KITSAP PUBLIC HEALTH DISTRICT

345 6th Street, Suite 300
Bremerton, WA 98337
360-728-2235

KITSAP PUBLIC HEALTH BOARD
MEETING AGENDA

October 1, 2019
12:30 p.m. to 1:45 p.m.
Norm Dicks Government Center, First Floor Chambers Room
Bremerton, Washington

12:30 p.m.	1.	Call to Order *Commissioner Rob Gelder, Chair*	
12:32 p.m.	2.	Approval of September 3, 2019 Meeting Minutes *Commissioner Rob Gelder, Chair*	*Page 2*
12:33 p.m.	3.	Approval of Consent Items and Contract Updates: See Warrant and EFT Registers and Contracts Signed Report *Commissioner Rob Gelder, Chair*	*External document*
12:35 p.m.	4.	Public Comment *Commissioner Rob Gelder, Chair*	
12:45 p.m.	5.	Health Officer and Administrator Reports *Dr. Susan Turner, Health Officer & Keith Grellner, Administrator*	

INFORMATION AND DISCUSSION ITEMS

1:00 p.m.	6.	Executive Session Pursuant to RCW 42.30.110 (1)(i): Discussion Related To Potential Litigation *Keith Grellner, Administrator* *Michelle Fossum, Sayre Sayre & Fossum and* *Susan Looker, Enduris (By Phone)*	
1:15 p.m.	7.	Syringe Exchange Program Update *Dr. Susan Turner, Health Officer*	*Page 12*
1:45 p.m.	8.	Adjourn	

All times are approximate. Board meeting materials are available online at
www.kitsappublichealth.org/about/board-meetings.php

KITSAP PUBLIC HEALTH BOARD
MEETING MINUTES
Regular Meeting
September 3, 2019

The meeting was called to order by Board Chair, Commissioner Robert Gelder at 12:30 p.m.

REVIEW AND APPROVE AGENDA

There were no changes to the agenda.

BOARD MEETING MINUTES

Commissioner Charlotte Garrido moved and Mayor Becky Erickson seconded the motion to approve the minutes for the July 2, 2019, regular meeting. The motion was approved unanimously.

CONSENT AGENDA

The September consent agenda included the following contracts:

- 1749 Amendment 9 (1926), *Washington State Department of Health, Consolidated Contract*
- 1749 Amendment 10 (2023), *Washington State Department of Health, Consolidated Contract*
- 1893, *Mason County Public Health, Nightingale Notes Sublicense*
- 2002, *Clallam County Health and Human Services, Tobacco & Vapor Product Prevention & Control Program and YMPEP*
- 2003, *Jefferson County Public Health, Tobacco & Vapor Product Prevention & Control Program and YMPEP*
- 2004, *Kitsap County, Tobacco & Vapor Product Prevention & Control Program and YMPEP*
- 2016, *Washington State Department of Ecology, Local Source Control*
- 2024, *Washington State Department of Ecology, Solid Waste Management Local Solid Waste Financial Assistance Agreement*

Mayor Rob Putaansuu moved and Commissioner Charlotte Garrido seconded the motion to approve the consent agenda, including the Contracts Update and Warrant and Electronic Funds Transfer Registers from June and July. The motion was approved unanimously.

PUBLIC COMMENT

There was no public comment.

HEALTH OFFICER/ADMINISTRATOR'S REPORT

Health Officer Update:
Dr. Susan Turner, Health Officer, provided the Board with two updates:

Firstly, Dr. Turner provided an overview of a recent outbreak of gastrointestinal illness at a Kitsap senior living facility. Dr. Turner said Health District investigators responded rapidly. The Health District used an Incident Command Structure to provide rapid response and prevent the spread of illness in the facility and community. Thirty-six people became ill during the outbreak. Stool samples collected tested positive for norovirus. Based on epidemiological analysis, the Health District believes one ill individual brought the virus to the facility and it spread quickly from person to person. The response took about one week and required 250 staff hours by 23 employees and an estimated cost of just under $15,000.

Next, Dr. Turner gave an update on a multi-state outbreak of lung disease related to vaping. The Health District recently issued a health advisory related to the outbreak and the Centers for Disease Control and Prevention (CDC) also sent an advisory. The CDC reported 215 cases in 25 states as of Friday. State investigations are ongoing. One person was reported to have died from the illness. No known cases have been identified in Washington. The state Department of Health has held weekly calls with the CDC and passed on information to the Health District. The cause of the illness has not been identified. All the reported cases involved e-cigarette use or vaping. No specific product has been linked to all the cases. In many cases there was a gradual onset of symptoms, including difficulty breathing, shortness of breath and chest pain. All cases have been hospitalized. Some experienced gastrointestinal illness. Antibiotics have not proven effective in treating the illness, but some cases have responded to steroids. Many, but not all, of the people involved in the cases acknowledged using THC. The CDC is reiterating its guidance that e-cigarettes shouldn't be used by adults not already using tobacco products. youth, or pregnant women or The CDC provided guidance for health care providers and coroners, which the Health District passed on to providers and the coroner in Kitsap.

Mayor Becky Erickson said news media reported the products involved in the cases contained THC. She asked if Dr. Turner had also heard this from formal sources.

Dr. Turner confirmed that most, but not all, the cases involved THC products, but no specific product had been identified.

There was no further comment.

Administrator Update:
Mr. Keith Grellner, Administrator, provided the Board with several updates:

First, Mr. Grellner commented on the accounting of costs associated with the norovirus outbreak response. Mr. Grellner said the Health District is making an effort to better track these costs to keep track of expenses related to Foundational Public Health Services (FPHS) and to advocate for funding for the work the Health District does. Also, with budget season approaching, the

Health District can provide examples to show the kind of work the Health District does in board members' jurisdictions. Mr. Grellner noted the 250 hours dedicated to the response was in addition to staffs' regular daily workload. The Health District had to figure out how to continue serving clients and balance other work.

Second, Mr. Grellner said the Health District's 2018 Annual Report had been distributed to the board.

Mr. Grellner said the Health District struggled in past years to produce an annual report. The Health District has a broad breadth of services and didn't have a system in place for recording achievements from year to year. The 2018 report is the first report produced through the Health District's performance management system. Mr. Grellner said the Health District has gotten better at setting up this system to track outcomes of the work the district does and track which achievements are connected to strategic goals and which are related to Foundational Public Health services, so the Health District can tell that story in a concise manner. He welcomed feedback from the board and thanked staff for their work on the report.

Commissioner Gelder commented that the infographics in the report were a helpful way to understand the facts provided. He noted that if it's not fast, you're not going to get anyone reading it.

Mr. Grellner agreed and said the Health District's previous annual reports were too long, which is one reason the Health District didn't produce reports over the past two years.

Mayor Erickson said she would like to borrow the design for the City of Poulsbo.

Mr. Grellner said the Health District credited Peninsula Community Health Services for some of the design elements.

Next, Mr. Grellner said the Health District would be holding an all-staff meeting on Wednesday, September 18th. The meeting will focus on the health indicator and health disparity reports and would include a presentation from Kody Russell of Kitsap Strong on trauma-informed care. Mr. Grellner said the meeting would keep staff informed, help them learn about the community they serve and improve the Health District's services. He invited board members to stop by the meeting.

Next, Mr. Grellner reported that Health District clients would soon be receiving information about environmental health fee changes. The board adopted a new fee schedule in 2017 (Resolution 2017-03) with increases in 2018, 2019 and consumer price index increases for 2020 through 2026 to keep fees current and avoid another large increase. The Health District will begin updating the public and industry about the increases. Mr. Grellner said the Health District has identified a few fees that don't need further adjustment and is reviewing whether a separate resolution is needed to make those changes to the schedule.

Finally, Mr. Grellner highlighted recognition Health District programs had received over the previous month.

- The Community Health division and Chronic Disease Prevention program hosted a team from the CDC, to learn more about the District's work in increasing physical activity and healthy eating to reduce chronic diseases. The team was also interested in the Health District's collaboration with the City of Bremerton on Complete Streets projects.

- The Environmental Health Division and the Food and Living Environment program were recognized by the Food and Drug Administration for meeting two national standards in the Voluntary National Retail Food Regulatory program.

- The Community Health Division and the Kitsap Connect hosted the National Academy of Medicine's Future of Nursing 2030 committee. The committee is studying how nurses can help address social determinants of health and was interested in how Kitsap Connect nurses have reduced the use of emergency care services among high utilizers by linking clients to housing and health care services. Mr. Grellner said the program has succeeded in reducing costs for emergency services providers. The program is mostly funded by a Kitsap County 1/10th of 1 Percent grant, but is becoming more difficult to sustain. Mr. Grellner noted the program was started as a pilot project started three years ago and the Health District has been unsuccessful in finding an organization to take over the program. The Health District will have to decide if it can sustain the program beyond 2020.

Mayor Greg Wheeler thanked the Health District for keeping Kitsap Connect going. He said the program was an example of helping people with mental health and substance use conditions. Mayor Wheeler said a lack of stable housing can create public health hazards due to unsanitary conditions.

Mayor Wheeler asked what funding sources the Health District has looked for to sustain Kitsap Connect.

Mr. Grellner said the Health District has applied for several grants but has not heard back yet. The District has also considered requesting funding from emergency service providers benefiting from the program.

Mayor Wheeler asked if the Health District has considered 1/10th of 1 Percent funding again.

Mr. Grellner said the Health District has applied again for 1/10th of 1 Percent funding, but he noted the grant program was not intended as a long-term funding source, potentially making it more difficult for Kitsap Connect to qualify. Kitsap Connect is also expensive to operate. The Health District will know in October if the program will receive grant funding. Based on the level grant funding, the Health District will have to decide whether to scale back the program, continue to fully fund it with general health fund money or end the program.

Mayor Wheeler asked if Kitsap Connect funding would be brought up at future Health Board committee meetings.

Mr. Grellner said the topic would be on the agenda of upcoming finance and policy committee meetings, but any discussion will be preliminary until the level of 1/10th of 1 Percent funding is determined.

Commissioner Gelder commented that, without the state fully funding FPHS, a burden is shifted to local resources.

Mr. Grellner said that if the state fully funded FPHS, local health agencies would have more flexibility to use local funding to pay for programs like Kitsap Connect.

Commissioner Gelder said this was something to keep in mind for the 2020 Legislative agenda.

There were no further comments.

QUALITY IMPROVEMENT PROGRAM UPDATE

Ms. Jessica Guidry, Public Health Emergency Preparedness & Response and Performance Management Manager, and Ms. Dayna Katula, Food and Living Environment Program Manager, approached the Board to present an overview of the Health District's quality improvement (QI) program.

Ms. Guidry explained that the Health District's Performance Management System consists of structures, roles, and processes that:

1. Link and coordinate our planning, performance monitoring, and continuous quality improvement (CQI) efforts so they will be efficient and effective; and

2. Standardize how the Health District establishes goals and measures, monitor and evaluate performance, identify and implement improvement strategies, and report results.

Ms. Guidry said local, state, and federal influencers help shape to the Health District's work. The Health District's Community Health Improvement Plan, also known as Kitsap Community Health Priorities or KCHP, is the county's set of priority health issues, developed using a collaborative health improvement process involving a wide range of community sector representatives and stakeholders. Standards include those from the Public Health Accreditation Board and Foundational Public Health Services. Mandates include legal requirements, such as local codes, the Washington Administrative Code, and grant requirements.

Ms. Guidry said the Health District considers all these influencers as it develops and updates its strategic plan. To achieve the goals of the strategic plan, each program develops work plans and logic models that describe what the programs do, and the short-, mid-, and long- term outcomes of their activities. The Health District improves its processes through quality improvement

projects or by implementing quality improvement practices. Throughout these various stages, The Health District uses strategic partnerships, best practices, staff engagement, and embraces a learning culture.

Ms. Guidry described quality improvement as the use of a deliberate and defined improvement process in a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of services or processes. Ms. Guidry discussed the Health District's Quality Council, which advises the Executive Leadership team, leads quality improvement projects and provides staff training, among other functions.

Ms. Katula provided an overview of the Health District's quality improvement training efforts. She said the Health District now requires staff to take quality improvement training based on the Lean Six Sigma methodology in order to broaden participation and buy-in on quality improvement efforts. All non-management staff must complete a basic White Belt training, which provides an overview of what Lean Six Sigma is and why organizations use it. Managers and QI Council members are required to take higher levels of training.

Ms. Katula said some Quality Council members had completed the 32-hour online Green Belt training, which provides participants with the information needed to lead QI projects. She said 97% of eligible staff are currently trained in White Belt or higher and the Health District has had experienced a positive shift in attitudes toward quality improvement efforts.

Ms. Katula provided examples of in-person trainings of training and tools provided to staff to apply quality improvement principles to their workflow and workplaces. She informed the board that the QI Council is developing a Lean Six Sigma demonstration for staff called "Jurassic Pork," which will walk staff through an entire quality improvement project using a fictional scenario involving food truck permitting in "Jurassic County."

Ms. Katula said staff have worked on 10 quality improvement projects so far, some of which were still underway. Projects addressed processes like performance evaluations, medical provider messaging, use of technology, and how public inquiries from the website were handled. She described three examples of successful quality improvement projects:

- A 2012 project that streamlined and improved the Health District's process for preparing and sending health alerts to medical providers.
- A project that simplified staff performance evaluations and gave staff greater opportunity to participate.
- A project to capture feedback from customers and improve customer service. This work will be piloted by the Emergency Preparedness and Response program, Drinking Water & Onsite Sewage System program, and Food & Living Environment program.

Ms. Katula said the QI council keeps staff updated on quality improvement work through meetings, email updates and a SharePoint site, and is looking for additional ways to keep staff informed.

Commissioner Gelder said the County also embraced a formal quality improvement process in 2010 or 2011, in response to the economic recession. He said the County had to make sure its processes were streamlined. He said quality improvement was a great investment and it was interesting to see how ideas for projects came up.

Commissioner Garrido agreed that county staff were excited about quality improvement. Commissioner Gelder said one benefit was staff felt ownership of process improvements.

There was no further comment.

RESOLUTION 2019-04, SUPPORTING KITSAP PUBLIC HEALTH DISTRICT'S REACCREDITATION EFFORTS

Mr. Grellner approached the Board regarding Resolution 2019-04, Supporting Kitsap Public Health District's Reaccreditation Efforts. Mr. Grellner said the initial process of becoming accredited by the Public Health Accreditation Board (PHAB) was transformational for the Health District because it provided a framework for continually improving the agency. The original accreditation was good for five years and will expire in May 2020. Health District leadership must decide whether to pursue reaccreditation or let it lapse.

Mr. Grellner said the Health District first attained accreditation through PHAB in 2015 with the goal of improving the agency. The Health District was undergoing changes in leadership and needed structure to improve its work. When it first earned accreditation, the Health District was one of three agencies public health agencies in Washington and 75 nationwide (out of 3,000) to become accredited. It is now one of 275 public health agencies that is accredited, including five in Washington (including the state Department of Health, Spokane, Tacoma-Pierce and Benton Franklin).

Mr. Grellner said Health District leadership feels seeking reaccreditation will help the agency build on its quality improvement efforts hold itself to the highest standards. He noted the Health District has experienced significant leadership turnover since 2015 and the reaccreditation process offers an opportunity to strengthen its management team and enhance cooperation across divisions and programs.

Mr. Grellner provided examples of outcomes and benefits from the initial PHAB accreditation process:

- The 2011–2021 Strategic Plan and Mission and Vision Statements
- Kitsap Community Health Priorities and Improvement Plan
- The QI Council and Program and the Health District's "quality culture"
- The Performance Management System and annual work plans
- Resolution 2015-03: Appointing Deputy Health Officers
- Resolution 2016-08: Approving a Line of Succession for the District Administrator
- Health District branding for internal and external communications

Mr. Grellner said some of these items may have been accomplished independent of accreditation, but the PHAB process helped the Health District achieve these milestones quickly and to a high standard. He said the Executive Leadership Team had voted unanimously to pursue reaccreditation, but Health Board approval was appropriate because of the costs involved. Mr. Grellner explained the costs of reaccreditation include a $12,000 application fee, annual fees of $8,400 for four years and staff costs for documentation estimated at $30,000. He said much of the staff work involved would be necessary whether the district applied for reaccreditation or not. Mr. Grellner requested the Health Board's support for the Health District's plan to pursue PHAB reaccreditation.

Commissioner Gelder asked how the application fee for 2020 compared with the fee the Health District paid when it was originally accredited.

Mr. Grellner said the application fee paid by the district in 2014 was $36,000. The fee is lower now because the Health District has already participated in the process and PHAB has restructured its fees based on feedback. PHAB now charges a lower application fee as well as annual reaccreditation fees, for a lower overall cost.

Commissioner Gelder asked how the $30,000 in estimated staff cost is "over and above" the Health District's typical costs, if the work required is work the Health District would do anyway.

Mr. Grellner explained PHAB staff will have to compile about 100 narratives explaining how the Health District's work meets PHAB standards. Each narrative will take about three to five hours to produce and vet. The Health District expects it will need to put in additional work to meet two or three of PHAB's standards, accounting for about $20,000 of the estimated staff cost.

Commissioner Gelder asked if PHAB offered a library of best management practices as a resource outside of its accreditation process. Dr. Turner responded, saying PHAB had initially considered offering such a resource but had decided it could present the appearance of a conflict. Instead, the National Association of County and City Health Officials offers those resources to help members seek accreditation.

Dr. Turner recalled a Health Board member wondering why so few public health agencies had become accredited and whether it was an indicator of the value of the process. Dr. Turner said she feels that fact is mostly related to the average size and capacity of local public health agencies, which is very small. Kitsap Public Health is a comparatively large public health agency. Dr. Turner said PHAB is aware it needs to address this issue and ensure more public health agencies are able to meet standards and thereby better protect the public they serve.

Commissioner Garrido said she was supportive of the process but wondered how the accomplishments Mr. Grellner attributed to PHAB accreditation have improved public health.

Commissioner Gelder said it boiled down to having metrics to measure outcomes.

Dr. Turner replied that PHAB had recognized the need to tie its accreditation standards to evidence-based practices for improving public health. PHAB is collecting data to help with that effort.

Mr. Grellner said the Health District is also working to improve its messaging and has made strides in that direction with the hiring of a new public information officer. He noted the Health District, as with many public agencies, is still rebuilding from the economic recession and communications work was one of the areas sacrificed during the recession.

Additionally, Mr. Grellner said when the Health District initially applied for accreditation, there was a hope that accredited agencies would be better positioned for funding opportunities. That has not been the case. The Health District hopes that at some time in the future, high-performing agencies will be eligible for funding.

Commissioner Gelder noted the county Public Works department went through a similar accreditation process. Accreditation didn't necessarily make the department more eligible for funding but did improve the quality of the department overall.

There was no further comment.

Commissioner Garrido moved and Mayor Kol Medina seconded the motion to approve Resolution 2019-04, Supporting Kitsap Public Health District's Reaccreditation Efforts. The motion was approved unanimously.

BOARD DISCUSSION & ANNOUNCEMENTS

Prior to adjournment, Mayor Erickson asked if there was any update on the syringe exchange restructuring. She said she had talked to Peninsula Community Health Services (PCHS) CEO Jennifer Kreidler-Moss and was told PCHS was just waiting for contracts. Mayor Erickson said she wanted to have the process wrapped up by the end of the year.

Dr. Turner said the Health District has provided PCHS with supplies to help PCHS roll out its service, without a contract in place. The Health District also shared its draft syringe exchange procedure with PCHS. Dr. Turner said she did not know what date PCHS would begin providing services at its five pharmacy locations but expected it to begin shortly.

Mayor Erickson said Kreidler-Moss also told her PCHS has many openings for its medication-assisted treatment program and had expanded counseling services for opioid treatment. Mayor Erickson asked when Baymark (opioid treatment program) was expected to open.

Dr. Turner said she understood Baymark was expected to open in Kitsap in October and the Port Angeles location would open in September.

Mayor Erickson said the county had medication-assisted treatment services available and Medicaid dollars to support those services. She said now is the time to get people into those services and she looked forward to getting the syringe exchange modified.

Commissioner Gelder remarked it was unclear what could happen with Medicaid funding next year after the change to managed care.

Mayor Erickson said PCHS had more than 1,700 available slots for treatment with relatively few being used.

Commissioner Garrido announced the county would mark World Suicide Prevention Day on September 10th at the administrative building.

Dr. Turner thanked Kitsap County Human Services for its work on that issue.

ADJOURN

There was no further business; the meeting adjourned at 1:39 p.m.

Robert Gelder	**Keith Grellner**
Kitsap Public Health Board	**Administrator**

Board Members Present: *Mayor* Becky Erickson; *Commissioner* Charlotte Garrido; *Commissioner* Robert Gelder; *Mayor* Kol Medina; *Mayor* Robert Putaansuu; *Mayor* Greg Wheeler

Board Members Absent: *Commissioner* Ed Wolfe.

Community Members Present: Roger Gay, *South Kitsap Taxpayers;* Monte Levine, *People's Harm Reduction Alliance*; Lauren Funk*, People's Harm Reduction Alliance;* Dan Pedelaborde*, Troop 1539;* Pam Hamon*, League of Women Voters – Kitsap.*

Staff Present: Amy Anderson*, Public Health Educator, Public Health Emergency Preparedness and Response;* Karen Boysen-Knapp*, Community Liaison, Chronic Disease Prevention;* April Fisk*, Program Coordinator, Contracts Management/Public Records Officer;* Keith Grellner*, Administrator;* Jessica Guidry*, Manager, Public Health Emergency Preparedness and Response;* Karen Holt, *Manager, Human Resources;* Siri Kushner*; Assistant Director, Community Health Division;* Melissa Laird*, Manager, Finance and Accounting;* Megan Moore*, Community Liaison, Chronic Disease Prevention;* Tad Sooter*, Public Information Officer; ;* Susan Turner*, MD, Health Officer.*

KITSAP PUBLIC HEALTH DISTRICT

345 6th Street, Suite 300
Bremerton, WA 98337
360-728-2235

MEMO

To: Kitsap Public Health Board

From: Dr. Susan Turner, MD, MPH, MS, Health Officer

Date: October 1, 2019

Re: Syringe Exchange Program Update

The purpose of this agenda item is to provide the Health Board with an update of the Health District's work to redesign its syringe exchange program (SEP) and obtain the Health Board's concurrence with these efforts.

Background. In mid-2018, some members of the Health Board expressed concerns about injection equipment waste (e.g., used syringes and associated materials) illegally discarded in the environment, and the Health District's SEP procedures. In response, the Health District formed a SEP Workgroup comprised of representatives from the Health District, cities, law enforcement, parks, and community SEP participants to discuss and review the program. The Workgroup met several times between September and December 2018.

As a result of those interactions, District staff made a presentation to the PH Board in January 2019 about the status of the SEP. Dr. Susan Turner recommended changes to the program that would increase access to safe legal syringe disposal as well as expanding access to syringe exchange services at multiple locations across the community to "make the healthy choice the easy choice," and increase the likelihood of engagement in healthcare and substance use disorder(SUD) treatment services. The Health Board asked staff to develop an improved syringe exchange model over the ensuing months with the guidance from the Health Board's Policy Committee.

Health District Staff engaged in extensive research to identify potential and existing SEP models that would address Board Member concerns. **Attachment 1** to this packet is a draft summary of that research. The Policy Committee has met three times, most recently 9/17/19. Concerns about the current Kitsap SEP model include:

- Negative impacts to law enforcement, parks, and citizens (crime, used syringes/needle sticks, litter)
- Used syringes illegally discarded in the environment
- Connections between drug addiction/drug use and crime

- Cost of SEP and who is paying for it
- Too many syringes exchanged
- Too few safe disposal options available
- Lack of comprehensive data gathering for SEP (e.g. number of SEP users is unknown)
- Exchanges should be done by medical professionals to compel and provide treatment
- Need to treat addiction as a medical condition
- SEP is too easy and enables crime because people who inject drugs (PWID) do not have to access SEP in a medical environment
- Mobile services contractor conducts exchanges in residential areas/private homes
- Exchanges may occur with "proxies", so people who inject drugs (PWID) are not getting referrals
- Exchanges may be enabling PWID
- Mobile services may be facilitating de-facto "safe injections sites"

Concerns about making changes to the SEP include:

- Number of encounters may be drastically reduced
- Transmission of communicable disease may increase
- Number of syringes distributed and collected/properly disposed may be significantly reduced
- Numbers of referrals, naloxone kits, and condoms may be significantly reduced
- There do not appear to be any local service providers (existing or new) who will be able to address the apparent SEP service needs of PWID, or the volume of need
- Transitioning/changing too fast
- Willingness to accept treatment cannot be forced
- Cost to the Health District

SEP Update. The Policy Committee has recommended a "Syringe Exchange Network" in which behavioral health and healthcare providers provide syringe exchange services and risk reduction counseling. Major goals of this type of service delivery are to better engage clients in substance use disorder (SUD) and other treatments, and to reduce risk behaviors, disease transmission risk, and improper syringe disposal. Improving data collection is seen as a key facet of the new model. Please see **Attachment 2** for the current concept diagram for the new Kitsap SEP Network.

Below, please find summaries by task of Health District work accomplishments to date under the guidance of the Policy Committee:

1. (High Priority) Secure partnerships with Peninsula Community Health Services (PCHS) and Genoa Pharmacy at Kitsap Mental Health Services (KMHS), as well as other willing partners toward creation of a network of syringe exchange services providers.

Work Results: Discussions have been held with some of these entities concerning their interest and ability to participate in a syringe exchange program (SEP).

- PCHS is about to launch syringe exchange services in their four integrated medical/behavioral health facilities with pharmacies, followed soon by syringe exchange utilizing their mobile behavioral health services van.
    - We have provided supplies
    - We are negotiating with Stericycle to pick up used sharps containers directly from each site
    - PCHS has agreed to provide data; final list of data to collect and report pending
- Kitsap Mental Health Services initially suggested a two-part provision of services, including field staff syringe exchange and pharmacy-based syringe exchange. Their exploration of field exchange services found the model to not be feasible for them. They referred us to their onsite private pharmacy provider, Genoa.
    - Dr. Turner met with the Genoa Pharmacy Manager, who was excited about and committed to beginning syringe exchange services as soon as possible
    - The pharmacy manager has been out on parental leave and we are following up with him.
- Substance Use Disorder (SUD) services provider outreach:
    - Dr. Turner met with Kitsap County Human Services, who noted it may be unlikely that these providers will agree to participate since they require drug abstinence. Agape Unlimited was recommended as a top candidate for outreach.
    - Dr. Turner met with the Nursing Supervisor for Agape Unlimited, and they declined to participate in the SEP Network, since they contract with all participants to abstain from drug use during treatment, and clients are discharged from treatment if drug use occurs.
- Summary of overall outreach through 9/25/19:
    - Port Gamble S'Klallam Tribe provides syringe exchange services; the Health District plans to invite the Tribe's participation in the network.
    - Kitsap Recovery Center currently collects and disposes of used syringes.
    - Kitsap County detoxification center is considering providing SEP services.
    - Kaiser Permanente is interested and is consulting with corporate offices.
    - Suquamish Tribe is considering providing SEP as part of its wellness services.
    - The Harrison Medical Center's Family Medicine Residency Program declined to provide SEP services at this time but has agreed to accept Hepatitis C screening referrals from the SEP, which will provide significantly improve access to Hepatitis C evaluation and treatment.

2. Support mobile syringe exchange services, including naloxone distribution until the SEP network can meet SEP needs within urban areas—this ensures no one is left without services and avoids unintended consequences related to increased disease transmission

and overdose events/deaths. Once the exchange is more complete, consider reducing mobile syringe exchange services, prioritizing areas where most needed.

Work Results:

- People's Harm Reduction Alliance (PHRA) – The contract extension for July through December 2019 was completed as approved by KPHB; better data reporting and invoicing are built into extension, although there has been limited success in collecting this information from PHRA. Outcomes of 9/25/19 meeting with PHRA will be shared with the Board.
- Point Defiance Aids Project (PDAP) has not yet been contacted. Previously, Point Defiance was reluctant to initiate operations in Kitsap because the People's Harm Reduction Alliance (PHRA) was already active. The District will include PDAP in the next request for proposals for SEP services.
- Request for Proposals for 2020 SEP Network mobile services would need to be announced in October to allow startup on 1/1/20 and should include requirements that all network partners will meet.

3. Address budget issues (supplies and disposal costs) and balance with SEP network partner needs to reduce barriers to participation.

   Work Results: As the District works on the transformation of the SEP, the District has decided to maintain total SEP costs for 2019 and 2020 at 2018 levels (status quo budget).
   - We have offered and provided an initial batch of supplies to PCHS for the opening of their syringe exchange services.
   - We are awaiting cost documentation before providing additional supplies to PHRA
   - We will be notifying PHRA that the District will be limiting SEP supplies to 2018 levels for 2019. With the addition of PCHS to the SEP network, this will likely result in a reduction in supplies for PHRA before the end of the year.
   - Genoa Pharmacy at KMHS expressed the desire to receive financial assistance with supplies and for KPHD to arrange for disposal. This matter will be addressed with Genoa in October.

4. Talk to pharmacies and other healthcare and behavioral healthcare services providers about syringe collection and/or exchange toward further extending the initial network.

   Work Results: Capacity has limited outreach at this time, but recently KPHD was informed that we will receive a small grant to cover the cost of a portion of a staff member to act as a coordinator of the syringe exchange network, and work with community partners to improve the network. This will include outreach to potential network partners.

5. Talk to Kitsap County Solid Waste about additional syringe disposal options.

Work Results:

- Commissioner Gelder spoke with Kitsap County Solid Waste, and they recommended use of the existing county transfer station collection system and the syringe exchange program.
- Outreach to Kitsap County Solid Waste by KPHD staff about the possibility of adding disposal collection kiosks in addition to transfer stations is planned.

6. Research ordinance structures

   Work Results: Work is ongoing. The District is planning to see how the SEP changes manifest themselves before bringing ordinance models or recommendations to the committee.

7. Improve data tracking to allow program monitoring and evaluation and to prevent the loss of DOH resources if visit numbers drop

   Work Results: Preliminary data list proposal is included in Attachment 2, on the right-hand side of the model.

8. Consider changes to the syringe exchange model that limits the number of syringes distributed in one visit, such as calculating the number of syringes needed by the client for a one week period, and such as only providing sterile syringes "one for one" (as estimated by return container size)

   Work Results:

   - The District has completed a draft SEP Procedure (see **Attachment 3**)
   - KPHD has limited sterile syringe distribution to one-for-one exchange, providing no more than 10 syringes in the absence of returns in exceptional cases such as jail release *on a one-time basis per person*.
   - The District will request all SEP Network partners receiving supplies and/or disposal services through the District to follow general District SEP Procedures in 2020.
   - The District's SEP will transition away from mobile exchanges at residences within city limits by the end of 2020 if adequate service is available through SEP network partners. The goal is to create a network where the Health District, PCHS and other pharmacy/clinic environments will provide SEP services within urban areas and cities.

See **Attachment 4** for proposed SEP transition timeline.

The District is looking for the Public Health Board's feedback and concurrence on the proposed changes to the Kitsap SEP.

DRAFT Research Summary on Integrated Syringe Exchange Services

Last updated 9-20-19

Susan Turner MD, MPH, MS

> **"One of the things that was striking to me is that, as a syringe exchange, we had been almost exclusively concerning ourselves with the transaction of the syringe exchange…but we were not paying enough attention to the holistic needs of the people that we were working with. So, it might be dealing with a diabetes diagnosis, but we were doing nothing to ensure any kind of coordination of care around their diabetes because we were laser-focused…So we were giving out a needle but their toes were falling off from diabetes-related blood circulation issues."**
>
> --Robert Cordero, President and Chief Program Officer of BOOM!Health (an integrated harm reduction healthcare center) [32]

Introduction:

In the United States, syringe exchange programs (SEPs) have developed as independent community- or public health-based organizations apart from medical care, providing harm reduction services to people who inject drugs (PWID). International experts recommend the provision of syringe exchange services to reduce the transmission of infectious diseases, to decrease the complications of injection drug use, and as a means of engaging PWID with behavioral health treatment services, health services and other sources of assistance. SEPs not only protect participants in the services from the spread of disease, but also protect the community.

> **"Preventing infectious diseases among persons who use drugs illicitly can also help prevent infections among their sex and drug-using partners and among other members of their communities."[11]**
>
> --Centers for Disease Control and Prevention

Generally, research over time has shown that SEP participation improves entry into substance use disorder (SUD) treatments, improves retention in SUD treatment and treatment for communicable diseases, and reduces drug use and risk behaviors. The Centers for Disease Control and Prevention (CDC) has identified "Access to Clean Syringes" as one of its "Hi-5" evidence-based initiatives to make a health impact and reduce healthcare costs in 5 years.[10] Most major medical professional societies have issued statements in support of the provision of clean injection equipment to PWIDs, especially when paired with other preventive services and connection with treatment.[2,3,5,7] In recent years, research on SEPs has shown promising results in improved health outcomes among participants when healthcare services are provided at the same location and/or integrated with SEP services.[8,19] Some SEPs have begun providing Medication Assisted Treatment (MAT) onsite as way to improve client outcomes without making offsite referrals. Unfortunately, the costs and expertise associated with providing clinical health services may

be prohibitive for most SEPs.[32] As a result of this, SEPs are not routinely able to provide infectious disease screening and other preventive services needed by PWID.[21]

The focus on "whole person care" of Washington state healthcare reform efforts, which calls for the integration of healthcare and behavioral healthcare services, provides a unique opportunity for the integration of harm reduction services in those same settings. SEP/harm reduction participants "…share many characteristics with the broader Medicaid population such as significant socioeconomic disadvantage, multiple chronic health conditions and a history of crisis-oriented episodic care", often resulting in high healthcare costs.[32] Stand-alone SEP models are skilled at providing low-barrier services to connect people with support services, but face barriers to achieving successful client entry into care such as delayed time to appointment, having to navigate differing service sites for differing appointments, etc. The National Institute on Drug Abuse has published 13 "Principles of Drug Addiction Treatment," including that treatment should be readily available and accessible, that mental health assessment/treatment be integrated with addiction treatment, and that patients should also receive evaluation/treatment for infectious diseases.[31] Integrating syringe exchange services in healthcare/behavioral healthcare settings can utilize low barrier access to syringes (along with safe disposal) to engage PWID in those settings, creating "earned trust"[32,41] that facilitates eventual engagement in higher threshold services like preventive healthcare and behavioral healthcare treatment, including SUD treatment. "Service integration in the form of co-location of services potentially makes care management more cost-efficient as well as more effective." [32]

The CDC recommends an integrated approach to service delivery for PWID including: prevention and treatment of substance use and mental disorders; risk assessments for illicit use of drugs and for infectious diseases; screening, diagnosis and delivery of integrated prevention services. They also recommend counseling regarding infectious disease prevention, vaccination, prevention of mother to child transmission of infectious diseases, interventions for the reduction of risk behaviors, partner services, and linkage to follow-up care. "Many settings, including primary care settings, are important venues for providing integrated services."[11] One of the major benefits of single-venue services is the lack of repeated registration procedures, waiting periods or other administrative barriers to care, therefore increasing the likelihood that clients will receive services. This is especially important, since: "…patients [receiving health screenings] frequently are lost to follow-up in transition from the detection and diagnosis to the treatment of disease."[11] Another benefit of integrating harm reduction, chemical dependency and medical services is that not only does integration improve retention in opioid addiction treatment such as MAT, but in addition MAT: "…can promote adherence to needed medical care."[11]

The National Alliance of State and Territorial AIDS Directors published "Syringe Services Program [SSP] Development and Implementation Guidelines…" in August of 2012, evaluating the benefits and limitations of various models/sites for providing syringe exchange services, including risk behavior counseling, actual syringe exchanges, and other social service assistance. Co-location with healthcare and behavioral healthcare services is recommended in multiple models: "Providing services on-site increases utilization rates," and, "…co-location of services has advantages in both acceptability and effectiveness for SSP participants…"[30] The report emphasizes that co-location of services increases PWID access to other services and costs are reduced as services occur within the healthcare/behavioral healthcare organizational framework.[30] This report also mentions a pharmacy-based distribution model, and encourages the use of multiple models to: "…expand syringe coverage and reach the greatest number and diversity of (injection drug users) within a given health jurisdiction."[30]

In a 2017 Washington State Syringe Exchange Health Survey, conducted by the University of Washington's Alcohol and Drug Abuse Institute, 58% of survey participants reported having a main health concern not related to drug use. Eighty nine percent reported having health insurance, so they could theoretically be engaged in care that would improve health outcomes. Fifty eight percent had received care in a clinic or hospital, and 56% in an emergency department in the prior year. These survey participants have shown an openness to receiving care in a healthcare setting.[1]

"SEPs are an example of harm reduction based on the acknowledgement that there is no way to completely eliminate IV drug use (IDU) and, therefore, the reduction of adverse consequences of IDU is vital."[38] Harm reduction is often employed in both healthcare and behavioral healthcare settings, and the providers work to 'meet a patient where they are' when working together with the patient to advance their health. Behavior change is required to improve health outcomes for many chronic conditions, and providers practice harm reduction when they continue to see a patient unable to make swift behavior changes in active living and healthy eating, and as they prescribe medication to treat the patient's chronic disease that may be unneeded once lifestyle changes are instituted. In the case of illicit drug use, harm reduction: "Accepts for better and or worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects…" and "understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence…"[19] Finally, harm reduction: "Affirms drug users as the primary agents of reducing the harms of their drug use ..."[19] "A key harm reduction strategy is to support the reduction of drug use among [PWID] in accordance with participant goals, and medication-assisted treatment is an important tool in those efforts."[32] This is not unlike treatment for any chronic disease.

> **"The notion that a patient has to adopt the prescribed behavior of no illicit drug use in order to have their medical or mental health needs addressed… would effectively exclude injection drug users from all but emergency care."**
>
> --New York Academy of Medicine[32]

Integration Addresses Barriers

The results of studies looking at barriers to engagement in healthcare services and behavioral healthcare services are not surprising, and illustrate the advantage of integrating both types of services along with syringe exchange services. A study in Ohio in 2008 found that the most commonly cited barriers to engagement in substance use disorder treatment included treatment accessibility, time conflicts and financial barriers.[22] The most frequently needed services among PWID include substance use disorder treatment, primary care, hepatitis C treatment, mental health care and housing assistance.[40] Providing syringe exchange services in integrated settings results in proximate access to these services for PWID.

Multiple studies on healthcare services access in general have demonstrated increased utilization of services when they are more geographically available to the people accessing them.[14] Many communities throughout Washington have access to only one physical syringe exchange location. This means that any person wishing to participate in syringe exchange must travel to the physical site to accomplish the exchange. Several studies have examined the

likelihood of syringe reuse by PWID based on their physical proximity to a syringe exchange services provider. A 1995-2006 evaluation of the proximity of syringe exchange and PWID reuse of syringes in New York City found reduced chances of syringe reuse with proximity to a syringe exchange program or pharmacy providing syringes without a prescription.[14] "Syringe exchange programs and pharmacies that sell syringes without a prescription…are healthcare services that substantially increase the likelihood that drug injectors will use sterile syringes, thus reducing their probability of becoming infected…as with other health services, proximity increases utilization."[14] Exchange services provided using a field outreach and/or mobile model are intended to optimize the importance of proximity to maximize sterile syringe availability and used syringe return.

Legal and Policy Issues

Syringe exchange programs legally distribute "injection syringe equipment" in Washington state "…through public health and community based HIV prevention programs, and pharmacies." (RCW 69.50.4121 (3)) It is also legal for adults to: "…possess sterile hypodermic syringes and needles for the purpose of reducing blood-borne diseases."(RCW 69.50.412(5)). Section 70.115.050 RCW allows for the legal retail sale of syringes and needles if the retailer: "… shall satisfy himself or herself that the device will be used for the legal use intended." In 1999, the Washington State Board of Pharmacy determined that "legal use" includes the distribution of sterile hypodermic syringes and needles for the purpose of reducing the transmission of blood-borne diseases.[15, 43] The interpretation is further bolstered by revised drug paraphernalia language enacted in 2002, which allows pharmacies to provide syringes legally to adults without a prescription, and makes the possession of syringes by adults legal. The Washington State Board of Pharmacy, The Washington State Pharmacy Association and Public Health-Seattle & King County distributed a letter to Washington State pharmacists in 2002, highlighting the legality of syringe sales by pharmacists in Washington State, and requesting pharmacists' assistance in preventing the transmission of HIV, hepatitis and other bloodborne infections among injection drug users by selling new, sterile syringes.[43] Washington State University published a useful tool in 2009, the *Washington Pharmacy Law: A User's Guide*, which contains a legal analysis of Washington state laws pertaining to pharmacy practice within the context of national regulations. The legality of syringe exchange in Washington State is underscored on page 109.[16]

In 2000, the Beasley School of Law at Temple University published a thorough review of ethical issues in prescribing and dispensing syringes to injection drug users by pharmacists and physicians in Washington.[25] The review is useful in evaluating the ethical and legal issues surrounding healthcare-located syringe services in Washington state. Accompanying articles by Lazzarini from the Case Western University School of Law describe the legal status of syringe exchange services provided by pharmacies, clinics and hospitals in all US states in 2002.[41]

> Many commentators have suggested that the health care system can help increase access to safe injection equipment through prescription, pharmacy sales, and other measures such as hospital or clinic-based needle exchange programs…[41]

The Beasley School of Law's 2002 legal analysis concludes: "…physicians may legally prescribe and pharmacists may legally dispense syringes to injection drug users (IDU) as a health care intervention to prevent a patient acquiring or transmitting HIV." [41] The article includes useful references to case law establishing the legal precedent. The main supporting points for this conclusion include:

- Validity of a prescription is judged by the Controlled Substances Act, and it is valid if written "…in good faith for a legitimate medical purpose in the usual course of professional treatment." "A prescription for sterile injection equipment, issued to a patient who cannot or will not enter drug treatment, for the purpose of preventing the transmission of a serious communicable disease during injection, would seem to be well within the parameters of allowable discretion set by this standard."
- After June 13, 2002, [article was written in 2000, how could it reference this?] pharmacists in Washington State were allowed to sell an unlimited number of syringes without a prescription. The author concludes that provision of syringes as a public health measure to prevent disease transmission is a legal purpose, and cites the Washington Board of Pharmacy interpretation of the term "legal purpose" which includes preventing disease.

The Case Western University School of Law ethical review by Lazzarini describes the ethical framework supporting sterile syringe distribution by physicians and pharmacists, concluding: "The physician has an ethical duty to care for his IDU patients.[25] This can take several forms: education and counseling, referrals to drug treatment, or aiding patients in obtaining sterile syringes." Lazzarini's supporting tenets include:

- Physician duty to act in their patients' best interest, to avoid harming their patents, and to act as their advocates when necessary.
    - Ethical theories supporting this duty include consequentialism, virtue, respect for persons, beneficence, nomaleficence and justice.
    - "Basic ethical obligations—to help, not to harm and to advocate for patients—support both protecting patients from bloodborne diseases and discouraging drug use…physicians can work to 'enhance' their patients autonomy by offering them support for stopping drug use, but also giving them the means to protect themselves from deadly diseases."
    - Regarding the principle of nonmaleficence/the duty to do no harm, providing a clean syringe is not doing harm, because: "… there is ample evidence…that in the absence of sterile syringes, IDUs will use whatever is available…If the physician fails to act and the patient contracts HIV, no future act can undo the harm. By taking action, the physician can help prevent further injury to the patient and preserve the chance to treat the patient for drug addiction at a later time."

- Pharmacist duty to protect the health of their patients as described by the American Pharmaceutical Association Code of Ethics as placing concern for the well-being of the patient at the center of professional practice, promoting the good of every patient, and serving individual, community and societal needs.
    - Per the Commission to Implement Change in Pharmaceutical Education, pharmacy practice includes rendering pharmaceutical care that is complementary to a prescriber's medical care, with the pharmacist's role focusing on risk management (i.e. the risks the drug presents to the user).
    - The Pharmacist's role has grown over time to act as therapeutic consultants to patients, counseling patients with diabetes, hypertension, and asthma.
    - The American Pharmacists Association (APhA): "… encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases," supporting pharmacists' dispensing of syringes.[4,25]
    - To discharge the risk management role, pharmacists could provide information on safe injection practices, disposal of needles and means to access drug treatment.

Preventive Services

Injection drug users are at high risk for a number of preventable diseases and complications of drug use, in addition to substance use disorders and mental health disorders.[11, 33] Other chronic conditions, including cardiovascular, respiratory, and behavioral health conditions, burden high numbers of harm reduction program participants.[32] Unfortunately, PWID are unlikely to receive preventive services.[21] "Women who use drugs illicitly, for example, are less likely to use family planning services than other women and pregnant women who use drugs illicitly are more likely to initiate prenatal care late pregnancy or not at all." [11]

Prevention services for PWID that are recommended by CDC include[11]:

- Services for prevention and treatment of substance use and mental disorders.
- Information and training in overdose prevention.
- Referrals to outreach workers.
- Assessment of risk for illicit use of drugs.
- Assessment of risk for HIV infection, viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB).
- Screenings for HIV, viral hepatitis, STDs, and TB.
- Prevention counseling for HIV infection, viral hepatitis, STDs, and TB.
- Vaccinations against hepatitis A and B and human papillomavirus, as recommended.
- Counseling and services for prevention of mother-to-child transmission of infectious diseases.
- Information on risk-reduction of high-risk behaviors.

- Health education and risk-reduction interventions and programs.
- SUD treatment, including medication-assisted therapy.
- Access to new, sterile needles and to clean drug preparation equipment.
- Access to condoms.
- Partner services and contact follow-up.
- Services to those who test positive for HIV infection, viral hepatitis, STDs, and TB.
- Referral and linkage to treatment and care.
- Treatment adherence counseling.

The World Health Organization recommends that syringe exchange programs be supported by a range of complementary services because syringe access alone will not control HIV infection among PWIDs.[8] Many of these services are already offered in primary care settings, especially those offering integrated behavioral health services and medication assisted treatment. A 2014 report on a nurse-led health promotion and disease prevention program integrated into syringe exchange sites across New Jersey found that: "… clients seek out and are receptive to services that will benefit them immediately, such as wound assessments and hepatitis immunizations."

When sources of needed services and healthcare/behavioral healthcare are provided in separate locations, PWID encounter multiple family, social and system level barriers to care, and report fear of discrimination, unmet basic needs and unfriendly hospital environments. "In contrast, studies describing fully integrated harm reduction approaches reported positive patient perceptions, especially of holistic care provision to address unmet social needs."[18] Integration of services not only offers important benefits to patients, but also to the outcomes of the enhanced services they are more able to access.

Notwithstanding, PWID may have experienced stigmatization in healthcare settings, and the normal wait for appointments within healthcare and behavioral healthcare settings create access barriers to needed services at the point of readiness. People need to feel comfortable about their privacy and the confidentiality of their data in order to share their behaviors with providers. According to the CDC, "…fear of arrest by law enforcement officers and fear of discrimination by health-care providers can discourage persons who use drugs illicitly from using health-care services adequately."[11]

Healthcare/Behavioral Healthcare Services Integrated with Syringe Exchange Services

> *"Once you are an addict, you forget about your health. But I came here, and they all listened and every day the same thing, except one day I stopped, and I said yo, even though I don't like it, they're telling the truth. I'm being irresponsible with my life, with my health. I'm not taking care of what I need to take care. These people helped me go into treatment for my liver."*
>
> --Program participant in integrated harm reduction healthcare center BOOM!Health [32]

Unfortunately, limited research has been done to examine the effectiveness of various syringe exchange models. However, the co-location of primary care and drug treatment has been well-

studied through the provision of buprenorphine in medical clinics, as well as medical care offered in drug treatment clinics. These studies demonstrate higher client utilization of ancillary services, higher substance use disorder treatment adherence, and improved health outcomes for PWID.[30] Examples of integrated healthcare, behavioral healthcare and syringe exchange/harm reduction services can be found in the literature involving hospitals, primary care settings, pharmacies, and behavioral health settings. Expansion of syringe exchange services to include more routine provision in healthcare settings has the potential to complement existing disease control strategies and syringe exchange services in community settings, as well as increasing the efficiency and effectiveness of providing critically needed services to PWID. Masson et al. cite studies illustrating that: "Policies that attempt to increase access to health care, enhance patients' integration into the health care system, and engagement in longitudinal prevention services may lead to reductions in the use of high-cost emergency health care among illicit drug users."[28]

Hospital-based syringe exchange services provide the opportunity to reduce unnecessary emergency department use, especially since these settings regularly see PWID, representing an important site at which to attempt to engage PWID in services. Several studies have examined this model, finding positive results (engagement of PWID).[28] High rates of emergency department use by PWID for medical complications of drug use illustrate the adverse health status and barriers to primary care within this patient population. This is not only expensive for communities, but also provides inadequate, episodic, and costly medical care for this population's complex and high-level needs. A 2006 study comparing a community syringe exchange program with one provided in a hospital setting, found that high rates of retention in the hospital syringe exchange program was achieved. More participants in this model of syringe exchange services used ambulatory care services as opposed to utilizing the emergency department. The authors concluded that: "Syringe exchange services that are integrated into public hospital settings may serve as a valuable strategy to engage hard to reach IDU populations in preventive care."[28] Colorado's thinktank on addressing opioid and other substance use disorders researched various models of syringe exchange, and recommended syringe exchange at emergency department sites.[46]

Although there are multiple examples of syringe exchange provision integrated with healthcare services at federally qualified health centers and residency programs (see the case studies starting page 12 and listed in the references section), there has not been much scientific research evaluating these specific models. Pollack et al. examined outcomes in a setting in which syringe exchange services were provided in a mobile healthcare clinic. The use of this mobile healthcare clinic reduced emergency department use significantly.[33] New York State passed legislation in 2000 to expand syringe access by legalizing syringe exchange at all pharmacies, healthcare facilities and healthcare practitioners that can legally prescribe or provide syringes. The program was to be a temporary demonstration program. An independent evaluation conducted in consultation with the New York State AIDS Advisory Council was submitted to the Legislature in 2003, but the author of this paper could not find documentation of the report or of outcomes. However, the New York State Legislature established the changes as permanently legal in 2009. Further information can be found at

https://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm. Quebec instituted an expanded syringe access program across the entire province. Syringes, sterile water, filters, cookers and sharps disposal containers are provided at no charge, along with used syringe disposal at injection equipment access centers (CAMIs). CAMIs include pharmacies, community service centers, hospitals, clinics, family medicine groups, drug addiction rehabilitation centers and community organizations. Several articles referenced outcome evaluation of this program, but the author of this paper could not find any formal evaluations. More information can be found at https://www.quebec.ca/en/health/advice-and-prevention/alcohol-drugs-gambling/distribution-of-new-injection-equipment/.

A slightly different approach for integrating syringe provision in a healthcare setting involves the healthcare provider writing a prescription for sterile syringes. In Washington state, the Health Care Authority covers the purchase of syringes for its beneficiaries if a prescription is written.[44] Even in states where prescriptions are not legally required to purchase syringes, like Washington state, having a prescription can improve access by reducing fear of harassment by pharmacists. [7] Physicians prescribing syringes can then serve as a conduit to substance abuse treatment and other healthcare services. The American Public Health Association[7], the Centers for Disease Control and Prevention (CDC)[12], and the American Academy of Family Physicians (AAFP) [38] all encourage and support prescribing of syringes by healthcare providers to injection drug users who cannot or will not stop injection drug use, in order to prevent disease. A study in Rhode Island demonstrated that physician syringe prescription for PWID is feasible and provides PWID with links to medical care, SUD treatment and social services. These models demonstrate reductions in PWID risk behaviors and increased participation in medical and substance use treatment.[37]

In 2015, the New York Academy of Medicine was asked to examine the issues surrounding the integration of harm reduction into emerging healthcare reform initiatives as part of the implementation of a Medicaid Managed Care 1115 Waiver, much like Washington state's Delivery System Reform Incentive Payment Programs (DSRIP) work that started in 2016. The academy published its findings in a report entitled: "The integration of harm reduction and healthcare—implications and lessons for healthcare reform." [32] Some of their policy recommendations include:

- "Partnerships between harm reduction providers and healthcare providers hold exciting promise to achieve meaningful integration and should be encouraged…"
- "Proposed solutions to the substantial challenges for "Health Home" care management agencies to facilitate integrated healthcare for Medicaid's most fragile and marginalized populations should be implemented, evaluated and further developed."
- "Medication-Assisted Treatment…for opioid drug users should be more widely and uniformly available…"

Pharmacies

Services by pharmacies that sell syringes without a prescription are healthcare services that substantially increase the likelihood that drug injectors will use sterile syringes, thus reducing their probability of becoming infected. As with other health services, proximity increases

utilization. A look at New York City PWID reporting syringe re-use found that the chances of syringe re-use decreased with proximity to pharmacies.[14]

Pharmacy-based sterile syringe distribution holds the promise of increasing the convenience of accessing sterile syringes across entire communities by expanding locations and hours of syringe access beyond those typical for syringe exchange programs. Studies in the US and Canada have demonstrated that syringe exchange at pharmacies provides better access for certain marginalized populations, and enhanced acceptability among casual PWID. At Canadian pharmacies, "The anonymity of obtaining injecting equipment as well as free HIV and Hepatitis C testing at pharmacies has led to increased utilization of pharmacies as injecting equipment exchange sites." [45] Multiple national pharmacy organizations have advocated for the pharmacist's role in addressing the opioid crisis.[4,36] Ideally syringe sales would be accompanied by safe syringe collection as well, to accomplish expanded access to syringe exchange. According to the APhA: "As a growing number of pharmacies offer public medication disposal, public syringe disposal is a natural low-cost intervention that a small percentage of pharmacies already provide."[4] In addition, people from many different social and economic backgrounds visit pharmacies, which may assist in reducing stigma felt among PWID purchasing and/or exchanging syringes.[39] Preventive services, such as vaccination, and access to counseling, condoms, naloxone, and other medications are also provided at pharmacies, increasing PWID access to needed services in one location.[4] Pharmacies maintain relationships with providers that can be useful in making efficient referrals to healthcare, mental healthcare, and substance use disorder treatment. Some pharmacists provide medication assisted treatment.[4,45]

The International Pharmaceutical Federation (FIP) encourages the involvement of pharmacists in reducing harm from drugs of abuse around the world, including in the US, by providing syringe exchange, medication assisted treatment, naloxone supply, and health education.[5] The APhA supports the unrestricted sale or distribution of syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of bloodborne diseases.[25] In addition, APHA "encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice … to provide and promote consistent, unrestricted, and immediate access to evidence-based … interventions … including: sterile syringes, needles and other safe injection equipment, syringe disposal…"[4]

Studies examining pharmacist provision of syringes have found that many pharmacists may be unaware of the legality of providing sterile syringes, and a reluctance to sell syringes to PWID.[4,6,- 45] In a 2001 effort by the Washington State Board of Pharmacy, the Washington State Pharmacy Association, and Seattle-King County Public Health, the latter partnered with community pharmacists to increase voluntary syringe sales to prevent bloodborne infections.[15, 26] They then surveyed community pharmacists and compared their responses to a prior survey from 1996. "Nearly all pharmacists surveyed in 2003 and 1996 agreed that pharmacists should play a part in helping to prevent the spread of HIV, hepatitis and other bloodborne infections in the community. Most expressed a willingness to keep and maintain sharps containers for syringes brought in by the public."[15] They noted that many corporate managers allowed individual pharmacist managers to set syringe sales policies in each pharmacy.

A 2016 Indiana study examining community pharmacist support for syringe exchange found that about half of pharmacists were supportive of syringe access, believed that dispensing syringes would reduce harm to PWID, and that over the counter sales of syringes would help protect PWID health. [29] The study also found that three quarters of pharmacists were uncomfortable dispensing syringes to PWID. The authors suggest offering continuing education on non-prescription syringe distribution. A similar 2015 study in Kentucky, published in an open access journal, reported that 30% of community pharmacists there were "very willing" to provide clean syringes, and 39% not willing. Chain/supermarket pharmacists were 39% less likely than community pharmacists to be willing to dispose of used syringes.[17] A Canadian study found that: "Pharmacists generally have a positive attitude toward providing health promotion and harm reduction programs and express some interest in increasing their role in this area." [45]

Barriers to the adoption of syringe sales and/or disposal include fear of harm to staff, of losing other clientele, of increased shoplifting, and of increased used needle disposal.[45] However, "Pharmacists in New York noted no increase in crime or discomfort among staff and customers following the introduction of clean needle sales, despite fears to the contrary. Furthermore, pharmacists offering needle disposal services and providing sharps containers to IDUs felt that these services had reduced the number of used needles being disposed in their neighbourhoods." [45]

A 2016 meta-analysis on the effectiveness of pharmacy-based syringe exchange, examining the outcomes of 14 studies, found that these programs are effective for reducing risk behaviors among PWID. They noted that: "…many developed countries have [needle syringe programs] and opioid replacement therapy clinics run and managed by pharmacists."[39] Unfortunately, few of the studies they reviewed reported the outcomes related to safe syringe disposal. An Australian study described reduced heroin use and criminal activity when rural Australian pharmacies provided clean injecting equipment.[45]

Behavioral Health Services Providers

Behavioral healthcare services are increasingly being provided in primary healthcare settings in Washington as part of healthcare reform efforts, and there are also many examples where behavioral healthcare settings have incorporated healthcare onsite, providing a whole-person approach to healthcare. This type of setting provides an ideal location for syringe exchange services, along with accompanying counseling toward reductions in risk behaviors and entry into treatment. As noted previously, PWID experience a high rate of comorbid mental health and healthcare needs, so this type of colocation best serves the needs of PWID, making it a natural setting to prevent communicable diseases until successful recovery from SUD.

Chemical dependency treatment professionals and other behavioral health services professionals are trained in client engagement and retention in services, as well as behavior change and management. These skills are often not found in healthcare settings and present an added advantage for providing syringe exchange services in behavioral healthcare settings,

potentially resulting in higher rates of engagement into treatment of PWID. With colocation of services, referrals to SUD treatment services can be provided in-house, as can referrals for co-occurring mental health disorders, increasing convenience and likelihood of use (see "Integration of Services Addresses Barriers" section of this document).

Case study Highlights

The references section of this paper includes multiple examples of integrated syringe exchange services in Canadian healthcare organizations, family medicine residencies, federally qualified health centers, medical schools, behavioral healthcare organizations and integrated healthcare/behavioral healthcare settings. That section also references several publicly-available operating procedures for syringe exchange services that can serve as resources for new models of syringe exchange.

Quebec's wide net of injection equipment access centers across Quebec was highlighted earlier and incudes pharmacies, clinics, family medicine groups, drug addiction rehab centers and community organizations.

The Lummi Tribal Health Center started their successful "Primary Integrated Care Syringe Service Program" in 2015. They have integrated harm reduction services and practices with their primary care clinic to:

- Decrease transmission and acquisition of bloodborne infections
- Reduce the number of contaminated syringes in public places
- Reduce sharing of all injection equipment
- Promote wellness through education, referrals, medical care, specific testing and treatment (including treatment for hepatitis C)

Examples of Family Medicine residencies that have integrated syringe exchange services into their health clinics include the Mercy Medical Center Merced Family Medicine Residency, which won the 2016 Family Medicine Cares Resident Service Award, the Swedish First Hill Family Medicine Residency Downtown Seattle, and the Ventura County Medical Center Family Medicine Residency.

Federally Qualified Health Centers (FQHCs) are increasingly integrating syringe exchange and other harm reduction services across the United States. This change is very much in line with their transformation to integrated behavioral health and healthcare services providers. The services are considered "in scope" by the US Department of Health and Human Services in states such as Washington where the services are legal and the state or location has been designated by the CDC (as Washington state has) as at risk of an HIV outbreak. The director of regulatory affairs for the National Association of Community Health Centers has provided a legally vetted "policy and procedure for syringe exchange programs" for Community Health Centers and FQHCs to help them navigate the continuing prohibition on the use of federal funds to purchase syringes. In Washington state, Cowlitz County's FQHC, the Family Health Center, integrated syringe exchange into their family health clinic in 2017, and they tout the change as the transformation of a syringe exchange program into a harm reduction program.

The Family Health Centers of San Diego and the Swedish First Hill Family Medicine Residency Downtown health clinic, also an FQHC, are additional examples. The previously referenced New York Academy of Medicine report on integrating harm reduction services into healthcare services as part of healthcare reform, recommended FQHCs as the most feasible model of syringe exchange integration in the short term.[32]

Medical schools with syringe exchange services integrated into their clinics include the UC Davis School of Medicine Joan Viteri Memorial Clinic and the University of Miami Miller School of Medicine.

Examples of behavioral health organizations with integrated syringe exchange services include Seven Hills Behavioral Health in Massachusetts and Tarzana Treatment Centers in California. Trillium Health and Homeless Health Care Los Angeles both offer fully integrated healthcare services, behavioral healthcare services and syringe exchange services.

Conclusion

Syringe exchange services comprise trust-building, non-stigmatizing contacts with PWID, that can be leveraged to improve the health of participants and increase entry into care in ways that are convenient and acceptable to PWID. Multiple locations offering convenient syringe exchange, closely connected to healthcare and behavioral healthcare services offer enhanced options to PWID, assist in making the healthy choices easier and more convenient, and ultimately present the potential to increase engagement in health and recovery services.

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Related Laws:
RCW 69.50.412 Prohibted acts: E—Penalties
RCW 69.50.4121 Drug paraphernalia—Selling or giving—Penalty
RCW 70.115.050 Retail sale of hypodermic syringes, needles—Duty of retailer

Case Studies:

1. SEP available in multiple types of healthcare organizations:

    a. North Carolina Harm Reduction Coalition: http://www.nchrc.org/

    b. Quebec Injection Equipment Access Centers (CAMI): www.quebec.ca/en/health/advice-and-prevention/alcohol-dugs-gambling/distribution-of-new-injection-equipment/#c417

2. Clinic-based SEPs:

    a. Lummi Tribal Health Center Primary Integrated Care Syringe Service Program: http://www.npaihb.org/wp-content/uploads/2018/01/5-J.Rienstra_SYRINGE-SERVICES-PROGRAM-AT-A-TRIBAL-HEALTH-CENTER.pdf

    b. HIV/HCV Resource Center, at two family health clinics in Vermont: http://www.h2rc.org/syring-exchange; http://www.goodneighborhealthclinic.org/

    c. Family Medicine Residencies with SEP services:

        1) Mercy Medical Center Merced Family Medicine Residency : https://www.aafpfoundation.org/foundation/our-work/grants-awards/all/fmc-resident/2016-awardb.html; https://www.mercedsunstar.com/living/health-fitness/article217838145.html

        2) Swedish First Hill Family Medicine Residency Downtown Family Medicine Clinic: https://swedish-fh.squarespace.com/dfm

        3) Ventura County Medical Center Family Medicine Residency: https://www.venturafamilymed.org/rotations/infectious-disease/clean-needle-exchange

    d. Federally Qualified Health Centers with SEP Services:

        1) Family Health Center, Cowlitz County, WA: https://tdn.com/news.local/family-health-center-s-needle-exchange-half-a-year-later/article_487b0ae0-e5e3-5055-8f61-96259852781b.html; https://www.nwrpca.org/news/382381/Converting-a-Syringe-Exchange-into-a-Harm-Reduction-Program.htm

        2) Family Health Centers of San Diego: https://www.fhcsd.org/substance-use-disorder-services/safe-point-san-diego/

3) Swedish First Hill Family Medicine Residency Downtown Family Medicine Clinic (and FQHC): https://swedish-fh.squarespace.com/dfm

e. Medical schools with SEPs:

1) UC Davis School of Medicine Joan Viteri Memorial Clinic: https://jamanetwork.com/journals/jama/fullarticle/1838995

2) University of Miami Miller School of Medicine: https://www.medscape.com/viewarticle/901753

3. Behavioral Health Organizations with SEPs:

a. Seven Hills Behavioral Health, New Bedform Massachusetts: http://www.sevenhills.org/programs/hiv-aids-sti-services

b. Tarzana Treatment Centers, California: https://www.tarzanatc.org/hepatitis-risk-assessment-and-testing/

4. Integrated full service healthcare/behavioral healthcare settings with SEPs

a. Trillium Health, New York: https://www.trilliumhealth.org/

b. Homeless Health Care Los Angeles: https://hhcla.org/how-we-help.html

Operating Procedures/guidelines that can be used in healthcare-based SEPs:

1. National Association of Community Health Centers (includes FQHC guidance): www.nachc.org/wp-content/uploads/2017/08/syringe-PP-FINAL-July-2017-pdf.pdf

2. New York State Department of Health AIDS Institute. (2016) Policies and procedures syringe exchange programs: https://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/syringe_exchange/docs/policies_and_procedures.pdf

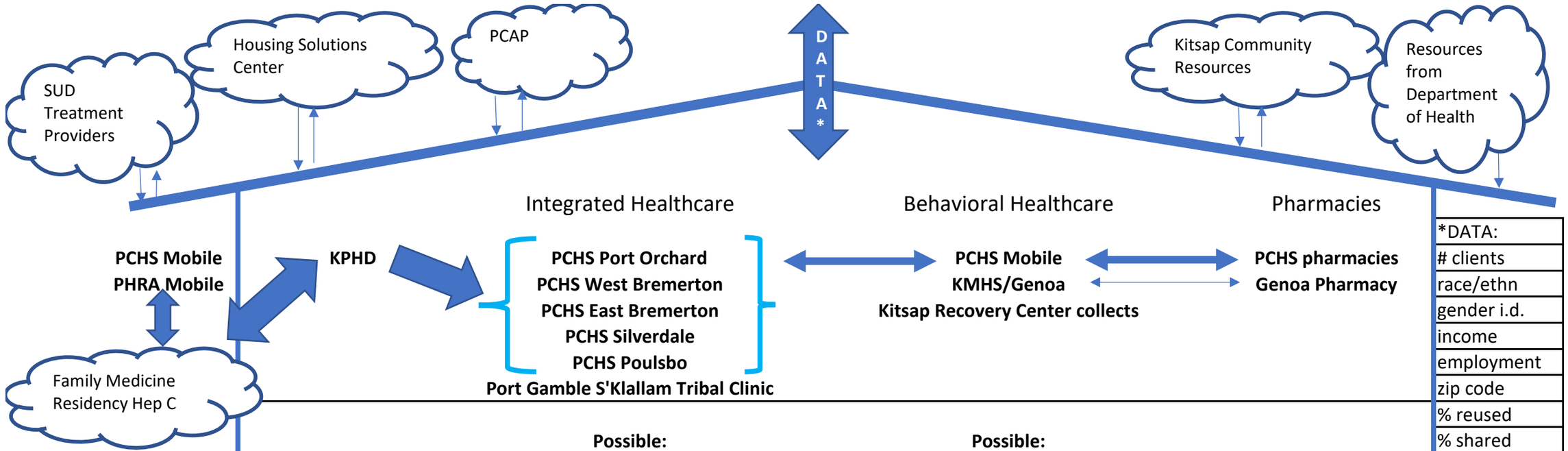
3. City of San Francisco: https://harmreduction.org/wp-content/uploads/2012/01/SPPPGVersion2-3-1-2011.pdf

4. Santa Cruz County Health Services Agency: http://www.santacruzhealth.org/Portals/7/Pdfs/SSP/SSP%20Policy%20and%20Procedure%20092014.pdf

5. Vermont Department of Health: www.healthvermont.gov/sites/default/files/documents/2016/11/ID_HIV_prevention_2010%20SEP%20Guidelines.pdf

ATTACHMENT 2

Kitsap Syringe Exchange Network



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Syringe Exchange Services Program Procedures

Procedures Overview

The purpose of this document is to provide guidelines for the implementation of syringe exchange services at the KPHD syringe exchange site.

Goal: To ensure access to sterile syringes and injection equipment in order to eliminate the transmission of bloodborne pathogens among people who inject drugs.

Strategies:

- Utilize evidence-based strategies while developing and implementing syringe exchange services.
- Provide access to sterile syringes (1:1) and injection equipment, and safer sex supplies.
- Promote safe disposal of syringes and injection equipment, including collection and disposal of used syringes.
- Develop and deliver education and health promotion activities relevant to the goal.
- Facilitate referral services including; substance use treatment, medical care, healthcare insurance navigation and other community services.
- Offer communicable disease screening and prevention services and/or facilitate access to these services in the community.

Hours of Operation and Staffing:

Kitsap Public Health District
Norm Dicks Government Center
Bremerton, WA

Hours: Tuesday and Wednesday 12:00 to 4:00pm

Staffing

Primary contact	Kaela Moontree Desk phone: (360) 728-2286 Cell phone: (360) 633-9757
Secondary contacts	Anna Gonzalez Desk phone: (360) 728-2255 Beth Phipps Desk phone: (360) 728-2309 Keisha Murray Desk phone: (360) 728-2273

Syringe Exchange Operations

- During syringe exchange hours clients are welcomed at the front desk and directed to the small waiting room.
- Syringe exchange staff is notified and brings client back to the syringe exchange room.
    - Only adult clients can be served through this program
    - Minors will be counseled by syringe exchange staff about proper/legal syringe disposal, and every effort will be made to connect minor client with substance use disorder treatment services and other resources.
- Number of syringes brought in for exchange are estimated by staff and placed by client in large 43-gallon biohazard bin before offering additional services. Estimates are made based on:
    - Size and shape of container
        - 1 quart = 50 syringes
        - 1 gallon = 200 syringes
        - 2 gallon = 450 syringes
    - How full the container is observed to be
    - What is actually in the container (if there is "garbage" that takes away space from syringes)
- Clients are asked to place their container(s) into the biohazard bins located in the hallway.
    - Staff are not allowed to touch syringes or containers with used syringes.
    - Syringes (also called "Sharps") are never to be dumped from client's container or bag into the large sharps container.
    - If the client's container does not fit into the large sharps container, ask client to take an empty large sharps container outside the building and empty the container with used syringes into the sharps container provided. Offer the client tongs.
    - During the visit, if a syringe falls on the ground or otherwise does not make it into the sharps container, KPHD personnel will ask the client who brought it in to place it in the sharps container. Offer the client tongs.
    - At no time are contaminated syringes to be touched using hands.
- Staff asks client what supplies they request and collects demographic data from client
    - Number of syringes distributed is based on estimated number of syringes brought in.
    - Clients that do not bring in syringes for exchange may be offered up to 10 syringes on a one-time basis.
    - When providing syringes, round to nearest 10 – do not open a package to give an odd amount (i.e. client brings in 6 used syringes, provide with a pack of 10, if client brings in 14 used syringes, provide with a pack of 10).
    - Staff offers sharps containers to every client at every visit. Staff advises client to never fill sharps containers beyond the fill line and to only use containers for used syringes.

- Staff facilitate referral, communicable disease screening, prevention and treatment services.
- Staff educates clients on appropriate disposal sites and methods.
- Staff gathers supplies the client has requested.
- Staff instructs clients to return used syringes at the next visit.
- Client is escorted to lobby.
- Pharmacists and physicians may tailor these procedures to best meet the unique needs of the patients they serve.

Supply Management

- Syringe Exchange primary contact is responsible for ordering and managing supplies and maintaining inventory log and will conduct monthly inventory.
- Supplies are stored in a storage closet on the 3rd floor as well as a storage room down at the loading dock. When supplies get low in the closet on the 3rd floor, supplies are brought up from the dock storage and are deducted from the inventory log.
- Syringe Exchange supplies removed from the storage room or storage dock for any other KPHD program needs to be noted on the inventory log with the specific program name listed.

Amounts indicating supplies need to be restocked and/or reordered:

SUPPLY	Description	When to restock 3rd floor from loading dock:	When to order to restock loading dock inventory:
Syringes 1 case = 500 syringes	27 gauge	3 cases	5 cases
	28 gauge	6 cases	10 cases
	29 gauge	6 cases	10 cases
	30 gauge	3 cases	5 cases
Sterile water		when last case is opened	1 case
Alcohol wipes		when last case is opened	1 case
Sharps containers	1 quart	14 containers (2 stacks)	1 case
	1 gallon	18 containers (1 row)	1 case
	2 gallon	14 containers (1 row)	1 case
	8 gallon	3 containers	1 case
Tourniquets	Latex	As needed	1 box
	Non-latex	As needed	1 box
Cookers		As needed	0

Ordering Supplies

- Most supplies are ordered from McKesson and take 2-3 days to arrive after being ordered.
- There are two processes for ordering supplies: 1. Directly from McKesson; and 2. DOH in-kind supply ordering.

- The Health District will order supplies from DOH in-kind supplies until they are gone, and then proceed to order additional supplies from McKesson until the annual budget for supplies is met. Once the budget allocation is met, no more supplies will be ordered.
- Orders will be completed on a monthly basis. Orders from partners must be submitted by the 25th of each month for delivery the following month.
- Shipments may be delivered directly to offsite locations, but all ordering and packing slips will be maintained by the Health District.
- Once supplies arrive, the receiving entity should check the packing slip against the original order to verify that the amount received matches the amount ordered.
    - If the receiving entity is not KPHD, the verified packing slip should be submitted to KPHD monthly
    - If the invoice does not match what was received and/or ordered, the vendor should be contacted directly.
- KPHD facilities staff will put supplies in basement storage room from the loading dock.

Training for Syringe Exchange Program Staff

Program staff associated with syringe exchange will complete the following trainings:

a. Mental health first aid
b. Child Protective Services training on when to make a call
d. Review of this policy *
e. Bloodborne pathogen and needlestick injury *
f. Motivational interviewing
(those in asterisks are required to be completed prior to performing syringe exchange activities as outlined in this policy)

Disposal Procedures

Staff involved in the transport of hazardous waste must receive appropriate training in handling and disposal procedures prior to being authorized to transport waste.

Facilities staff will replace the 43-gallon biohazard collection container regularly and take full ones to the storage area for packaging in preparation for Stericycle pick up from the loading dock. Stericycle picks up bi-weekly. Note that Facilities staff will place 43-gallon biohazard collection containers on the loading dock so that the mobile exchange may place syringe containers directly into them to ensure they are ready for Stericycle pick up.

Partner Exchanges

- Mobile services provider is contracted with KPHD as a mobile exchange. Contractor delivers syringes on Tuesday, Thursday and Saturday. Clients need to call a minimum of 1 day prior to delivery. Contractor will meet the client at their preferred location. Contractor offers naloxone kits to clients, as well as Hepatitis C screening and referral to treatment. Business cards for contractor will be available to clients in the small lobby as well as in the syringe exchange room.

- Peninsula Community Health Services (to be filled in later)
- Genoa Pharmacy (to be filled in later)
- Corporate pharmacies (to be filled in later)

Appendix A

Code of Conduct

At the Kitsap Public Health District Syringe Exchange (the exchange), we seek to provide exceptional care and the best possible experience for every client. We want to work together with clients to ensure they receive the respect, compassion and services they need. The exchange is a safe place free from violence, threats and negative language.

Staff will review the following program expectations with the clients at initiation of services:

- Clients receiving services through the exchange will be treated with respect and dignity.
- This is a one-for-one syringe exchange. Staff will estimate and have the final determination of the count of syringes.
- Staff cannot touch used syringes.
- Clients must bring used syringes in a hard plastic container with lid or proper sharps container which fits in the 8 gallon sharps container.
- Clients must treat staff, interns, volunteers and community members with courtesy and respect without physical, sexual, verbal and /or emotional abuse, threats or intimidation.
- Drug sales and /or substance use are not tolerated at the Health District. Any staff observing this behavior will ask the individual to leave. If the individual does not cooperate, law enforcement will be called.
- Clients are asked to protect the confidentiality of other clients encountered while participating in the exchange.

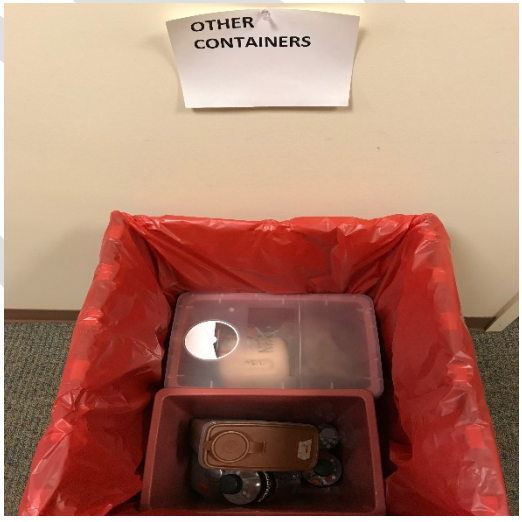
Clients are asked to verbalize that they understand these guidelines and that if they do not follow these guidelines they may not be served.

Appendix B

Syringe Exchange steps for staff

- Greet client at the door into the small lobby and walk them to the syringe exchange room
- Introduce yourself while walking down the hall and ask them if they've been here before
- Ask client to put used syringes in appropriate bin:
  -Full sharps containers go into the bin on the right side of the door

-Non- sharps containers and large amounts of loose syringes go in the sharps container inside the bin on the left side of the door



- Once in the room client and employee should sit on opposite sides of the table with employee closest to door.

- Ask client what supplies they would like– if they returned used syringes, estimate amount based on size of container
  1 quart = 50 syringes
  1 gallon = 200 syringes
  2 gallon = 450 syringes

  Do not give out syringes in smaller increments than 10 as they are packaged in pack of 10—round to the nearest 10. Client who have no used syringes to exchange can have a maximum of 10 syringes one time.

- Ask what other supplies they need, and provide them in the following amounts per 10 syringes;
  Cottons – 1 pack
  Alcohol Wipes – 1 for 1
  Sterile Water – 1
  Tourniquets – maximum of four
  Sharps containers – as many as requested
  Cookers – as many as requested
- Ask client questions on data form
- Assess other referral needs, including substance use disorder treatment, mental health services, primary care, food, housing supports
- Make it a priority to provide clients with referrals to resources in the community. Below is a list of resources that should be considered when referring clients to needed services.
  - Provide information about PREP and refer to providers who offer PREP in the community
  - Provide clients with safer injection and safer sex counseling
  - Offer bloodborne pathogen testing and vaccination
  - HIV and Hep C testing sites
  - Recovery services, detoxification, and Medication Assisted Treatment
  - Primary integrated care (medical home)
  - Mental health
  - Social services, food pantries, housing support programs
  - Sharps Disposal Locations brochure (Kitsap County)
- Leave clients in the exchange room while you gather their supplies – close the door to the closet while you get supplies together
- Use brown paper bags to pack up supplies unless client brought a bag of their own
- Take supplies back to client in syringe exchange room and have client confirm contents of the "order"
- Offer business cards for the KPHD Exchange and other partner exchanges as appropriate
- Escort client to the exit

ATTACHMENT 4

Proposed Kitsap Syringe Exchange Network Timeline

	Current	End 2019	Beginning 2020	End 2020	Beginning 2021	End 2021
Secure Network Partners	PCHS	Genoa	Kaiser, tribes	SUD Tx, CHI, VM	Corporate pharmacies	
Provide Services	PGS	PCHS, Genoa				
Maintain Mobile Exchange	PHRA ext.	RFP	Winning contractor complies with KPHD procedure		Move to rural services only (requires urban penetration)	
Additional Disposal Options	transfer stations, KPHD		research kiosks	Discuss kiosks with SHWAC?		
Research ordinance structures as last choice						
Improve SEP Data collection		All partners collect same data				
Report SEP data			Report preliminary data			
Limits on Exchanges	KPHD procedure	contracts use KPHD procedure				