Maryland
DEPARTMENT OF HEALTH

Standing Advisory Committee
Opioid-Associated Prevention and Outreach Programs
September 17, 2021
10:00 AM – 12:00 PM

I. Welcome

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

Thank you to committee members and members of the public on the call this morning. We are recording this meeting. I am the Chair for this advisory committee I have been unable to participate as fully as I would like, working as hard as I can to dedicate time to this important topic. I'm glad to be joining you today. There is ongoing work we must double our efforts on because as we look at the landscape of COVID pandemic and its impact on our lives and lives of Marylanders, we are seeing our numbers increasing in the last year in part because of COVID and its devastating impacts on families and individuals. The work being done by this committee and the providers across the state is more critical than ever. We are looking forward to hearing more about the work that's being done, where we can go next, and what else we can do.

Standing Advisory Committee Roll Call

Committee Members Present
CAM Kerr
Deanna Dunn
Dr. Malik Burnett
Harriet Smith
Dr. Jinlene Chan
Katie Carroll
Dr. Susan Sherman
Victoria Sterling
Zachary Kosinski

Committee Members Absent
Freedom Diamond
Dr. Sarah Kattakuzhy
Terry Prochnow
Dr. Gregory Branch

Others Present
Adetola Ajayi
Alex Wilson
Allison Thomson
Amanda Walton
Andrea Lopez
Anita Ray
Anita Robinson
Anjana Rao
Arielle Davis
Arron Hall
Augusta Gribetz
Awawu Ojikutu
Ben Stevenson
Caitlin Hall
Catie Brenneman
Charese Smith-Demory
Chelsea Simms
Chelsie Dever
Cola Anderson
Doug Fuller
David Washington
Dennis Rivera
Derrick Hunt
Dianna Abney
Dwayne Dean
Elizabeth Murphy
Emily Winkelstein
Eric McCullin
Erin Russell
Erin Woodie
Gregory Frailey
Holly Luther
Izelle Van Zuylen
Jack Latchford
Jeff Beeson
Jeffrey Long Sr.
Jesse Dunleavy
Jessica Ellis
John Flickinger
Jordan Strieter
Kate Dunn
Katie Evans
Kristin Schneider
Kyle Kenny
LaTasha Brickhouse-Frazier
Lisa Morrell
Lisa Parker
Marie Stratton

Mark Robinson
Melissa Clark
Miera Corey
Mike Massuli
Miles Morris
Peter DeMartino
Rachel Speranzella
Rae Elkasabany
Rodney Hill
Sal Corbin
Sara Rose
Shirley Gordan
Sohail Qarni
Talia Pettway
Tammy Hubbert
Tarsha Moore
Tiffany Cox
Tiffinee Scott
Tolu Arowolo
Tonya Green-Pyles
Tonya Sanders
Tracy Agee
Tracy Schulden
Victoria Cohen
Whitney [unknown last name]
Zoe Renfro

II. Introduction of Committee Members

Erin Russell, MPH, Chief, Center for Harm Reduction Services

First committee introduction is Lt Josh McCauley. He has been a critical member. Want to thank him for additional time and resources he gave to us in the center beyond his time on the committee. He has been our representative for local law enforcement. He services in Washington County; they've done a lot of work to align harm reduction. He was instrumental in their Law Enforcement Assisted Diversion Program. HE also supported us in developing a guidance document for SSPs about how best to engage law enforcement. It was created last year in response to challenges programs have had. This guidance document as well as sample slides programs can utilize while doing roll call presentations with law enforcement. We created a standardized Maryland card for SSPs, which is being piloted in Cecil county. Lt. McCauley was instrumental in developing that card. This means our law enforcement seat will be opening. He wanted me to share his apologies and contact information, because he wants to keep in touch. He wants to stay connected and is available if needed.

Dr. Susan Sherman is here today. Deep gratitude to Susan. She's supported harm reduction in Maryland, in Baltimore, and nationally. We're lucky to have her wealth of knowledge and expertise to the committee, bringing context to the work we do. Her team is presenting on their evaluation of center's work over the last year. Dr. Sherman has been an incredible partner to us beyond her role on this committee. Thank you for your time and for filling this seat since Day 1. We generated a couple e-cards with some sentiments from the rest of the committee that will be sent shortly.

Katie Carroll: Harm reduction program coordinator at Cecil County Health Department. I represent a person with lived experience on the committee. I was involved early with the committee to learn how to best provide services to people who use drugs and represent my local community.

Dr. Deanna Dunn: I am a pharmacist, came to the committee when I was working with Hope Core program at Salisbury, an AmeriCorps program that educated people on heroin and opioid prevention education. Generally, I have been an advocate for the best services for people who use drugs. I'm honored to be a member of the committee.

Zach Kosinski: Harm reduction coordinator at Harford County Health Department. Person with lived experience, trying to represent rural Maryland in a county where we don't really have SSP but are working towards it.

Cam Kerr: Community outreach Coordinator at Baltimore Harm Reduction Coalition.

Victoria Sterling: Director of Behavioral Health Services, MACCO Representative. I was very excited when the health officer asked me to be on the committee and really believe in harm reduction.

Harriet Smith: I serve as the Director of Education at Baltimore Harm Reduction Coalition. I'm excited to part of a committee that's trying to get quality services out there in all different places.

III. Maryland Department of Health Updates

New Center for Harm Reduction Services Staff

Erin Russell, MPH, Chief, Center for Harm Reduction Services

Introducing Emily Winklestein, the Center's new Deputy Chief. She will be assuming responsibilities for managing all our capacity building work, working with Division Chief of Capacity Building, as well as all our local programs and grant initiatives that's overseen by Dana Heilman. Emily will be playing a big role in influencing the programs and grants and trainings that we do in the Center, she's well suited for this role, I feel lucky she joined us. She moved from New York City to Maryland. She's familiar with the state. She's been with us since July.

Center for Harm Reduction Services Strategic Goals: Fiscal Year 21 & 22

Erin Russell, MPH, Chief, Center for Harm Reduction Services

To set the stage for data updates and evaluation, I want to share our strategic goals. The Center created this vision statement and strategic goals in FY20 and has maintained the goals for FY21 and moving into the next year.

CHRS envisions a Maryland where CHRS envisions a Maryland where: 1) Health care and social service systems meet the needs of people who use drugs in a comprehensive, community-based manner, 2) People who use drugs have equitable access to high-quality care, 3) Services provided to people who use drugs are free from stigma and discrimination; by focusing on people who use drugs, we'll have a broad impact on substance-related morbidity and mortality.

Our strategic goals have given us more specific marching orders for that vision. The first goal is related to naloxone distribution. We seek to achieve naloxone saturation in all counties—naloxone is available at the scene of every overdose and readily available by refill if it's used. We are tracking how many counties are reaching saturation.

The next few are related to integration of care: SSPs should have Hepatitis C testing available. That is required by statute that provide testing onsite or provide a referral to Hepatitis C test. We've been doing mobilization of programs and support to get Hep C test provided on the spot and make sure people can get tested immediately as easily as possible. We want to expand low barrier buprenorphine. We are defining low barrier. We want harm reduction-oriented treatment in all the counties that we're funding. We're supportive of mobile SSPs. We have counties purchasing vans. We want those services to be as comprehensive as possible. At least two will co-locate buprenorphine induction on mobile SSP. We're developing plan for quality of services.

The final goal is related to insurance coverage, reflects case management that programs are doing, and how important the referrals that harm reduction programs make. Those referrals are strengthened if someone has insurance coverage. Asking programs to measure how many people they serve are insured.

Dr. Jinlene Chan: There may be opportunities. There is a lot of work with OOCC and others at BHA with work they're doing and group you're in in terms of Hepatitis C and expanding to look at how we can minimize impact of Hepatitis overall, A and B overall, what strategies can SSPs look at integrating, go beyond hepatitis C. The testing element is important. I'm also keen to speak about vaccinations for hep A and B. Since COVID has impacted individuals who use drugs disproportionately we need to make sure COVID vaccinations are accessible in every setting possible, for people who go to SSPs because that's their trusted connection. Ensuring SSPs have connection directly or partnership with someone who has COVID vaccine.

Syringe Service Programs Data Presentation: Fiscal Year 21

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

I am presenting on SSP program data for fiscal year 21 and best practices from site visits and evaluation.

Program Development: This is a map of Maryland that highlights jurisdictions with current programs, total of 19 approved programs and Baltimore city. Eight out of 20 are community-based organizations. Number in parentheses represents total programs in that jurisdiction. Baltimore city has 7, Cecil 2, Prince George's has 2 but unique situation—one operating. FMCS works collaboratively with Prince George's County Health Department.

Growth in FY21: 8 new approved programs. Thank you to subcommittee that reviewed the applications, reviewing more than one application at once, was so helpful to our programs. Two were LHDs, six were community-based organizations.

Operational growth: during recent fiscal year, exceptional operational growth. If you've heard this presentation before, you've seen the map. Happy to announce all approved SSPs are currently operational. 7 became operational during FY21. Did star FMCS, because they were already providing services. Since the start FY22, four programs have become operational.

Program models: SSPs in Maryland utilize a variety of program models. 75% use fixed, 40% backpack/street-based, 40% mobile, 20% satellite sites, 25% delivery services. In total, 65% of SSPs use more than one model to provide SSP and expand access.

FY21 Program Data: Data in the following slides is from the 16 operational programs during the fiscal year. During FY21, there was a total of 9,133 new participants registered. On the graph, majority were registered by Organization of Hope, BHRC, and Baltimore City Needle Exchange Program. 164% increase from FY20. Total participants served: combination of 18,098 served by SSPs during FY21, 74.2% increase from FY20 when there were 9 operational programs. Programs have reported summer months have increased street outreach, safer environment for covid prevention outside. Top zip code map: each quarter reports to MDH the 3 most common zip codes. Most common were North east, South, and East Baltimore. Due to large number of programs in Baltimore. Shows highlighted areas of top zip codes during the year. Total encounters: 60,319. Almost half of programs had over 4,000 encounters each. 134.4% increase from FY20. Most common drugs reported: Heroin, cocaine, and fentanyl most common drugs reported use. Small increase in reported opioid pills. Syringe distribution: 3.6 million syringes distributed during FY21. 79% increase from FY20 where over 2 million distributed. In Wicomico and Frederick, pharmacy voucher programs distribution 29,260 syringes. Average ranged from 159-260 per person. Small decrease seen in Q3 (Jan-Mar). Due to winter months, having less street outreach and encounters because of weather. Breakdown: Cecil County distributed most syringes among programs outside of Baltimore City, and second most of all programs.

Just Baltimore city: Baltimore city NEP distributed most, over half of all syringes distributed in FY21 in Baltimore City. Thank you to Harriet who has been giving us separate information for BHRC and satellite sites, we were able to document different encounters and syringes distributed by BHRC and by organizations that BHRC has allowed to operate under their authorization and expand services. In the next quarter hope is to collect that satellite information for all programs.

Over 1.5 million syringes collected during FY21. Collection rate is 43.3%, which is a 60.2% increase. Highest collection rates: Voices of Hope, St. Mary's County, FMCS, Frederick, Cecil, and Baltimore County and City have over 40% collection rate in FY21. Lastly for the data, total of 37,447 referrals or linkages to care provided by SSP staff in FY21. Highest amount during most recent quarter. Majority were overdose education and naloxone distribution at over 20,000 linkages/referrals. 194% increase in referrals from previous fiscal year. Total of almost 4,000 other linkages—access to COVID vaccine, housing case management, other vaccines, insurance navigation. Our programs have been so innovative in past year to be comprehensive access to care for the people they serve. Virtual site visits from April to May to ensure best practices and compliance with law. Pulled some highlights to share prominent innovative methods to reach people who use drugs. In no way

inclusive of all efforts, just highlights.
We evaluated programs to sure they are providing needs-based and low threshold services. All programs provide supplies based on need. Most use motivational interviewing or assessment to determine need. Use this method to ensure participants using clean supplies for each use, always encouraged to take what they need. Only instance where SSPs may limit supplies is during outreach encounters—during street-based outreach, programs typically prepackage and limit supplies to ensure they can provide for the full shift, may have to limit distribution to ensure everyone gets supplies. Needs based is not just with syringes—ensure equal numbers of ancillary supplies. Our programs educate participants on using new equipment for each use and take time to educate on their supplies. Programs will navigate through various challenge. Weather for example—will frontload extra supplies to participants in case they're not able to access services.
In addition to all our programs meeting needs-based qualification—all are confidential and do not require an ID. Will provide services if person is unwilling to become a participant—will educate on benefits and protections but will still provide services as needed. Only exception is HCH, FQHC status requires patient interaction to provide services.
Variety of supplies: wide variety of supplies provided. Programs will survey participants to ensure providing what participants need. Some programs have capacity to respond to direct requests and provide within the week. Also standard across programs to offer other supplies including wound care, hygiene, and various other supplies.
Safe disposal: Programs make continuous efforts to ensure that people have safe disposal options. 100% of our programs offer at least one disposal option—fit packs most common option, there were common themes and barriers in addressing litter and disposal—programs trying to build capacity within community. Participants have expressed concern about returning supplies because of fear of law enforcement negative encounters. Programs have worked to address by providing messaging about disposal, provide options for disposal, sometimes laundry detergent bottles, use motivational interviewing to determine best options, engage with participants who are not returning syringes to determine how best to support them. Community cleanups. Some programs offer incentives. A lot of programs have installed syringe kiosks for public use. CHRS, Baltimore City Health Department and community-based organizations have worked collaboratively to address increasing litter in Baltimore City. Installed first at Amazing Grace Church, will be evaluating the effectiveness and determining more locations for kiosks soon.
Secondary Exchange: 100% of programs have formal or informal programs. Formal procedures involve program documenting how many individuals program is receiving supplies for, some programs use volunteers or champions, most important during those encounters there's discussion about protections and how to extend them to people receiving secondary supplies. Important for people to know if they're not registered participants they may not be protected. Other programs provide for this by being truly needs based. All programs educate individuals on protections and try to gain better understanding of how many people the program is reaching.
Responsiveness to community and participant needs: Programs prioritize participant and community feedback using various methods; Surveys, incentives for surveys, gauging participant satisfaction and needs, supply preferences. Document feedback received on encounter forms, with that feedback, change services, hours, locations, or supplies, based on that feedback. In attempt to be responsive to community, programs utilize various data sources to observe trends, gaps, and target areas. SSPs also participate in efforts to increase knowledge of harm reduction and SSP and reduce stigma. Many provide training to community and other stakeholders, including LEO, businesses, state's attorney, etc., receive information about encampments and target areas, common with LHDs—receive info from LE to target those areas for SSP. Collaborate with organizations to establish referral partners. Address negative encounters with LE and maintain direct line of communication. More urban jurisdictions prioritize that outreach to community organizations and stakeholders, in rural jurisdictions, was more important to maintain communication with law enforcement.

Continuum of services to meet needs: a lot of programs bring services onsite to limit barriers for our participants. Utilizing advanced practitioners to provide primary care, co-locating with OTPs, direct naloxone, wound care assessment, our programs have built capacity to offer more wound care; HIV and Hep C testing and access to PrEP and PEP. Expanded access to reproductive health services. This is a short list of all services that programs have brought onsite and brought to participants. A lot of programs have brought vaccination efforts—for COVID and others. Goal of programs in Maryland is to be a comprehensive care model and they are successful in doing so. Challenges and barriers: short list of common challenges programs reported. Staff and supply reallocation for COVID. Peer employment especially for local health departments—challenging to onboard and maintain—unable to pay them a livable wage and employ them quickly. Programs have experienced COVID exposure which have subsequently limited hours. Have been mandated to building closure or isolation of staff. Had trouble in ordering supplies—as supplies were needed for COVID efforts has become more difficult to order things and get them quickly. Generally, programs had trouble with biohazard contracts—some require threshold of syringes to be collected regularly—with SSOs, it varies how many syringes you'll collect in each week, so that's been challenging. As to not end on low note with challenges—pictures provided by SSPs, thank you for sending them in. *Shared pictures of SSP services provided by programs.

IV. Johns Hopkins Evaluation Presentation

Johns Hopkins University Bloomberg School of Public Health
Kristin Schneider, PhD, Assistant Scientist, Department of Health, Behavior and Society
Miles Morris, MPH, Project Director, Department of Health, Behavior and Society

Thanks to Allison and state department and CHRS for the work you are doing is not going unnoticed. We appreciate the collaboration. All credit to Glenna and Saba. Number of strategic goals CHRS identified. Will focus on Goal 2 HCV testing and Goal 4 mobile SSP and co-located buprenorphine. Data we'll present today come from FY20 access grantees—33 grantees across 19 jurisdictions. 15 were community-based organizations and 18 were LHDs. A total of 17 of those were SSPs. Data we're presenting come from the Cognito survey and the ACCESS reporting. Glenna would have reached out to any of you who participated, this is one of the data products. For goal 2, state goal was to have every funded SSP make HCV testing available to participants through co-located services. Broke out into three targets we evaluated: 2a) 100% of funded and operational SSPs will provide HCVV testing, 2b) 100% of funded and operational SSPs with co-located HCV testing services will provide linkage to treatment 2c) reductions in HCV incidence from FY19-20 to FY20-21 will be observed in jurisdictions that offer co-located SSP and HCV testing. Results: 79% offered collocated HCV testing and 100% offered referrals. Programs reported a lot of competing priorities: covid prevention and vaccination. Staffing issues—reallocation, staff who became ill related to COVID-19. Programs had to suspend certain services. Challenges in reporting from different programs as a result of these competing priorities on immediate health needs.

Goal 4: at least two jurisdictions were offering mobile SSP in combination with or collocated with buprenorphine. Chart of counties where there were grantees. A least one grantee offered mobile SSP in most counties. State met target goal of having 2 jurisdictions that offered mobile buprenorphine and mobile SSP—Baltimore City and Calvert County. Prince George's county did meet the goal after the evaluation was over—of having both buprenorphine mobile and SSP mobile. Acknowledge challenges related to COVID-19—a lot of services were suspended or disturbed. Many providers were only offering virtual services.

Dr. Jinlene Chan: Thank you for presentation and evaluation. I think these are great. With evaluation of programs, how can you also begin to look at individual outcomes—health outcomes and such, because what we continue to try to communicate and stakeholders—as

the group knows, there is still a lot of bias and misinformation about SSP and impact. I think that this kind of evaluation helps to communicate what the benefits are of these programs and services they provide. Is there an opportunity to think through how we could better look at what the health outcomes related to SSPs are for the participants?

Dr. Kristin Schneider: In the coming year, we are getting data from different statewide organizations—we have info about when SSPs were authorized and services began—we will look at relationship between services provided and HIV/HCV, and wound rates so we can evaluate those concrete outcomes. In past studies, we've evaluated peer-based services. There have been opportunities for individual data outcomes. We're currently at the environmental level, we're working with Erin Russell to get DUAs in place to get that data. It is forthcoming.

Dr. Jinlene Chan: As we are looking at this collectively, there's a lot of work we're doing to integrate information from across health services of which this would be one, looking at CRISP to understand picture for individuals we serve with goal to better serve them. Or if there are services not working, how we can improve, whether we need to realign resources. Those are things I'm looking forward to.

Dr. Susan Sherman: we work closely with CHRS team. It is amazing how challenging it is for everyone—JHU, MDH, to get some of these state data. In general, it's hard to coordinate data even across the same agency. It's a rate limiting factor people have talked about for a long time. We don't have overdose data, fatal or nonfatal, it's a structural barrier for people to see impact of their work, aside from even evaluation.

Dr. Kristin Schneider: starting quality of care evaluation. Will be looking at aspects of participant perceptions of services, are their needs being met, are they getting services they need, to improve their own health, especially around wounds and infectious disease. We are doing that along with formal environmental level data.

Dr. Jinlene Chan: There's work that given COVID we're looking at regarding integration of data systems and how we can improve data access. There's obviously lots of needs and as we work to morph our system into a person-centered—we talk about person-centered; I think part of that on data side is to make our data won't pigeon-hold someone as an SSP participant but looking at how they intersect services across the spectrum, they also need assistance with connection re-diabetes care, screening for colon cancer, etc. integration there we're working towards.

Dr. Susan Sherman: Your team have been great advocates.

[Chat] *Doug Fuller:* Glad to see all this effort towards low barrier and mobile Buprenorphine access which is so needed. However, I believe Methadone is still the most effective medicine for treating people with long term opioid dependence (and/or SUD) ---- at least that is legal in this Country. In Canada and other countries results with hydromorphone and diacetylmorphine orally or via sterile injection. For now, we need to expand methadone.

Erin Russell: When we established the strategic goal, mobile methadone wasn't allowed. Now that it is something that programs are incorporating, we see it as an opportunity for us to look closely at that and see how it aligns with our activities. Thank you, Doug Fuller for the reminder and recommendation [in the chat] and we'll be sure to incorporate it moving forward.

V. Advisory Committee Actions

Dr. Jinlene Chan: Do I have a motion to approve minutes?

Zach Kosinski: Motion to approve

Victoria Sterling: Second.

Dr. Jinlene Chan: Those in favor say aye.
[lots of ayes]

Dr. Jinlene Chan: any opposed?
[none]

Dr. Jinlene Chan: Next agenda item, selection of community co-chair. Erin Russell, can you talk about this and development of draft bylaws.

Erin Russell: We have been discussing role of community cochair over last few meetings with the committee, have looked to other committees as template. Model that seems to work best—I have edited our bylaws to incorporate. Next slide has draft bylaws update, this was sent to committee with agenda for this meeting. Based on discussion and input from committee, community co-chair is member of harm reduction community through lived, professional, and/or volunteer experience. Just wanted to give some description to qualifications of this role. Goal to have it complement the MDH government role. Term for cochair will be two years, that's voted by the committee. We had discussed an opportunity for the community co-chair to provide guidance and support to whoever their successor will be, whoever the next co-chair is. If serving a two-year term, committee will elect next co-chair in the in-between year so their terms will overlap for one year. Supports onboarding of next co-chair throughout the term. Duties are to facilitate meetings on behalf of chair or along with chair. Participate in development of committee meeting agenda, joining calls with myself and CHRS team as we draft agenda and perhaps recruiting speakers or helping to identify appropriate agenda topics or who we might want to invite to the meeting to discuss those topics. Support identifying new members of the committee. We have a couple vacant seats; we can also add members to the committee with secretary's appointment. Besides rules written into the statute, we can add to the committee as much as is necessary and helpful. Community co-chair can help identify new members. Would be great to vote this through to nominate and have someone be elected at next meeting.

Victoria Sterling: I'm with Washington County health department, representative for MACCO. In draft bylaws, it says the community co-chair will serve a one-year term.

Erin Russell: That was an edit I caught,notes from last meeting said committee preferred a two-year term. What's shared on the screen here is updated version with two-year term.

Dr. Jinlene Chan: I would be explicit that we're talking about electing a community co-chair among members of the committee. We're not talking about nominating—it implies that it would be another member. We're talking about electing someone who is already a part of the committee as a community co-chair.

Erin Russell: Was topic of discussion from last meeting. Committee voiced that would be nice to have someone external to the committee be the co-chair, not sure that's feasible. Starting with

co-chair being existing member of committee. My understanding of way statute is written, we can only have someone who's been vetted and, on the committee, to start.

Dr. Jinlene Chan: Can we make that explicit in the wording?

Erin Russell: Yes.

Dr. Jinlene Chan: Have you also run this by Kim Bernardi and the Secretary's office?

Erin Russell: Yes

Dr. Jinlene Chan: And did she have any comments?

Erin Russell: No.

Dr. Jinlene Chan: Is it something the secretary would need to approve? Should I take that question to Kim?

Erin Russell: In past committee has voted to updates to bylaws, there isn't a role for Secretary in approving bylaws, but if you think it's important to do, we can.

Dr. Jinlene Chan: Want to be sure he's aware. He's interested in the committee and the work of the group. This is something that as related to overall strategies to combat opioid use and harm reduction, he's interested. That's why I bring it up, it's come up in recent conversation. There will be an amendment to bylaw explicitly stating committee will elect co-chair from among its members on an annual basis.

Cam Kerr: I was under the impression that initially it was going to be someone internal to the committee, but there would be room to adjust to let someone outside do.

Dr. Jinlene Chan: Regardless of whether elected by co-chair, would still need to be appointed by Secretary as member of the committee. Because there are many community members on committee as of now, it may make sense to start with existing members. If we were to select community co-chair from outside committee, it's a sense from group that we don't have enough community representation period, because we're talking about adding another member. Is that the desire? That might be a separate discussion.

Cam Kerr: My desire specifically was to include people who might not have the opportunity or training to do this on a regular basis, to be this person, come through and shadow someone who's doing it. not sure if that speaks to make-up of the committee. A lot of people on the committee know how to write emails and do spreadsheet—I am a person who kind of knows how to do those things—trying to create an opportunity for someone who kind of knows how to do those things. It's difficult to make this space representative for a myriad of reasons.

Dr. Jinlene Chan: Community co-chair needs to take on fair number of responsibilities related to committee. Given how important the group is—there's a lot of qualified individuals who are already on our committee that can serve in this role. Perhaps it's a separate discussion in terms of creating a new position or new member within the committee itself to enhance representation and to develop that capacity.

Harriet Smith: Just a follow up on that thread. What do we mean by community co-chair—not a government official—or something else.

Erin Russell: The preference being that it is someone who does not represent a government

agency and that they have lived experience.

Harriet Smith: Of using the drugs we are talking about? What does lived experience mean?

Erin Russell: Someone who's been a program participant. I don't know that we're limiting substance we discuss in this space. There aren't limitations to that.

Harriet Smith: So, received SSP services and is not an employee of the government.

Dr. Jinlene Chan: That's not what the wording is here, because it talks about lived, professional, and/or volunteer experience. Does it exclude an individual who works or volunteers for a LHD, and it doesn't say anything about nongovernmental—was that the intent

Cam Kerr: Off the definitions we've been given, that's basically what I'm trying to say. I was feeling that this position had the potential to be accessible to non-governmental employees, professional development for people who want to be in the space but don't know how to operate in the space, in a way that is acceptable to governmental people. For me the first update of the bylaw, assumed that was the wiggle room space, one of these three things—community through their lived experience, or if we don't have that person, someone that has the professional, and if not that, the volunteer experience. I'm trying to make this space more accessible for people who don't work in government, that still want to participate in this space, that have lived experience, that have ability to shadow someone on the committee to get the experience and tools they need to operate in the space.

Dr. Jinlene Chan: Who would they shadow?

Cam Kerr: The first person is going to be a committee member, then opening it up to someone not on the committee that was the idea.

Dr. Jinlene Chan: I'd like to table that part of it if possible, only because we'd need to expand membership or create that as a separate member perhaps.

Erin Russell: I could update this to say that a community co-chair is elected every two years. Then have a separate line that says, the committee will nominate a co-chair in the second year of the community cochairs term, so that the next cochair is nominated, so they're not officially on the committee—they could still be a current member—but if they're not and they're nominated, they have a year to shadow, submit application, become a member, so when their term starts, they've had a year to start. Opens door for them not to be. Gets around our requirement that those on our committee go through vetting process. That's a suggestion. Happy to make sure it's all legal and feasible.

Dr. Jinlene Chan: Comment or raised hand from Deanna.

Dr. Deanna Dunn: I'm confused. Sounds like we're looking for a specific person. To me, sounds like co-chair means someone on the committee. Seems we're excluding most of our committee members.

Dr. Susan Sherman: However, this committee can be used, whether co-chair, Cam's notion—a lot of people who haven't been in these types of meetings, being asked to function in that role—whatever this committee can do to support people to be in committees like this. Whatever it is, which could include being a co-chair—don't want to set someone up for failure, being involved in something they haven't been involved in before. Regardless of whether this

or another position, lots of resources here to help uplift people.

Dr. Jinlene Chan: Talking about creating another committee member overall. I'm not opposed. If we want to push forward today, I propose we amend bylaws to say that community cochair will be selected among the current committee members and leave the—if it's intended to be a nongovernmental or non-MDH, which I am ok with—we specify that, because that's not clear there. Being expansive in terms of the lived, professional, volunteer experience, seems to capture what is being thought through here.

Cam Kerr: if it doesn't include giving people the opportunity to move into this space—that's the only thing I care about. You had mentioned that one year, bring people in having them vetted, then they could be on the committee, something like that.

Zach Kosinski: Also agree with all that. Important to make space for people. Not setting people up to go into position, have responsibilities they're not prepared for. Shadowing process gives people time, they have opportunity to do that.

Harriet Smith: I was going to offer—Erin, if you want to look to greater Baltimore HIV/AIDS Planning Council, there's been a lot of work to make sure consumers of Ryan white services are on the council and so they're not set up—ex. if they're a patient—that they get coaching and support they need to participate. I would connect there, look there, for some guidance. I've found that to be an intentional place.

Dr. Jinlene Chan: I would propose that we—I guess I'll look in chat to see where Erin put some of the language. But that we then—if this doesn't already exist, I'm surprised to hear that. I haven't looked at makeup of the committee. If we don't have consumer, representative, someone that's accessing services, that's an important voice to have at the table. That I think would be an important separate step to add to the committee.

Cam Kerr: A lot of people here who have skills to do the job we're talking about. Not a lot of people in the space who are actively using syringe spaces. I know I'm not using SSP, so I can speak for myself. It's a nice trade, to bring someone in and give them opportunity to operate in this space as themselves and give some skills on how to operate in this space. And for them to share with us, the knowledge they have of being active in receiving the care and things we're trying to provide for people.

Dr. Deanna Dunn: We're talking about two different things. If we're not including person with experience as member in our committee, that's a discrepancy we need to address. Because of population we are addressing aspect of what we're doing is supposed to include people who use drugs. I see the committee co-chair as separate thing. Person committee sees as person most fit to lead the meetings. Am I understanding that right?

Dr. Jinlene Chan: I think that's what I'm proposing what we take in terms of actions—separate the two. Because 1) The action now that we could take if committee ready to make vote, is to update bylaws about electing committee cochair from among existing members on annual basis. However, revisiting the committee membership and representation if it does not include a consumer or someone who uses services, we should address that and propose as new member of the committee. Therefore, once that person—and it can be more than one—those people would be eligible for being elected as a co-chair, because they're a member of the committee. First, we act on committee co-chair, then separately at another meeting, take another look at membership representation and if it's not already to make sure that we add

that. Does that sound like a path forward?

Cam Kerr: Want to also uplift that there are multiple reasons why people don't want to be in this space who actively use SSP services, that's being mentioned in that chat and is information a lot of us have. Want to uplift that and bring that to the table so we can think about that when we are in this space to figure out how to operate in this space in a way that is as trauma informed as possible.

Dr. Jinlene Chan: Thank you for bringing that into the conversation as well. The proposal on the table, do we have time to move on this, Erin? This has been a good discussion. Haven't had a chance to read all comments in the chat, but do we want to move this forward? This has been a rich discussion and we have some action steps to take after this.

Erin Russell: I've been noting and making edits based on this conversation to this draft, I will resend draft bylaws to the committee after this meeting. I understand we have a couple steps internally at the department to ensure we're informing Secretary and Kim Bernardi about the change.

Dr. Jinlene Chan: When is our next meeting?

Erin Russell: December 14 [corrected in chat with December 10th]

Dr. Jinlene Chan: Do we feel like we have edits and information together enough to take a vote? Feeling like we have a couple more steps to ensure we capture conversation that was had here and do revisions to bylaws.

Erin Russell: Some discussion to be had about activities of co-chair.

Dr. Jinlene Chan: And review of membership overall.

Erin Russell: Yes, and then representation on the committee, and separate but equally important activity of ensuring space is trauma-informed and becoming more accessible as we embark on this change in direction.

Dr. Jinlene Chan: Thank you everyone, I apologize we went over time. This has been a rich discussion and we'll make sure to capture comments in the chat as well. We'll revisit this at our next meeting.

VI. Closing