Standing Advisory Committee
Opioid-Associated Prevention and Outreach Programs
March 5, 2021
10:00 AM – 12:00 PM

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

Standing Advisory Committee Roll Call

In attendance:

- Katie Carroll
- Dr. Deanna Dunn
- Freedom Diamond
- Dr. Chaulk
- Lt. Joshua McCauley
- Candy Kerr
- Dr. Sarah Kattakuzhy
- Dr. Susan Sherman
- Terry Prochnow
- Dr. Malik Burnett
- Harriet Smith

Others Present:

- Aleah Robinson
- Alicia Lebon
- Allison Thomson
- Amanda Walton
- Amber Bolyard
- Amy Hecht-Zizes
- Andrea Shearer
- Anita Ray
- Arron Hall
- Augusta Gribetz
- Bakari Atiba
- Barbara Allen
- Ben Stevenson
- Bob Stephens
- Candy (BHRC)
- Chelsea Simms
- Chiwendu Mengarpuan
- Claudia Jackson
- Cola Anderson
- Crystal Phillips
- Dana Heilman
- Daniel Atzmon
- David Washington
- David Williams
- Dennis Rivera
- Derrick Hunt
- Desirea Tosten
- Emily Clouse
- Emily Heinlein
- Erin Russell
- Erin Woodie
- Haley Detrich
- Howie Newton
- Jess Nesbitt
- Jesse Mesenburg
- Jessica Ellis
- Jessie Dunleavy
- Jim Hedrick (GOCCP)
- Jordan Strieter
- Ju Park
- Kyle Kenny
- LaTasha Brickhouse-Frazier
- Leslie Evans
- Lisa Morrel
- Maria P
- Marie Stratton
- Mark Artius Robinson
- Miera Corey
- Natanya Robinowitz
- Patrecia Williams
- Peter DeMartino
- Rae Elkasabany
- Romona Gould
- Rosemary Burrell
- SPARC Outreach
- Talia Pettway
- Tasha Jamison
- Tolu Arowolu
- Tonya Green-Pyles
- Tyler Wert

Welcome

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

Welcome on behalf of Dr. Chan. Syringe Service Programs have a very clear goal that align with the Infectious Disease Bureau. We are incredible proud to be one of three statewide harm reduction centers in the country. Today is a year since our first COVID-19 diagnoses in the state of Maryland. In the past year, we have gone through many changes in the bureau and I know many organizations have been deeply impacted. This year there has been a very clear standout, the Syringe Service Programs. I have been pleasantly surprised with the mobility and the quick thinking and ability to remain resilient. The programs are so in touch with the programs they serve, they were the first to identify the impacts, first to develop solutions, and have been so incredibly impacting of the lives of Marylanders who use drugs. Thank you so much for all the work that you do. I hope we take this opportunity for restructuring and rebuilding to make things even better. I am really looking forward to all the amazing work that has occurred in the past year in meeting people where they're at, when they're there, and allowing them to find responsive and attentive public health services in the form of harm reduction and syringe services. I look forward to bringing that resiliency and those strengths into whatever comes next. Thank you again and welcome!

II. Standing Advisory Committee Overview

Erin Russell, Chief, Center for Harm Reduction Services

The Standing Advisory Committee established in statute, the same statute that authorizes entities to implement a Syringe Service Program. The committee is tasked with advising the Department on improving access to sterile syringes and has grown to advise on a multitude of issues, expanding system of care for PWUD more broadly. The function of the committee is to review policies and procedures of programs and make recommendations to operate at best standard. Committee members are appointed by the Secretary of Health, there is a vetting process for all members. This meeting is an advisory meeting to the department, meaning when there is a quorum, it is open to the public.

The committee is subject to the Open Meetings Act. This means we have to give reasonable advance notice of any meetings which includes date, time, and agenda. We post this on the Maryland Register and the Center for Harm Reduction Services (CHRS) website. We also try to do some outreach by posting on the Maryland Harm Reduction listserv, inviting our community partners and inviting al of our Syringe Service Programs. Anyone is welcome, if there are other places we should post this publicly to ensure transparency and availability, let us know. Meetings have to be reasonably accessible. Minutes must be approved and made available to public. You can find all agendas and meeting minutes from past meetings on our CHRS website. We take meticulous notes, to capture verbatim decisions are made and items that are considered by committee. The public are allowed to attend. We are not required to allow public to participate by the Open Meetings Act. We always encourage participation and welcome the public comment period at the end of the meeting. The Open Meetings Act gives us the ability to close the meeting if we need to, remove disruptive members of the public if necessary. If we need to close a meeting it

has to be requested in advance for a specific purpose. This committee has never closed a meeting before, but if we did, we would follow the specific rules.

There is a Maryland Department of Health Attendance Policy. This requires appointees to attend at least 50% of meetings, and attending by phone counts. Every year, the CHRS as the administrative point for this committee submits an attendance report. If a member fails to attend, they can submit a request for waiver directly to the Secretary of Health that explains why they were unable to attend all the meetings and can maintain their seat on the committee if they have a justification.

Standing Advisory Committee role: They provide technical assistance to each program during the development of their application. They specifically review the program operating procedures, the community outreach and education plan, and the referral protocols. There is currently a subcommittee who reviews these applications. We liaison between the committee and the applicant. The program applicant will make revisions, discuss questions with committee, and adjust policies and procedures accordingly. The committee contributed to the development of the regulations.

The following individuals must be represented on the committee by statute:

- Deputy Secretary for Public Health Services (chair) – Filled
- One individual from academia who specializes in public health issues related to substance-related disorder or infectious diseases – Filled
- One representative from law enforcement, nominated by the Executive Director of the Governor's Office of Crime Control and Prevention – Nominated
- One individual with expertise in the prevention of HIV or viral Hepatitis – Filled
- One health care practitioner with experience providing services to individuals who inject drugs – Filled
- One individual with substance use experience – Filled
- One family member of an individual who injects or has injected drugs – Filled
- One representative of local law enforcement – Filled
- One local health officer – Filled
- One representative of a local or regional hospital – Filled
- One individual with experience in syringe service programs – Filled
- Any additional members recommended by the Department
    - People with lived experience – 3
    - Pharmacy expertise – 1
    - Harm Reduction organization – 1
    - Maryland Association of County Health Officers Representative – 1 (nominated)

MDH roles: The MDH, and particularly CHRS ensures technical assistance is provided to programs, that they follow best practices, we provide support in whatever way they need to meet those standards. We facilitate the review of applications and liaise between SAC and applicant. The committee is chaired by Deputy Secretary for Public Health. We administer the meetings: we draft and publish the agendas, we take notes, publicize the meetings, follow up with action items, keep committee business moving forward.

III. Introduction of New Syringe Service Programs

Voices of Hope

Erin Woodie, Chief Operations Officer

We've been around for a while. We've had the pleasure of partnering with Cecil County Health Department since beginning of their SSP in Cecil, as backpack model portion and they were fixed site. We've partnered for last two years, we are grateful for the partnership and have learned a lot. We applied for SSP and approved. We look to continue to offer the backpack model. Peers go out into neighborhoods, collect data from the heroin coordinator where overdoses are happening in Cecil County. Peers are on foot with backpacks, trying to keep people safe and build relationships. We've been doing that for a while, and going to continue to do that. Layout of Cecil is spread out, clusters of neighborhoods that might not have access to public transportation. It is a barrier to access services. We're going to continue that model. We are also going to have a fixed site now, and will continue to collaborate with the health department. When we applied for our syringe services approval, we applied for after hours when the Health Department is closed and weekends. We don't want to duplicate services, we just want to extend them in the county. Plan to continue working closely with CCHD to extend services. Just last week got our mobile RV up and running. We are doing a lot of wound care, we have a wound care nurse. There is a big need for wound care services in Cecil County. Last week we went on first mobile outreach with the wound care nurse on the RV. Other things we do: Not just harm reduction and peers getting out there and SSP, we also offer low barrier buprenorphine induction through our backpack outreach model utilizing telemedicine. We partner with the LHD on other programs. We have a 24/7 virtual crisis line. We build relationships and bring services to people. If they want other services, treatment access, anything else, we have those services here available. We are super excited just to expand services. Definitely not moving away from our partnership, just collaborating to extend services in Cecil County.

Erin Russell: Voices of Hope is our first nonprofit approved for Syringe Services outside of Baltimore City.

Montgomery County Health Department

Ben Stevenson II

Us getting to place of being able to have SSP in Montgomery has been a journey. Something that the county has been wanting for some time. Process of going through capacity building of conducting community readiness assessment in Montgomery was a large undertaking. We learned a lot of the needs in the county with regards to harm reduction and syringe services. We're going to have a fixed site, utilizing a needs-based distribution model. Our plan is to help clients within the county to improve health outcomes and prevent disease transmission. Also, we have someone on staff to be sexual health and HIV tester to provide that services to clients on site while providing linkages to care. The benefit of being housed in HHS, a lot of those services are built in. We work in tandem with public health to provide additional support and counseling to people who test positive for HIV. We have the ability to provide naloxone onsite and education on overdose. Another

benefit with the fixed site is being housed at 981 Rollins Avenue, in which we have our MAT program housed in same building, along with our adult drug court services, outpatient addiction services, and urine drug monitoring program. The plan is to initially provide services Tuesdays, Thursdays, and Fridays 10-4, late day on Wednesdays 1-7. Openings on first and third Saturdays of each month for a couple hours. We're flexible with timing to make sure we can meet the client needs. We have great partnerships established with the Coalition for the Homeless, with law enforcement, fire and rescue, and other community-based providers and partners. Our nurse is in process of doing training to provide wound care, that is something we plan to provide as well. In process of applying, we had received questions and inquiries from MAT program about clients that might be good candidates for wound care, education, and support. We have access to a 24-hour crisis hotline and have program called STEER—deploy peers out to overdose incidents in the county. We work in tandem with fire and rescue to identify clients who are good for the program. Happy to get to place of being a provider. We are looking forward to great things coming from the program. Working in partnership with public health to reduce HIV cases in county.

Candy Kerr: There is a question in the chat for Ben to share the SSP schedule and his contact information.

Ben Stevenson: I will share with the Center for them to disseminate.

Erin Russell: We have a program guide posted on our website and we add new programs and changes in hours and locations.

IV. Something to Hold Onto: Experiences of Emergency Housing and Homelessness During COVID-19

Aleah Robinson, Manager of Supportive Services for Charm City Care Connection

Starting last spring, Charm City Care Connection (CCCC) started a quick hotel program in partnership with a few other organizations. Initially were just putting some of our folks up and it grew into this larger project. CCCC is a harm reduction drop in center over east (Baltimore City). We've been there since 2009. The drop-in center has been functioning for two years now. A bit about the timeline: Late march, early April, COVID-19 cases were rising in Maryland. We witnessed firsthand how this affected our participants who lost access to shelter space, rooms they were renting, or different living situations became unsafe or inaccessible. We started with a couple people we put up in a hotel on Pulaski Highway. In April, we began forming more intentional relationships with hotels. Hotel program ran for 8 months, April through October. After that, we shifted into what is now our small 4-unit housing program.

The units were at Home2Suites downtown. Individuals dad access to a kitchenette, desk, TV, and laundry downstairs. Each resident had a small 10$ per day to spend in market for snacks. We arranged grocery delivery. The most important thing was that people had space to socially distance and rest.

What was required to maintain a program for PWUD grounded in harm reduction? A lot of what we learned is that it was important to prioritize relationships in our service provision. In addition to providing resources and education, we found it was essential to establish and maintain trust so

people could be open with us and know they weren't going to lose housing the next day, we were giving as much information as we had. We weren't going to tell people not to use in their rooms. We learned it is easier and more effective to run a hotel shelter program when people are open about their drug use. It really served to build trust, because we were able to provide support and services where participants are identifying they need support, versus we're saying what people need. We took step back and started with, what are regulations of the hotel? And outside of that we don't throw on additional rules without context.

I want to share some outcomes from this report. It was a study done in partnership with YES and Hopkins and research were led by Dr. Sherman's team. As we know, a sense of security has a lot of quantifiable and nonquantifiable benefits. Many of our people we witnessed them gain access to full time or part time employment, reconnect with their families, gaining weight, and being able to reconnect with primary care or other vital services such as access to ID while they were stabilized at the hotel.

Another positive outcome was increased food access. At the start of the pandemic many individuals lost access to food in the form of different centers shutting down or for a variety of other reasons. Over the time at the hotel it was nice to see people gain weight and put different ordering requests in. We were able to provide an element of choice, learned what people liked and what they felt nourished by. Rest and ability to access regular sleep schedule people reported as being very important to them during this time. Also, just want to say how powerful it was to changes in people and see when people were having access to rest and privacy and these things over time, how people's demeanors changed. Additionally, peace of mind, stability. One participant shared that the fact they can get up every morning and know they're going to have a good day because they're in their unit and have peace of mind based on that starting point. It was beautiful to see people reconnect with family and friends through having, not only room, but access to phone and consistent place where people could know they were going to be.

Takeaways: low barrier services work. Residents of our city and participants of our program specifically hear the opposite all the time. Folks entering shelter system and other services are told that they will not be able to access those services if they continue to use drugs. We saw firsthand that the program we're running worked for people and also worked for us in building trust with our folks. The main measure of success should be sustained housing for all Baltimore city residents, all people are housed, regardless of what it takes.

We want to acknowledge colleagues and friends who were instrumental in this program. Will Miller Sr. who personally connected with every participant in our hotel program. It meant a lot to everyone there as well. We hope we never have to talk about emergency shelter again. All people have a right to safe dignified and long-term housing. While we're all excited about how this program ran and what we were able to do, we hope that this is a moment where we can reflect on importance of long-term housing for all residents.

Dr. Deanna Dunn: Thanks so much for presentation. Can you expand on how you established relationship with the hotel?

Aleah Robinson: A little bit of we got lucky and also, I think a lot of communicating on the front end with hotel and with our folks. Really explicitly what the hotel requires, what would get someone kicked out. Being upfront with our participants, working with hotel staff, who were amazing. Just being very transparent. At the start of the pandemic, they were losing a lot of business, that worked in our favor. That was a lot of how we initially developed relationships. A lot of places will not accept folks without ID, and they were willing to work with us on that. Initially it required being present a lot to check people in and provide that reassurance to hotel staff. Also, being really present, being there twice a week or more if something came up, being available so that hotel staff knew we were supporting.

Report on Charm City Care Connection's website.

V. Maryland Department of Health Updates

Harm Reduction Program Role in Linking People to Vaccines

Erin Russell, Chief, Center for Harm Reduction Services

Maryland Department of Health COVIDlink page and Maryland Coronavirus Vaccine Page.

Maryland Department of Health's vaccine information is located on these websites. They also launched a hotline for priority groups. If you are eligible and looking for a vaccine you can call 1-855MDGOVAX. MDH has continued to create communication campaigns utilizing various outreach methods to help promote vaccine and inform people of its effectiveness and availability. We want to address the problems and issues of connecting the people we serve to the vaccine. There is existing distrust for medical providers in our communities of people who use drugs. There is also experiences of stigma at different levels of care and being judged creates a barrier. Additionally, there are structural barriers, we just covered one structural barrier, stable housing. For example, if you do not have stable housing, what do you do after you get the vaccine and have side effects. There are a lot of potential barriers that we are encouraging programs to consider.

To better understand the issues, we are funding some of our own research in Maryland. Maryland has incredible resources. We are taking advantage of existing relationship with Dr. Sherman's team at Johns Hopkins University, who are doing an evaluation of our work at the center and doing a quick qualitative study for us by recruiting people who use drugs to understand their impressions of the vaccine, reasons they do or do not plan to get the vaccine, what would help support them to get the vaccine, and to see what people's unique structural barriers will be. This will help us direct our resources to make the vaccine as accessible as possible for people. We have been providing guidance through email. Approved programs and grantees should keep an eye out for emails from us. Grantees and programs are already figuring it out, we are just backing them up. Our guidance is ensuring all staff have been offered the vaccine, that everyone is an ambassador for the vaccine; encourage programs to discover what is best for your program to link people to the vaccine. Either assistance with scheduling, transportation to sites, or obtaining approval to administer the vaccine onsite. Some of this is short term such as connecting people to a mass vaccination site, and some is long term planning once the supply of the vaccine is greater. We also encourage local health departments to bring the vaccine to where people are.

Jesse Mesenberg, CRNP, MS, Baltimore City Health Department

COVID-19 Vaccine Strategy Presentation

Erin Russell: We are open for questions, comments or recommendations on how we can best support our programs to get the vaccine to people who use drugs.

CHAT – Amy Hecht-Zizes: How can we prioritize getting the J&J specifically to people with unstable living conditions and lack of transportation? (I work for BCHD and I haven't gotten an answer to this).

Jesse Mesenburg: BCHD is getting supply of J&J very soon. We made it a priority to not give the less effective vaccine to the most vulnerable people. We are currently using Moderna to people experiencing homelessness and in shelters. Eventually we would love to be able to offer both options to people and then they can make the decision. We're working with facilities like shelters that have an eager audience to capture, not having follow up problem now, we're providing transportation if that's an issue. There's a place for a single dose in every population, including people experiencing homelessness and people who use drugs. Hopefully people will be offered both options as supply increases.

Dr. Deanna Dunn: On the Eastern shore, I have been involved with vaccination clinics. We do a much smaller scale than what I hear about in Baltimore. What we experience here—if I do a clinic for 240 people—what we're using for long term care facilities is the Pfizer vaccine. I got through a great deal of effort to make sure none of those doses go to waste. Are you connected to people doing mass vaccination clinics in Baltimore? I work with nurses who travel all over the state doing these. When you have people and 900 expected doses, hundreds of people may not show up. We might need less supply if we waste less.

Jesse Mesenburg: We are lucky that we have Moderna as it just a little less finicky. When you open a vial, there are ten in a vial and you have to use those 10 in six hours. Our small team have not wasted any vaccines. There's more demand than there is supply at this point. We are cognizant of when we scale up, how to not waste. We've developed protocols and documents. Part of it is our database of locations and map. If we go to a location and have extra doses, we can check the database and say, where's the closest places that haven't been vaccinated yet. All of this plan is very much in development.

CHAT – Lisa Parker: Will there be any consideration about providing mobile vaccines during non-traditional hours (weekends, overnights)

Jesse Mesenburg: We have a very small capacity (team of 5) to do mobile vaccination at shelters. We know that's not enough. We're trying to gather and work with partners who have capacity. Two of those that we're moving forward with is two vans to go out with the needle exchange van that would start on Saturdays. We are definitely prioritizing weekends and after hours.

CHAT – Dr. Sarah Kattakuzhy: Are there any plans to expand criteria for vaccinators to non-credentialed folks?

Erin Russell: For time's sake, we will follow up on this question.

Syringe Service Program Data Presentation: FY21, Quarter 2

Allison Thomson, Center for Harm Reduction Services

Erin Russel: One of the questions in the chat box is regarding sharing the data with the Opioid Operational Command Center (OOCC). The OOCC publishes data reports on overdose data. Our data does not get included in any quarterly overdose updates. When the OOCC publishes their action plan or yearly report, we usually provide a high-level summary of what the center has accomplished. That includes how many syringes distributed, how much naloxone we have distributed, and more. We look collectively across our harm reduction programs to see how many people have been reached as a whole.

Dr. Malik Burnett: Are there any opportunities for programs to collaborate and share best practices across programs?

Allison Thomson: Technical assistance in practice typically looks like connecting programs to each other. A lot of programs are in constant communication with one another, but if a program reports certain barriers I can connect them with another program that has successfully worked through those issues or doing something successfully. We also hold collaborative calls monthly and we have a breakout syringe service call quarterly that allows programs a lot of time for open discussion to bring up concerns or brainstorm and discuss with each other.

CHAT – Jordan Streiter: Are you able to elaborate on the voucher program with certain pharmacy locations?

Allison Thomson: Each program has at least two participating pharmacies. There has been recent advancement in creating low barrier access to the voucher programs. In Wicomico in the most recent quarter, one of the pharmacies used to require the individual seeking syringes to obtain a physical voucher from the health department and wouldn't allow them to receive syringes without it. They have now allowed the vouchers to be placed within the pharmacy. It has created less barriers for individuals seeking clean and free syringes from that pharmacy.

Chat – Jordan Streiter: Are these independent or chain pharmacy locations?

Allison Thomson: Yes, I believe most if not all are independent.

Jessica Ellis: In Frederick County, we only have one pharmacy that participates. It is an independent pharmacy and we have been fortunate because they have always kept vouchers onsite. Someone could walk in with it, could ask for the free ten-pack. With COVID-19, we have been able to expand on that so people are able to receive syringes based on need, obtaining more than one-ten pack. Pharmacy has also begun offering fentanyl test strips with the syringes if they're interested in them.

CHAT – Tasha Jamison: We did not reach out to larger pharmacies as they were not viewed by our participants as "drug user friendly"

Jordan Streiter: Coming from pharmacy operations, has anyone thought about asking them to donate. I know my shelf at my location, we have boxes upon boxes that are gaining dust because we no longer utilize that particular manufacturer or have eliminated a particular program. Not sure

if you all have reached out to pharmacies to donate no longer used NDCs.

Erin Russell: That is a great recommendation and I'm curious to see if any programs have received any donations.

Tasha Jamison: I have not reached out to any pharmacies about any syringes they'd like to donate. I did have an individual reach out because they had a diabetic family member pass and had a lot of syringes. I accepted them but was told to not redistribute.

Dr. Deanna Dunn: I would suspect that if you were to receive a donation from a pharmacy prior to being dispensed that rule would not apply. But something that has been dispensed to a patient there could be a sterility issue.

Jessica Ellis: In Frederick we have come across the same thing. We were told we could not redistribute them but we could donate them.

Dr. Deanna Dunn: The way that this works legally, you have to become a reverse distributer site. Then you can accept donated drugs, syringes, whatever the prescription item to be redistributed. There is a process to determine if the item is okay to be redistributed.

Erin Russel: The Center will follow up and work on clear guidance regarding donations.

VI. Advisory Committee Actions

Structure of Committee Discussion

Erin Russell: Dr. Chan has tasked us with thinking about how the committee is structured. Last year we created a subcommittee for policy and procedure review. There are currently five members who are first to review new applications. We added that to committee bylaws last year. As we're building out structure this year, we are thinking about what a second in command to the chair might look like. Peter will help guide that conversation and share his experience.

Dr. Peter DeMartino: This group has been growing and evolving and now has the maturity that might benefit from examples from other planning bodies. On each of these bodies, the government chair is joined formally or informally by a community co-chair. On the Maryland HPG it has been extremely beneficial because it's the Advisory Board to the Bureau around how we approach HIV, how we plan, monitor, evaluate, and fund. Having the designated community co-equal at the leadership of the group, setting the agendas and providing a direct line of feedback has been incredibly helpful, not just with the state HPG, but with all the bodies I've worked with. I want to provide an opportunity to let this body consider that. It would involve a change to the bylaws, but might be beneficial because you have reached the point of having co-leadership of the government and community voice is something to consider.

Dr. Sarah Kattakuzhy: I am not opposed. Can you give examples of responsibilities and actions of that person might be?

Dr. Peter DeMartino: They would partner around everything including large scale planning of what are the goals and objectives for the committee this year, to tactical issues around how to set the

agenda, what agenda items need to be included, what needs to wait for the next meeting. Attending subcommittee meetings, and potentially chairing the subcommittee. Stepping in for the government chair when the government chair is not available. It really is a co-leadership.

Harriet Smith: What is the pay for this? For Baltimore City Ryan White Council, it is unpaid and also comes with no training. How is this part of bigger project to make sure there's meaningful participation beyond what might feel like a token position?

Dr. Peter DeMartino: I believe that is a larger discussion to have around what would make this meaningful participation. This is a really good point to bring up. We want to ensure someone is prepared for the role, has the skills and support to make the participation meaningful. We will take this back to Dr. Chan and bring it back to the group.

Erin Russel: Will have more conversations about this and get people thinking about what the structure will look like.

Approval of Meeting Minutes from December 2020

Candy Kerr: I motion to approve the minutes from December.

Dr. Deanna Dunn: Second that.

VII. Closing

Erin Russel: Thank you all so much. If we missed anything please reach out or if you have any agenda items you would like to prioritize for next meeting. Thank you for all of your work, and to all of our programs.