential that would include specific trainings like trauma informed care, harm reduction centered care etc.

Dr. Deanna Dunn: How do you access the registration; do you have to be an SSP or program connected with you all? Is it open to the public?

Rae Elkasabany: It's not "not" open to the public, but before we make some courses open to people, programs that are approved or in process of being approved in next six months will receive a registration link. In the past, we've gotten a list from programs that they wanted to complete the training, this time we'll give it to programs to give out. Of course, we'll make sure all new staff are people that need to complete it.

Syringe Service Program Data Presentation: Fiscal Year 21, Quarter 3

Allison Thomson, Harm Reduction Programs Manager, Center for Harm Reduction Services

I'll share data for FY21 Q3, the first three months of this calendar year. Program development—as you've seen, each meeting there are new programs. Currently 19 approved SSPs plus the Baltimore City Health Department. All programs funded primarily or entirely by ACCESS grant. Recent approvals are FMCS and Power Inside, two great programs. Since I'm nearing a year of starting this position, since FY21 beginning, we've approved 8 new programs. In the past year, 5 out of 8 are operational. Some barriers are community readiness, COVID-19 limitations, building relationships with law enforcement. With these four not operational, Calvert and Power Inside are due to launch July 1. Montgomery is awaiting a move to a new location, Wicomico is waiting for approval to open their building, called the Shore Center.

Dr. Deanna Dunn: I heard Wednesday they're aiming to open July 1.

Allison Thomson: Out of those 20 programs, 8 are CBOs—6 within Baltimore City, 1 in Cecil, and 1 in Prince George's. We still have 2 voucher programs, Frederick and Wicomico. Total of 2,059 people registered as SSP participants this quarter. Small decrease from previous quarter. However, 277% increase from this quarter the previous fiscal year. It's important to note that during 2020, these first three months, there were 9 operational, this past quarter were 14 operational. With new participants registered, this makes the total for this fiscal year 5,915 new participants registered. Total unique participants served Q3 is 3,960

(new registered plus returning previously registered). 97% increase from previous fiscal year Q3. Demographics, participants served: 40% reported Black, 46% white, 4% other, 1.5% Hispanic/Latino. A little over 1% for remaining categories. Age of participants, more than half (this is pretty typical) were ages 25-44. 21% were 44-54, 13% were over 55, 12% between 18-24, and only .2% reported under 18. I always find this interesting, because there no limitations in the statute for under 18, that might be a population we want to target in the future. Lastly, gender of participants, currently we collect three categories—57.5% male, 39.9% female. We've considered incorporating other gender options in reporting requirements to ensure we are reaching marginalized populations—options may change in the future, we're very open to feedback. Next is total encounters, number of encounters (each separate interaction with registered or unregistered, variety of services), total this quarter 12,813 encounters, total this year 39,590 encounters. Looking at this chart, SPARC and Charm City had most encounters this quarter over 2,000 encounters each. Both made significant changes during COVID-19 (as well as all our SSPs). They've incorporated a robust delivery system, adjusted and expanded their programming, offering housing, providing COVID-19 vaccines at fixed sites. It's been an interesting and challenging year, programs have flourished and found ways to continue reaching population. Zip codes of participants—this is the first time we've shared this information. Highlighted are the top zip codes of SSP participants in Q3. We're interested in analyzing the data more to see how zip codes are changing and reach is changing over time. At the center level, we ask for aggregate level, this is a required reporting variable—the top 3 zip codes that represent majority of participants. I created heat map to show reporting—this isn't indicative of all SSP participants, just 3 most common. Baltimore city is covered, there are six operational programs during this quarter. This will change over time, as Wicomico becomes operational and more programs in southern Maryland, we'll see this expand more in the future. Another metric is top three most common drugs used reported—heroin fentanyl and cocaine were top three. Others were speed, marijuana, other, opioid pills.

Syringes distributed and collected: these numbers are most profound to me. Just this quarter, all programs distributed 1,296, 811, not including other safe use supplies—so many supplies being distributed to prevent infectious disease. Majority are within Baltimore city (around 80%). Making total for this year over 3 million. So impressive because entire FY20, a bit over 2 million, we're well over that just in the first three quarters. Syringes provided through voucher programs not included in this number.

This quarters collection rate was low, a little over 19%, a little over 256,301 collected, making total for this fiscal year 1,069,207. Collection rate for this FY 32.2%. comparing to previous year, FY20, about 50% collection rate. Some of those things that programs reported to us is that they're distributing fit packs/discrete options, having various sizes of sharps containers available that meet needs. They bring sharps containers during outreach, take containers to local businesses, train them to safely dispose or let them know SSP is available to come pick up. All programs consistently communicating with community, some create anonymous form to report syringe litter. Programs realize this is important and making big changes to address it. There are big plans in Baltimore city to install syringe kiosks throughout the city. A lot of participants are not comfortable bringing syringes back

to programs. We've asked about education that's being provided—first thing is saying you are protected, if you're still not comfortable, giving other options to dispose safely (sharps containers, laundry detergent, bleach bottles, things like that)—finding the safest best way to dispose of syringes. some programs have started giving some containers that can be mailed, that's not included in these numbers.

Next are referrals and linkages. Q3 total of 9,862 linkages to care making total this FY to date of 24,511. This includes passive and active referrals. OEND is always accounting for majority of referrals. We always share these referral numbers. However, we don't know what that looks like in practice. Gathered more information about what that looks like. In each category, as SSP statute states, programs required to provide access to these services directly or through referral. With SUD related, 60% of programs providing formal case management, 100% of programs providing informal case management; ex. peers or other harm reduction specialists regularly community with participants. With OD education and naloxone, 100% of programs providing education on site. Everyone in SSP is trained, at least 99% of SSP staff has gone through ToT and is able to train people to use naloxone appropriately. This also looks like naloxone distribution, risk reduction education (ex. going slow), and FTS distribution important aspect of this. Wound care, 100% of programs at least providing basic wound care supplies. A lot of programs have taken wound care to make it a big priority, having medical staff able to provide antibiotics. A lot of participants unwilling to seek care elsewhere, but trust our harm reduction programs; moving towards one-stop shop model has been so influential. 100% of programs provide basic safe sex supplies. Some programs have incorporated mammograms, pap smears, offering birth control, pregnancy tests. Testing for HIV, viral Hepatitis, and STIS—80% of programs provide rapid testing—this has lessened due to COVID, as the precautions reduce, that number will increase. At programs, rapid and confirmatory on site, access to PrEP and PEP, and connection to treatment. As we said with access telehealth, can get treatment right at the SSP. Last slide is about site visits, past 2 months, we performed virtual site visits at all SSPs whether operational or not, obtained updated operating procedures, referral protocols, community outreach plans, and lists of supplies. Review programmatic and fiscal best practices. Programmatic best practices. Excited to share more information about best practices during these site visits. The next meeting there will be a lot more to share.

Erin Russell: [review of chat comments related to presentation]

- The incidence of IVDU in individuals under 18 is really low
- Agreed. we've served young people who snort though
- Do you think all the zip codes would help? We are seeing a lot more WV zips but not to meet the top 3.
- The per person number is great too! That means that people aren't being limited in what they can get, perhaps. So awesome!
- I can't wait to get public syringe disposal options in Baltimore City -- like Baltimore County has near the Drumcastle Building
- Wonder if they can separate case management verses peer recovery in that they can be different in some organizations?

- Is there a bench mark for the syringes per person? Apologies if I missed it!

Allison Thomson: With site visits, got more information about what type of case management is being provided. We could differentiate those different services in the future. SSPs per person is syringes distributed by participants served (not encounters)—average was around 327 for this quarter. Don't have a benchmark, calculate the average. Needs based metric shows we're meeting people where they are, they're comfortable saying they need this many, whether for themselves or secondary. Have built trusting relationships with programs to ask for large amounts that they need.

Dr. Deanna Dunn: each meeting, this portion of our talk is mind-blowing. Proud to be a part of this effort in Maryland because of amazing work being done here.

Malik Burnett: Strong work, always the best part of the meeting.

Erin Russell: Thanks to the programs, this is a testament to the data you're submitting to us.

V. Advisory Committee Actions

Approval of Meeting Minutes from March 2021

Dr. Malik Burnett: Motion to approve meeting minutes from March 2021.

Cam Kerr: Second.

Community Co-Chair Discussion

Erin Russell: Last meeting Peter presented this concept, facilitate some brainstorming. We've done some research into what a co-chair looks like in other formal committees and have landed on a proposal that I will share. Welcoming your discussion/feedback, you tell me what direction you'll like to go, I'll draft amendments to by-laws and you'll vote on it at next meeting. Community co-chair nominated by committee members, voted on by committee, serve 2-year term. They contribute to setting the agenda, identifying, nominating, and recruiting new members. Can lead meetings in the government chair's place—called co-chair because there's a government chair. By statute, deputy secretary of public health is the government chair. Would give authority to committee member for when Dr. Chan isn't able to attend, they can be run by someone on the committee who's been involved in agenda setting and prep. I will continue to play role of administrator, set meetings, run agenda, but would be great to have someone official on the committee who can do that and represents the community needs. On other committee, this position has stronger relationship with the committee and spends time following up with programs between meetings and makes sure community needs are represented when we draft agendas. Primary concerns raised at our last discussion was whether position could be compensated. Have not made progress on that. Because this is a meeting that is guided by

statute, all committee members are eligible to be reimbursed for travel costs, I'm struggling to find avenue through which we could pay community co-chair position. I'm not sure we can do that at this time. Open up for committee discussion.

Cam Kerr: Maybe have that person exist and someone work with them. Person who works with them to get a feel for what it is and if it's a two-year term, at beginning of second term, that's when we vote for next person and that person works with them so they can get the ropes of what's happening or what's already been in place and what they want to continue to build on when first person leaves. Reasoning for that is that I think it's a great opportunity to loop people in that don't have all of the experience doing that stuff, to train them in the capacity to do that on their own—help someone grow in their own personal development as well as for the greater good.

Dr. Malik Burnett: Is this a discussion or approving the position formally?

Erin Russell: Would love to have consensus that this is the model of what the committee would like. I can put it into the bylaws and we can formalize it at the next meeting. We could nominate the person at the next meeting if we decide now and I can get bylaws.

Dr. Malik Burnett: I don't see any risk to having an additional position. Having someone with lived experience.

Harriet [chat box]: Agree.

Katie Carroll [chat box]: Seconded.

Victoria Sterling [chat box]: I agree with a community chair.

Lt. Joshua McCauley [chat box]: I agree. Sounds good.

Erin Russell: Would it make sense for it to be someone from the SSP SAC?

Dr. Malik Burnett: Wouldn't see why it has to be.

Dr. Sarah Kattakuzhy: How do you envision the actual structure or delivery of meeting would change with a community co-chair?

Erin Russell: They would run the meeting. Typically, Dr. Chan would run the meeting, I've stepped in to run her meeting and previously Fran Phillips' absence. Someone else would run the meeting. CHRS would continue to create google meets, take care of public meeting act requirements, administrative aspects. CHRS exists and it's a natural role for us to play but the committee is set in statute and CHRS isn't on the committee. Formal role to move through decision making processes, call to vote, etc. They will have ability to craft the agenda, right now it's our team at the center. But we would meet with community cochair at least 6 weeks in advance of the meeting, brainstorm important topics, and who are potential speakers, talk through issues happening that need to be addressed, etc.

Dr. Sarah Kattakuzhy: I think it's a great idea. Don't think we should be limited by current members. With those responsibilities, helpful to understand structure and function. But if goal to add different perspective not served by limiting to current members.

Cam Kerr: Agree with all that. Think that the first one that exists should be someone from the committee to shape it, get the hang of it. I'm stuck on idea of doing an apprenticeship thing. Especially if it's open to people outside. It's a great opportunity for anyone to do it after it gets established. That person gets the hang of it, only 4 meetings in a year. People getting it established and have another person do it.

Dr. Sarah Kattakuzhy: I think that idea makes sense Cam.

Erin Russell: It's a strong step in the direction of making it a real advisory committee. Greatest potential in having formal advisory board that advises department on what we should do with harm reduction work. Hearing consensus. I'm drafting changes to bylaws that include in our section talking about the chair and subcommittee; add section that says committee will nominate committee co-chair, first co-chair will come from committee and help us to shape this in the first year ("apprenticeship"). Vice chair can be member outside of the committee, member of public. Role of co-chair is over two-year term to work with CHRS and government chair to set the agenda for meetings, meet with members, get to know members on committee, identify new members that we need to make sure we have a representative committee, they will lead the meetings in absence of government co-chair. Three main responsibilities identified there.

Cam Kerr: Propose motion

Dr. Sarah Kattakuzhy: Second.

Erin Russell: I will make these draft edits to bylaws, and if anyone wants to talk about this and nominate themselves or someone else, we could get started on this in the fall if we're ready.

Cam Kerr: is there some kind of application process? Yes, people are nominated, but do they have to write a page saying why they're qualified?

Dr. Deanna Dunn: Don't know we have the means to vet applications. We decide in meeting which of nominees we agree.

Erin Russell: Someone can take a couple minutes to talk about why they're interested prior to the vote. In our last two minutes want to see if anyone on the line has anything they want to bring, things we should consider on agenda for next time, what we should follow up on.

Dr. Deanna Dunn: That will be the completion of my three-year seat at the next meeting. Started in October 2018.

Erin Russell: I will follow up with all members. To renew seat, you will have to fill out application form again, should be smooth process. Only one seat we'll have to fill in the fall.

Chris Ora [chat box]: I think I have a team member in the Overdose Response team that may be interested but I need to consult before volunteering. I am talking about a Co-chair please send me the bylaws achikeo@peponline.org

Chris Ora: Harm reduction work, is there any thoughts on co-opting the CoCs in the jurisdictions.

Erin Russell: We have done some work with CoCs. They are our gateway to understanding how housing is addressed in each jurisdiction.

VI. Closing