

WEBINAR VIDEO TRANSCRIPT

Hidden Casualties:

Consequences of the Opioid Epidemic on the Spread of Infectious Diseases (Part 1)

February 22, 2018

Richard Wolitski, Ph.D. and Corinna Dan

Corinna Dan: Thank you very much. Good afternoon everyone and welcome to Hidden Casualties webinar, the Consequences of the Opioid Epidemic on the Spread of Infectious Diseases.

Hosted by the Office of HIV/AIDS and Infectious Disease Policy here at the Department of Health and Human Services.

I'm really thrilled to welcome all of you here this afternoon for a continuation of our work to really explore what folks are doing nationally at the state and local levels around the increases of infectious diseases, related to the opioid epidemic. And to really foster a comprehensive response to the opioid epidemic, overall.

I want to make sure that everyone is aware that—next slide please. The audio for today's webinar is via a phone line. And that information should be available through the confirmation that you received by email for this webinar. Next slide please.

Also, during today's webinar we have Eric Cortes here helping us through Twitter.

If you have questions throughout the webinar you can Tweet those to @hhs_viralhepatitis [Note: correct Twitter handle is @hhs_viralhep], use the #opioidcrisis, and also use the question box in the chat feature on the webinar interface.

So, there are a number of ways, we'll also be opening it up for oral questions after all of the presenters are complete.

So, with that I'd like to turn the webinar over to my colleague, our director of the Office of HIV/AIDS and Infectious Disease Policy, Richard Wolitski.

Richard Wolitski: Thank you so much Corinna and hello everyone. Pleasure to be here with you today.

Corinna Dan: All right, you're good to go.

Richard Wolitski: I'm going to go ahead and kind of cover some of the epidemiology that's related to the opioid epidemic and its spread in United States. And talk about some of the infectious disease consequences that we're seeing in the data.

Go ahead to the next slide, and here, this slide just kind of illustrates two of the main things to me.

This is the number of opioid prescriptions that are dispensed per 100 persons between 2006 which isn't [unintelligible] and so you see that one, if you look at the darker colors, the dark red colors, you see the concentration of higher prescribing rates in the southern states.

And we also see—when we look at the rates per 100 people we've got rates as high as, more in the high category, over 107.

So, we're seeing way more prescriptions than are probably medically necessary and programs are taking action to reduce those prescriptions. Let's go to the next slide.

What we've seen though as a result of the combination of prescription, drug misuse, and the use of heroin and other opioids, we're seeing a massive increase in number of deaths.

This slide shows the increase in deaths between 1999 and 2015. During that time more than 500,000 people have died from an opioid overdose, since 1999.

And if you look at the lines we see an increase in heroin and synthetic opioids, like fentanyl, as well as an increase among prescription opioids. And no increase in methadone.

So, it really seems to be driven by a combination of heroin, synthetic opioids, and prescription drugs.

We go to the next slide, here we really start to get at the interconnection between drug overdose and new hepatitis C infection.

If you look at the red colors in the map of the U.S. on the left you see a drug overdose death rates, with the red colors representing the higher rates.

Now compare that to the figure that's next to it for reported new HCV infections in the U.S. We see that there is a good deal of correspondence between the two—we see correlation in the data between them.

So, in the places where there is a greater increase in overdose deaths, we tend to see a greater increase in hepatitis C infections. Next slide.

Overall, we see an increase in injection drug use that's being driven by the opioid crisis.

Overall, heroin use has increased more than 60% and it's increased even more rapidly to 114% among whites in recent years.

The heroin prescription opioid epidemic could lead to new HIV outbreaks, and in fact we've seen that happen in at least one jurisdiction. Next slide.

So, I'm just going to breakdown the data a little bit by age group. And so, what we're seeing is that when we look at the increase in opioid injection by age, we see that there was a 400% increase amongst people between the ages of 18 and 29. And their mission for opioid injections increased by over 600%.

When we look at the people between the ages of 30 and 39 years old, we also see extremely high rates. HCV infection increasing by 325% during this period, and admissions to hospital emergency room for opioid injection by—it's just for treatment program probably—treatment program admissions, we see that increase by 83%. Substantial increases over a relatively short period of time. One of the markers of how severe this epidemic really is.

Let's take a look specifically about the impact in women on the next slide. So, we see that from 2004 to 2014 we see a dramatic increase in opioid injection among women.

Its [unintelligible] with a 99% increase in admissions for opioid injection and is followed by a 250% increase in new hepatitis C infections. Next slide.

Sadly, we're seeing the impact even translate to infants. Forty percent of infants are born to hepatitis C virus affected mothers will develop chronic infections and without treatment the core of them will die from liver disease.

In 2009 to 2014, HCV infections among women giving birth nearly doubled. And we're seeing the impact on really a wide range of people, particularly youth, people who inject drugs, women, and their infants. Next slide.

After years and years of decline—a consistent decline—we now see beginnings of potential increase in new HIV infections among people who inject drugs.

Over the past 10 years we saw 63% decline in new diagnosis among people living with HIV. And new diagnosis of HIV among people who inject drugs.

But between 2014 and 2015 we've seen our first increase in quite a while. There is a 4% increase between those two years, signaling the potential for national increase in new HIV infection rates.

But the risk isn't only limited to HIV and viral hepatitis. We see a number of other infectious diseases being affected by the opioid crisis as well. Go to the next slide.

We've seen from data starting from 2002 going up to 2012, hospitalizations associated with opioid use and dependent increasing for a number of infectious diseases. Pericarditis has gone up 46%; septic arthritis has gone up 156%; epidural abscesses have gone up 164%; and osteomyelitis has gone up 115%.

This was something that has an implication for many conditions and really threatens the health of a large number of people.

And speaking more specifically to that, the next slide looks at the distribution of counties that each has identified as being potentially vulnerable to an outbreak of HIV infections among people who inject drugs.

That's what is shown in the small dots, in the pink. And you see concentration of these, you know, sort of in the southern Appalachian region, and northeastern U.S. as well.

And what's shown in the green color, in the states, this is the 39 states or states that contain counties that have met the criteria for the determination of need that is required to allow the use of federal funds to support comprehensive [unintelligible] to ensure these programs.

This gives pretty good correspondence between the states that have been identified as having counties with a high risk of an HIV outbreak among people living with HIV—with people who inject drugs.

But, we don't see perfect correspondence in terms of, in a number of the states where these funds are not being used for prevention programs for people who inject drugs during services program. Next slide.

And we're going to talk today, on the webinar, more about the lessons that were learned in the outbreak in Scott County, Indiana.

As everyone knows in 2015 we had just really a large outbreak which was a centennial event that really drew our attention to the intersection between the opioid crisis, HIV, and HCV epidemic.

The largest, best documented outbreak of HIV and HCV infections among people who inject drugs. And it shows us the risks.

But I think one of the things that we don't focus on enough, in talking about Clark County and what was learned there, is how it shows that when you bring together the right resources, the right partners, the local state and federal levels, that you can turn this around, and you can stop an outbreak dead in its tracks. And we'll be hearing more about what they've learned in Clark County today.

What we've been focusing on here at the federal level, at HHS, is really what's needed to develop a comprehensive response to the opioid epidemic. And, how can we assist states and communities in building that type of response.

HHS has issued a five-point strategy to combat the opioid crisis that's comprehensive, evidence-based, targets the drivers of the epidemic, and is flexible to emerging threats.

It focuses on better addiction prevention, treatment, or recovery services that are overdose reverses, better research, better data, and better pain management.

Now, when we look at this though what we don't see and increasingly we're seeing this next wave of consequence of the opioid epidemic that are related to infectious diseases.

So, we've been working within HHS with a number of partners to define a framework that articulate what is possible, and what should be done with

regard to addressing the intersection of the opioid crisis, HIV, hepatitis, and other infectious diseases.

This model is one that is patient-centered. It's designed to address multiple needs and risk of the individual. It starts with clients. What they need, and what their risk are.

It's designed to meet the needs of all people who use drugs. And focuses primarily on people who inject drugs but recognizes that all persons with a substance abuse disorder, are at potential risk for progression to injection and additional risk associated with injection.

It's focused on helping the people to achieve the best health outcomes that are possible to them. It involves collaboration across program and funding streams that extend beyond traditional partnerships through the barriers of services.

It promotes information and resource sharing. It promotes integrated co-located services and, if that's not possible, active referral services to allow people to easily access services offered by other programs.

It builds on the existing infrastructure. We don't need to create another siloed program to address the opioid crisis and infectious diseases that come with it.

We can do with this an infrastructure that exists already today. And I think this framework gives us the general starting place for looking at what can and should be done to better address these intersections.

But I want to acknowledge this is a work in progress, and it's continuing to evolve. Let's go on to the next slide.

I think we've seen in a number of ways that comprehensive community action is key to this. It's something that we have to go where the problem is. Identify the areas of need, and mobilize community health and law enforcement sectors to address the issue collaboratively.

We know that comprehensive prevention programs are what's needed in substance abuse treatment, naloxone, HIV and hepatitis testing, linkage to treatment for people who are diagnosed positive.

And we know that doing service programs are an important component of a comprehensive response, especially with regard to HIV.

The evidence shows that people who use syringe service programs are five times more likely to enter drug treatment, and three times more likely to stop injecting.

So, this counteracts one of the main concerns that people have about these programs, that they may increase the risk when in fact they don't.

And data are showing that these programs are cost saving. These are good investments for our communities to make, they save lives, and they save healthcare costs as well.

So, as we go on to the next slide, we're going to talk a little bit about this. But, this is an evolving epidemic and each month, each year that we go through it, we learn more.

In the beginning, the earlier opioid response focused on activities that were about limiting supply and preventing deaths to the extent of substance abuse disorder treatment and naloxone availability.

We know that many infectious disease programs have not fully integrated key prevention services or partnerships that better serve people who use drugs.

And we're just saying essentially, we have to have a two-way street here. We have to have these programs doing their part to report the opioid response, and we have to have the programs that are supported by the opioid response funding to address infectious disease issues as well.

And I think we have to recognize that what we do, and how we do it has the potential to make a huge difference as it has in our culture, with regard to how people with injection drug use histories, with HIV, with hepatitis are treated stigma.

And how our public health system and our healthcare systems work together to better serve the needs of the patient and the community member.

So, this is going to be my last slide. And I want to kind of ask you to consider—what can you do?

See one of the most basic things that those of you working in the field can do, is to look at your programs and activity to assess how you're addressing the opioid and infectious disease risk for needs of your community and the clients you serve.

We ask you to identify opportunities and to join the response. We ask you to look for ways for how you can enhance your programs and serving people who are at risk for substance abuse disorders.

We want to encourage you to engage the new partners, to accept or refer recommended services.

And we want you to communicate with leaders in your communities and your local government, those funders about the needs of the community, and to provide them with the evidence that shows what works, what's effective in addressing these issues.

This is a big problem, it requires all of us. And, it requires that we work with new partners in new ways.

And I'm excited that you're here today with us to talk about it, and to learn from some of our partners who have been leading the way in this work.

I want to thank you for listening to the overview presentation of the data. And I'm excited to hear with you what's really happening out in the field. So, Corinna.

Corinna Dan: Thank you very much, Rich.

So now, I'd like to welcome Steve Davis, from the Substance Abuse and Mental Health Services Administration.

Steve is a Senior Medical Advisor in the Office of the Chief Medical Officer and is joining us here today to talk a little bit about the HIV and viral hepatitis related activities and SAMHSA's work in these areas. Steve.

Steve Davis: Oh, thank you Corinna, appreciate it. And thank you Rich, it's a good tee up of some of the data and sets the frame for all the work that we're doing.

So, I want to just spend the next five minutes or so, talking about some of the activities around HIV and viral hepatitis that SAMHSA is working on. And, my contact information is on my last slide, as well, if anyone wants to reach out.

So—next slide. So, SAMHSA's mission, I wanted to state that here for those of you who don't know, our mission is to reduce the impact of substance abuse and mental illness on America's communities.

The key message—the four key messages that we keep driving home is that behavioral health is essential to health in general, that prevention works, treatment is effective, and people do recover. Next slide.

So, this—the funds from the minority AIDS initiative are primarily what I'm going to be referring to here.

And SAMHSA is among eight other—a total of eight I think—HHS agencies and offices that are responsible for implementation of the Minority AIDS Initiative or MAI.

SAMHSA receives MAI funding to provide mental health and substance disorder prevention and treatment services to improve health outcomes, and reduce disparities in minority communities at high risk for or living with HIV/AIDS or viral hepatitis.

We have I think it's about \$130 million across three different centers here at SAMHSA—the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, and the Center for Mental Health Services. The next page.

So, I'm going to highlight the grants and programs, I may leave a couple out, but I think I've got the majority of them. Probably the biggest one is this Targeted Capacity Expansion HIV grant which will sometimes here refer to as TCE-HIV.

So, we've got about 120 grantees; it's a pretty large program. And the activities that this program results in, includes an increase in engagement and care for high risk minority populations with SUD or substance use disorders. Substance use disorder treatment and recovery support.

And also, HIV and hepatitis testing, and vaccination, which is critical because previously that wasn't done as much in many of these programs.

Referral and linkage to care, and case management for persons identified with HIV and/or hepatitis.

In addition to housing support services, outreach, and enhancement and expansion of infrastructure and capacity to retain clients in treatment. It's great to get them in, but you got to keep them. Next slide.

There is also a continuum of care pilot—MAICOC—a continuum of care, which has 34 grantees. And this grant focuses on stimulating co-location and integration of HIV and hepatitis services inside of behavioral healthcare settings. And also provides for behavioral health treatment and substance abuse prevention.

It includes set aside funds for viral hepatitis prevention, vaccination, testing, and linkage to care. And also, through some of the secretary's MAI funds, for some grantees, establishes and enhances linkage between their programs and existing communities syringe service programs.

Also included are wrap around services, recovery support outreach, and other engagement strategies. Next slide please.

Three more grants I'll talk about briefly. The first is Minority Serving Institutions Community-Based Organizations or MSI CBO.

This provides substance misuse education and testing in communities that are really at the highest risk for substance abuse disorders with HIV and hepatitis C.

A second grant is Capacity Building Initiative—CBI. The Capacity Building Initiative focuses on education and awareness programs in addition to social marketing campaigns, testing services in nontraditional settings in high risk communities—particularly targeting youth and young adults.

And then the Prevention Navigator Program, which uses a navigation approach to deliver comprehensive substance misuse and HIV-related support services to youth and young adults. And especially for males who have sex with other males, who are not in stable housing. Next slide, please.

Finally, just some other highlights of other activities that SAMHSA works on. There is this rapid HIV/hepatitis testing, I guess mechanism or forum for, that is available to all grantees. And I saw some numbers recently that we've had over 75,000 people tested.

This includes linkage to care for both prevention and treatment services. There is also an ongoing collaboration with HRSA's Ryan White Program, with the CDC, with the National Institute of Health on multiple projects.

We also collaborate on the National HIV/AIDS Strategy, the National Viral Hepatitis Action Plan, and the Federal Viral Hepatitis Implementation Group.

And then internally because we have three centers within SAMHSA that all have different aspects of that—of these grant funding responsibilities and some of them overlap—we have a monthly HIV team meeting that we hold here. Next page please—slide.

Before I go, I just wanted to highlight a couple of new resources that SAMHSA has put out just, I think, in the past two weeks.

One of them is TIP 63. TIP is—treatment improvement protocol. And this one focuses on medications for opioid use disorder. We had previous TIPs that were older that one focused on buprenorphine, one focused on methadone, mostly.

This really is a unified, updated TIP that combines all the medication assisted treatment options out there.

So, it's available now. And if you go to our main page, it's samhsa.gov. The link is on our last page. You're seeing it right in the front, because it's on the rolling screen that we have.

The other—so please download that—the other thing is if any you listening are treating pregnant women, or women who are parenting, who have opioid

abuse disorder and their infants, we developed a clinical guidance for treating this population for women with opioid induced disorder and that is also available now on our website. The last slide, please.

So, again I wanted to thank you for the opportunity to speak to you all today. And I will pass the baton back to Corinna. Thank you.

Corinna Dan: Thank you so much Steve. Really appreciate that overview. I think we've been working with SAMHSA for a number of years along with other federal partners. And really trying to facilitate that coordination that you were talking about in the last couple of slides.

So, I appreciate your highlighting that. And I hope that folks are aware that there are partners all across government like SAMHSA, CDC, HRSA, and others that are working to respond, and to encourage their network to respond, to the opioid epidemic.

And with that, next slide please. I would like to take just a moment to introduce folks at the Association of State and Territorial Health Officials.

This is a very strong organizational partner with our office. And we've seen them do some really great work independently as an organization. But, also with their members to encourage their health officials all across the country to get more engaged.

And so, really want to thank Christi Mackie and all of her colleagues at ASTHO along with their members and very excited to hear from Joan Duwve as well.

So, Christi do you want to kick it off?

Christi Mackie: Great, thank you so much. And thank you for the opportunity to speak today. Again, ASTHO is a membership organization serving state and territorial health officials. We see them as the primary public health strategist within a state. Some of—like key public health influencers.

And not only is it public health officials that we serve, we also take into account their principle leadership teams and support their public health agencies as a whole. Working from that perspective as an agency wide perspective.

So, today I just wanted to take a couple minutes to talk about a resource that ASTHO has developed.

It's really intended to bring together state efforts across government. Thinking about partners that can help us address the epidemic from a comprehensive, multisector approach versus just focusing on providers, the delivery system, perhaps even enforcement.

We call the resource, ASTHO's National Framework for Opioid Prevention. And I'll talk a little bit about that in a couple of minutes. Next slide, please.

So, bringing us back to prevention and the work of prevention. And, often times when we talk about prevention we don't always mean the same thing. So, there is a difference in the language that can be problematic.

As an example—are we talking about overdose prevention and the naloxone? Or perhaps overdose is a little late in the cycle. It's still extremely important, but we're thinking from that prevention standpoint we need to move upstream. Next slide, please.

Taking a look at—moving to the next side. Sorry. Taking a look at prevention also back to this language piece. Are we talking about prevention as are we going to address the opioid supply such as subscription monitoring programs?

Perhaps it's not in the space alone that we're going to be effective. Just because we think of this—the vector here is not—the vector within the epidemic is not just prescribers. And we need to look at this a little bit more comprehensively. Next slide, please.

So, thinking about primary prevention. Really looking at the misuse from the beginning. So, trying to prevent that piece.

We do know that there is a lot of promise in this space around primary prevention. But we just don't have a lot of evidence at this point. Next slide.

So, this particular slide is a pyramid that represents a three-tiered approach to the issue. And it doesn't focus on one single drug. I'm not sure is the slide progressing?

Man: It's (progressing).

Corinna Dan: Christi that was the last slide from your set. Preventing opioid misuse?

Christi Mackie: Oh no, it was there is one before that. I'm sorry. There is a lag here, I don't know.

Corinna Dan: Yes.

Christi Mackie: Yes, okay, this is where I'm talking. So, this is a pyramid, just really quickly, that represents this three-level approach that I just spoke of.

And it doesn't focus on one single drug. And it doesn't really take a look at one single approach. So, looking at this comprehensively from a primary, secondary, and tertiary prevention approach.

And really, this is, we're looking at five key goals here. Looking to reduce stigma and change those social norms, increase protective factors, and reduce risks factors within communities.

Strengthen that multi-sexual approach, taking a look at the collaboration, and also, improving prevention and that infrastructure. And, look—sorry, I'm working from home today—and taking a look at prospector partnerships. Next slide, please.

So, this I mentioned a little bit about this and this resource. And what it is, is ASTHO's National Framework for Preventing Opioid Misuse and Addiction.

This framework is really a comprehensive multiagency approach to assist agencies to respond to the opioid epidemic.

If—when you—it's a website, it's comprehensive, it's interactive, and it's pretty much a clearinghouse of information and programs that we've assimilated, collected, and housed on our website.

And it's really intended to reduce and control access to opioids, improve access to the use of and effective treatment and recovery support.

Improving monitoring and surveillance of the use of legal—excuse me, of legal and illicit opioids. Expanding and strengthening educational strategies and expanding evidence based of effective prevention and treatment strategies.

So, this framework is really intended to be an opportunity to help lead state public health responses to the opioid crisis. It's a way to align work across states and regions.

An opportunity to expand multisector collaboration around substance abuse and working with substance abuse and addiction agencies. Healthcare delivery systems, law enforcement amongst many others.

And it can be used also as somewhat of a checklist to kind of balance or check yourself or check your state efforts and the response plan to identify any gaps in planning.

I'll go ahead and chat in the website on the chat box when I'm done. But right now, you can find that at my.astho.org/opioids. And with that that's our last slide.

I'd like to introduce one of our members. Her name is Dr. Joan Duwve and she is with the Indiana Department of Health.

Dr. Joan Duwve: Hi and thank you Christi. Can you all hear me?

Corinna Dan: Yes.

Dr. Joan Duwve: Okay great. And thanks to Corinna and the folks at HHS for hosting the webinar. And for Christi and my colleagues at ASTHO, in particular my

colleagues on the Infectious Disease Policy Committee, for inviting me to join them today to present to you all.

So, I am going to present a model of effective community-based services for the prevention, diagnosis, and treatment of both HIV and hepatitis C. This was developed during the HIV response due to the epic response in Scott County, Indiana. Next slide, please.

In December of 2014 three individuals from the small rural community of Austin, Indiana, which has a population of 4,200, were diagnosed with HIV.

Our disease intervention specialist learned that two of these individuals had a common needle sharing partner. And HIV was then quickly diagnosed in eight additional people through contact investigation.

Only five HIV infections had been reported in Scott County during the entire previous 10 years. So, this was an ominous sign.

The first of HIV transmission we learned was injection of the prescription opioid Opana ER. And as of January, 228 individuals have been linked to this outbreak and tested positive for HIV. Nearly 95% co-infected with hepatitis C. Next slide, please.

Indiana, like other states, has seen an overall increase in rates of hepatitis C over the past decade. As you can see from the map, on the left, between 2012 and 2016 nearly all Indiana counties experienced an increase in rates of hep C with more than a third experiencing greater than a 100% increase.

When we look at hepatitis C diagnosis by age group, on the right, we see that the increased diagnosis that occurred mainly in individuals age 20 to 29 and

30 to 39 years. And injection and other illicit drug use was reported as the primary risk factor.

In fact, the rates of acute hepatitis C virus infection among young suburban and rural persons who inject drugs in Indiana, including Scott County, and across much of the Midwest and Appalachia, has increased significantly between 2006 and 2012.

And those increases you might say foreshadowed the Scott County HIV outbreak. Next slide, please.

The HIV outbreak really increased public awareness of injection drug use as a risk factor for HIV and hepatitis C transmission.

During the outbreak, there was a significant effort to deliver touching services for both HIV and hep C to those at risk in the places where they were likely to go, like emergency department, addiction treatment centers, doctors' offices, jails, and in their own homes.

The accessibility of testing really allowed us to rapidly identify individuals with HIV and hep C and provide linkage to care.

In addition, genetic testing and analysis of HIV done by our partners at the CDC estimated that by the date of the first HIV diagnosis in late 2014, four out of 10 persons, who would later receive a diagnosis of HIV, were already zero positive.

The peak on the Scott County hepatitis C infection curve on this slide occurred in 2015 at the height of the HIV outbreak response. This curve

though increases annually prior to the outbreak, and that reflects a similar pattern of ongoing transmission during the years leading up to the outbreak.

The surge in HCV diagnosis in 2015 mostly represent delayed identification of individuals previously infected, and highlights the really important initiatives to test individuals where they are likely to be. Next slide, please.

I can't overstate the importance of community engagement and community-based services during the response in Scott County. County healthcare providers and officials worked with state government to authorize and create the first legal syringe services program in Indiana.

This program established a model for providing care that has become the standard for others doing service programs in the state.

The syringe service program provides clean injection supplies, but they also provide harm reduction education, naloxone, and naloxone education, immunizations, health care, referral to addiction treatment, clothing, food, TB testing, and they link people to registration for our HIP 2.0 alternative Medicaid expansion here in the State of Indiana.

Over half of the participants interviewed during a study of people who inject drugs in Scott County, reported that they received their last HIV test at the syringe services program. So, they are accessing for more than just syringes.

Study participants with HIV who use the syringe services program indicated that they had dramatically changed their injection practices. Before the syringe services program, 90% reported sharing needles.

But after the syringe services began offering services, less than 10% reported any sharing and qualitative data that we had suggest that those with HIV who continued to share, did so only with others who had already been diagnosed with HIV.

Linking those individuals diagnosed with HIV and/or hep C to care was equally critical during the outbreak response. So, we could reduce the reservoir of virus in the community, and reduce ongoing transmission.

There were no infectious disease physicians in Scott County. But, Dr. Will Cooke the Primary Care Physician in Austin, enrolled in a HIV/hepatitis C ECHO Project.

ECHO—or Extension for Community Healthcare Outcomes—is an evidenced based model where experts in complex medical care work with providers in underserved communities to share knowledge during case-based learning.

Dr. Cooke became proficient in providing expert care to those in the community with HIV and hepatitis C.

And as the care continuum graph on your right demonstrates, the community-based model was truly a success for providing care to a population with substance abuse disorder, that many told us were difficult to treat and couldn't be done.

All individuals with HIV in the community are engaged in care. Nearly 75%, as indicated on the far-right bar, of those who have been linked to care have achieved and maintained viral suppression—a rate which is nearly twice the national average. Next slide, please.

This final graph illustrates, I believe, one of the most compelling outcomes of the community-based services including harm reduction and enhanced access to testing and treatment for people who inject drugs.

In 2016 LifeSpring which is a community mental health center in Scott County, co-located mental and behavioral health services and addiction treatment services with the syringe services program.

The federal relaxation of the buprenorphine treatment limits actually subsequently increased capacity for treatment at the site. And for the first-time treatment for addiction was accessible in Austin, Indiana.

Self-referrals and referrals from medical—the medical provider, the syringe services program, and the jail led to a dramatic increase in the number of people enrolling in addiction treatment. And that's represented by the light blue bars.

Anecdotally, we have heard that getting into treatment is really now the thing to do in this community. The green line represents daily numbers of syringes needed by clients.

Once at-risk injection behaviors in the community were identified, the syringe service programs staff learned to accurately assess syringe use and needs. And that happened early in 2015.

Since 2015, there has been no increase in the average daily number of syringes needed by clients.

The combination of increased awareness of HIV, hepatitis C and their transmission risk, the increased accessibility of testing, the availability of

clean injection supplies in a non-stigmatizing setting, access to care for HIV and hepatitis C in the community, and now access to medication assisted treatment have all played an important role in reducing the ongoing transmission of HIV in this community. As is evidenced by that red line trending toward zero new HIV infections through the last half of 2017.

I will end there. And thank you very much.

Corinna Dan: Thank you so much Joan. As well as Christi for giving us the overview for reviewing what has been effective in really a critical situation that you found yourself in.

Wonderful to hear the stories from that experience. And really appreciate your sharing.

And just in the spirit of trying to get back on track time wise, I want to go to the next slide. And introduce our next speaker.

Laura Hayman from the National Association of Counties and Cities National Association of Health Officials in Kansas City.

So, Laura want to welcome you today along with Michael Kilkenny from Cabell-Huntington Health Department. But so, Laura.

Laura Hayman: Great, thank you Corinna and Rich. I want to thank you as well as others in the HHS Office of HIV/AIDS and Infectious Disease Policy for inviting me to be a part of this important and timely webinar. Next slide, please. And next slide.

Great, so as the first line in defense in protecting community health, local health departments in collaboration with their community and state partners are leading the charge to curve the opioid the epidemic.

In this pictured issue of NACCHO Exchange, which is one of our regular publications. We highlighted the many ways local health departments are responding to this crisis.

From moderating and surveillance, to primary prevention and linkage to care and treatment, to policy initiatives among other.

A particular relevance to the topic of this webinar is an article that discusses lessons learned from the experience in Scott County, which you just heard about.

And ways in which, local health departments are responding to similar vulnerabilities in their communities due to increases and injection drug use and rising rates of infectious diseases.

NACCHO is working in a number of ways, which what I will highlight on the next slide, to increase awareness of and to support local health departments who respond to the infectious disease consequences of the opioid crisis.

Local health departments are key implementers of comprehensive approaches to addressing the opioid epidemic and infectious disease public health infrastructure and expertise is an important, yet under recognized, resource in our response to the opioid epidemic.

Local health departments have a long history of addressing hepatitis, HIV, and the prevention, care, and treatment needs of persons who inject drugs and are

critical to the scale of comprehensive harm reduction services for this population.

NACCHO's was committed to assisting local health departments in their communities find, develop, and scale up comprehensive solutions to the opioid crisis and its hidden casualties. Next slide, please.

So, this slide highlights examples of NACCHO's response to the opioid crisis and infectious diseases. Across many of these initiatives, we are providing support for on the ground work by local health departments to develop solutions to this complex and multi-dimensional epidemic.

For example, we have been working with the Lenowisco Health District in the Appalachian region of Virginia, to develop a comprehensive community response plan to address opioid driven increases in injection drug use and vulnerability to wrap dissemination of viral hepatitis and HIV among people who inject drugs.

This work is a direct response to the findings of CDC's vulnerability assessment that Rich talked about earlier.

The community response plan addresses efforts to undertake pre-outbreak activities associated with the immediate and intermediate response, and what is required for a sustained response.

It provides a valuable roadmap for jurisdictions to think about what they can do now to prevent an outbreak, and how they will respond in the case of an outbreak.

The plan can be assessed from NACCHO's website, which will be linked to on my final slide.

Current efforts with the health district are focused on engaging the community and its response and the implementing intervention identified in the response plan.

As noted in the second bullet point we are supporting the expansion of some of the incredible harm reduction work being led by local jurisdictions in West Virginia, which will—which you will hear about shortly from Dr. Kilkenny. Next slide.

Another key component of our response for the opioid epidemic is advocating on behalf of local health departments. Particularly as it relates to increasing awareness of their role, and the need for increased federal funding to support the local response to this crisis.

So far, NACCHO has had three congressional briefings over the last few years to try to increase the level of education by our policy makers at the federal level.

So, this is a multi-pronged epidemic that will take a multi-pronged approach and more resources than have yet been put on the table.

Shown here is data from the NACCHO's Forces of Change survey. Since the 2008 recession local health departments have struggled in terms of budget cuts over time.

The impact of these funding cuts impedes local health department capacity to respond to this urgent crisis.

And further, underscores how critical it is that additional resources be made available to support the comprehensive approach to our nations opioid epidemic and its many impacts, including the spread of viral hepatitis, HIV, and other infectious diseases.

In addition to resources, strong federal, state, and local partnerships are essential to combatting this issue as the speakers on this webinar so well highlight.

Local health departments are the boots on the ground that if given the resources can bring partners together across this spectrum to find solutions to this multifaceted and complex crisis. Next slide.

Thank you for your attention and ongoing support and engagement in this topic. For more information about NACCHO's response to the opioid epidemic and infectious disease, you can contact Gretchen Wise, and her information is here on the slide. And I also encourage you to check out the resources laid here from our website.

So now it's my pleasure to introduce our next speaker who is Dr. Michael Kilkenny, the Physician Director of the Cabell-Huntington Health Department in West Virginia. Which implemented the first sanctioned syringe services program in the state.

Huntington is also the focus of the Oscar Nominated Netflix documentary Heroin.

Dr. Michael Kilkenny: Thank you. In West Virginia the local health departments have taken a lead in battling this epidemic.

As you can see from the map, what started in 2015 as two free clinics and a couple of health department programs has coalesced into an organization called the West Virginia Harm Reduction Coalition which involved 53 of our 55 counties. And has offered services now across the state.

There are syringe service programs, either operating our plan in 15 or 16 counties now.

And we have had a lot of success pushing naloxone out, especially to our first providers. The Harm Reduction Coalition has been able to negotiate with a wholesaler to donate to us 16,000 doses of naloxone.

And our distribution network has been able to send that across the state training virtually any police department, or other agency that's on the front lines in the dispensing of naloxone. Next slide, please.

The services that comprise a comprehensive harm reduction program were pretty well described earlier. And the CDC has great resources for determining what constitutes comprehensive services.

We looked at education testing, treatment counseling, and syringe services as our core first five. And then we added community naloxone access as state laws permitted.

What we found is that every health department, or every site establishing these services has different capabilities. And we agree 100% that you have to collaborate with your partners; you have to form linkages. If you can't provide a certain service, link to somebody who does provide it.

And so, the list that I've drawn up here is pretty much based on what we are doing. But, where we might have to link to care for offering PrEP, another agency might have the capacity to offer PrEP on site. And they might need to link to community education, or something like that.

And always remember that these services exist in a local, political, and economic reality. In harm reduction we are not judgmental—we don't judge our patients, and we don't judge our partners. You do what you can do, but do something.

Our next slide shows what we've seen in acute hepatitis B in Capital County since we started our program. The trend has been upward—West Virginia leads the nation in hepatitis B and Capital County is above the state average in hepatitis B.

We started a syringe service program in 2015. And we saw a flattening on the bottom of the incidents associated with injection drug use. In 2017, we saw it decline in new cases of hepatitis B associated with injection drug use.

We're also very excited about what's happening in hepatitis C—if I can see the next slide. We had seen graphs go up, and up, and up, for so long that I thought my analysis software was broken. I didn't think that it could draw a downward curve.

But with the programs that we have here in Capital County despite a change in the definition of a case of hepatitis C in 2016 we have seen a decrease in 2017 in hepatitis C.

Hepatitis C more closely—total cases are aligned with injection drug use more closely. And so, we have seen a total decline in hepatitis C.

Those are the first victories that we've been able to show and our people need a win here. We've been fighting this as hard as we can for three years. And it just great to see something happening.

But that's the lower level view of what we can see at the county level. Counties are in—our health departments are in every jurisdiction in this country. And we're very interested in being involved in the fight some of us are more capable than others.

But, we're all willing to join. So, I will end there. And thank you.

Corinna Dan: Thank you so much Dr. Kilkenny, really appreciate that county perspective, and sharing the data that you've been seeing at the county level as well.

Think one of the things that Rich Wolitski highlighted earlier was that one of the first steps really is to assess what the trends are in your area, and that allows you, or enables you, then to monitor this and celebrate those successes as you have been able to since you saw that trend in hepatitis C infection reverse. And even with hepatitis C, reducing the number of new infections.

So, congratulations, and thank you so much for sharing your experience. And thank you Laura for sharing the NACCHO perspective.

So now I want to turn to Chelsea Kelleher at the National Governors Association. She's a Senior Policy Analyst and I'm really excited to learn about what the National Governors Association is doing in regards to this intersection of opioids and infectious diseases.

And just want to welcome also Kip Kaffener, as the Member from NGA. So, Chelsea.

Chelsea Kelleher: Great, thank you so much Karina and Rich for inviting me to speak about NGA's work in this area. We're very excited to be speaking with you all today.

Before I turn it over to my co-presenter, Kip, from Maryland, I'm going to quickly go through a brief overview of who the National Governors Association is, highlight the work that we've done in opioids over the past few years.

I'll give you a sense of how governors are thinking about this issue of opioids and infectious disease. And tell you about some new work that we're embarking in this area.

So, the National Governors Association is a bipartisan organization serving the needs of governors and their staff. The two largest components of NGA are our Office of Government Relations which speaks on behalf of the Governors in Washington, DC.

And then the Center for Best Practices which is where I sit. And the center is a 501C3 that operates as a combination of a think tank and consultancy for governors and their staff on a variety of policy issues.

As you can see here we cover education, economic opportunity, homeland security, and the health division, where I sit.

I should say that we work closely with governors, but also their senior staff, such as health policy advisors and health secretaries, and other state officials

in public health, behavioral health, or other agencies that are critical to accomplishing states goals and our various projects. Next slide.

I won't go into too much detail on this slide. But suffice it to say we've been working on this opioid issue for several years now.

Our opioid work is done in collaboration with our Homeland Security and Public Safety Division. And with the support of the Centers for Disease Control and Prevention, who have been really tremendous partners to us and to the state over the years.

I'll just highlight a couple of things that have been important in this opioid space in the past few years.

In July of 2016, 46 governors signed on to a compact to fight opioid addiction. And this was the first time in more than 10 years that the governors have used a compact to drive collective action.

And through that agreement they promised to redouble their effort in three specific areas: reducing inappropriate prescribing, improving education of our opioids, and ensuring pathways to treatment and recovery.

In conjunction with that compact, in July 2016 we developed what we call a roadmap, which is a tool to really help states access their current capacity to address the opioid crisis and select evidence based and promising practices.

Following the release of that roadmap, we launched a series of what we call learning labs, which are in-depth technical assistance opportunities to help states learn about and adopt innovative programs or policies that are working in other states

So, so far, we have helped four of these learning labs focusing on various different state initiatives, highlighting work that's been done in New Jersey and drug monitoring; Rhode Island's strategic plan on addiction and overdose; New Mexico's Project ECHO program for increasing access to opioid treatment; and then Massachusetts Opioid Use Disorder Treatment Model for justice in all populations.

In this coming year we're launching two more learning labs. The first of which will be—I'll be talking about shortly, which will highlight Kentucky's approach to preventing the spread of infectious diseases related to opioid use as well as highlighted Ohio's Moms Program, which is a program to help improve maternal and infant outcomes related to opioid use. Next slide.

So, this slide is really just to give you a sense of how governors are thinking about this issue and why this is so important.

So, I know Rich gave a great overview earlier of kind of what we're seeing in terms of a large uptick in the number of acute hepatitis C infections from 2004 to 2014, really seeing a large increase across the country but specifically within a couple of subgroups, which Rich discussed earlier.

I think we also saw very concerning increases in hepatitis C infections in particular areas of the country.

So, in that same study they highlighted that 15 states had seen acute hepatitis infections increase over 500%, and six states have seen that increase over 1000%.

So that is very concerning and I think really catches the states' attention to understand where that increase is happening.

Additionally, of course the CDC analysis has identified 222 counties—220 counties rather, in 26 states with a potential for the rapid spread of HIV and hepatitis C related injection drug use.

And so, I think that really underscores the fact that it's not just Indiana where this outbreak could happen, this is many states that have the conditions that could lead to an outbreak happening there.

And finally, this I think is concerning to governors because these conditions are very costly to treat. And a large portion of that cost falls on state Medicaid budgets.

The graphic here is from Amphar and it compares the cost of treatment for the historical average of cases in Scott County, which is five cases of HIV a year, to the post crisis cost of 135 cases.

And as Joan mentioned earlier that number has actually gone up over time. It is over 200 cases now. So, as you can see there is really a strong cost component to this as well.

And many of the individuals that are at risk for this are uninsured, or on Medicaid. And in the midst of the opioid crisis, states are very concerned about cost associated with the potential surge in cases of HIV, hepatitis C, and other costly conditions like endocarditis that are associated with drug use.

So, this is an issue that's really putting more and more pressure on state budgets. And crowding out other priorities. Next slide.

So, as I mentioned before we at NGA have just launched a new learning lab on addressing infectious diseases related to substance use.

This project will be highlighting Kentucky, which is the first southern state who broadly authorized during service programs in 2015.

And since then I believe 41 syringe service programs, which are known in Kentucky as Harm Reduction and Syringe Exchange Programs, or HRSEP, have been established across this state. And that visual there just shows you the number that has been established as of last month.

In addition to providing clean syringes the Harm Reduction Syringe Exchange Programs also provide linkages to critical services and programs including substance use sorted treatments; overdose prevention education and naloxone distribution; screening and care for HIV and viral hepatitis; prevention of mother to child transmission; hepatitis A and B vaccination; screening for other sexually transmitted diseases and tuberculosis; and other medical, social, and mental health services.

So, in addition to learning about the HRSEP and the states and project, we'll learn about Kentucky's work on data and surveillance, as well as best practices and treatment for infectious disease and infectious disease disorder.

We are really delighted to be working with seven states on this project. The states that we're working with are Alabama, Arkansas, Delaware, Michigan, Utah, Virginia, and Washington.

So, you can see it's a very diverse group, geographically and politically. And the states all have different goals, but the common themes among them

include a focus on expanding access to community prevention services in rural areas; improving surveillance for viral hepatitis, HIV, and other conditions related to drug use like endocarditis and other infections; and improving access to treatment for infectious disease and substance use disorder.

So, we will be working with these states for much of this year, and we will at the end of the project be disseminating lessons learned through a publication or a webinar that all states are welcome to join and learn from.

And our technical assistance for this group of states, we're of course going to be highlighting Kentucky, but we also expect to highlight best practices and lessons learned from other states that have made strides in this area—like the State of Maryland.

We think that Maryland is a great example of a state that's really getting ahead of the infectious disease spread by investing in prevention programs and partnering with local communities to expand these services.

So, with that said I'll send it over to my co-presenter. Kip Kaffener is the Chief of the Center for HIV and STI Integration and Capacity in the Infectious Disease Prevention and Health Services Bureau at the Maryland Department of Health.

So, I'll let Kip take it away.

Kip Kaffener: Good afternoon. Thank you all for this opportunity especially the National Governors Association and HHS. Next slide.

It was in this context of rising overdose deaths that we introduced legislation in the 2016 session of the Maryland General Assembly to make syringe services programs legal state wide, not just in Baltimore City, where they've been legal and operating since 1994.

The legislation passed, it came into effect October 1 in 2016. So since then we've been propagating regulation, convening an advisory board, identifying local partners, and providing technical assistance to local partners in their development of applications to operate their end service programs. Next slide.

So, we're grateful to the CDC for the determination of need guidance. It pointed to a list of non-HIV data elements that indicated the need for an HIV prevention intervention.

The guidance has been useful for us to direct counties to these data particularly in cases where they're HIV data don't yet tell the story of needing a syringe services program. So, thank you for that.

As part of helping Maryland counties gain easily timely access to those data, our behavioral health administration partnered with our health information exchange to create two data dashboards.

One is our prescription drug monitoring program dashboard, designed to help reduce the non-medical use of prescription opioids.

The other, that's pictured here, is the opioid indicators dashboard, which allows county level queries and comparison for overdose related hospital encounters.

These data are also helpful to local health officers as they make the case to other local officials about the need for syringe services programs based on everything that we talked about in the webinar up until now.

So, we're also grateful to the CDC for creating the Vulnerability Index which has helped us to establish priority for the western region of Maryland as we stand up new syringe services programs outside of Baltimore City.

So here is Maryland in the context of West Virginia, and those counties that scored in the top five percent.

So, the West Virginia Counties of Morgan and Berkeley are among those in the top five percent most vulnerable. And they border Washington County, Maryland.

So, I'm really pleased that we've received and approved an application from the Washington County Health Department to operate a syringe services program. And congrats to West Virginia on your amazing local response.
Slide.

So, some of you may be facing opposition to harm reduction approaches with traditional arguments like, they facilitate drug use. So, the main thing that I wanted to offer you today is to share our strategy to counter that.

We're finding it successful to teach the stages of change and locate harm reduction programs in that context.

So, in this slide we close lock the stages of change with the category of public health intervention.

Many, maybe as many as 80% of people who use drugs aren't yet ready for treatment. They're in an earlier stage of change. So, we need tools in addition to treatment.

And since the feature of worsening substance use is increasing isolation, syringe services programs are essential for sustaining connection to users, both to keep them alive, with Naloxone, and to use the connection to do motivational interviewing to support people through their change process.

The Seattle experience for syringe services as Rich mentioned has been that participants are five time more likely than non-participants to enter treatment.

Which I think speaks to the significance of meeting and accepting people, wherever they are in their journey, through the stages. And that sounds like this has been the Indiana experience as well. Next slide.

So, at this time we have programs designed to prevent the initiation of drug use, and we have substance use treatment. But for people who inject drugs who are not yet ready for treatment, our public health response is thin. Can you advance? There you go.

So, we invite you to consider this reimagined landscape for people who use drugs. In this landscape harm reduction programs meet people in the first three stages of change including those who have relapsed from later stages and support them where they are.

As specifically we mean syringe services, naloxone distribution, law enforcement, and system diversion, programs which put people are their journey through the stages of change until their ready for treatment.

In Maryland we are encouraging a comprehensive approach to this problem. And it's working for us to use the stages of change framework to validate harm reduction approaches as responding to the opioid situation at the stages in which people are actually overdosing. Next slide.

So here is a look at our progress toward standing our syringe services programs in Maryland.

In addition to Baltimore City's program, which is operated since 1994, the Baltimore County Health Department Application was approved last summer. And they are going to go live this spring.

As I mentioned the Washington County Health Department application was just submitted, and approved earlier today.

Lighter shaded jurisdictions are developing their application to do this intervention.

We require applicants to tell us how they're going to connect clients to other services for which they're ready, such as PrEP, HIV treatment, substance abuse treatment, et cetera.

And our viral hepatitis center is working with Johns Hopkins to train new providers to treat and cure HCV.

We're looking to expand HCV treatment capacity anywhere in any jurisdiction in which we're standing up syringe services programs, in order to stay ahead of the demand that we expect to find once we start testing more people, who use drugs, for HCV. Next slide.

Thank you again for this opportunity to talk about how Maryland is using data to sell and prioritize their end services programs, and how we're using this data to change framework, to dismantle opposition, and harm reduction intervention.

Corinna Dan: Thank you so much Kip. Also, thanks to Chelsea for reviewing the great work that's going on at the National Governors Association. As well as hearing some specific strategies that Maryland is incorporating.

I do want to take just a moment to thank all seven of the speakers from our partners at SAMHSA, ASO, NACCHO, and the National Governors Association this afternoon.

And want to move into then a little bit of a shorter than anticipated question and answer time.

So, reminding folks that we are taking questions via Twitter. Via the question box in the web internet interface for go to meetings. As well, we can work with the operator to unmute people's lines.

Operator could you give instruction for folks who would like to ask a verbal question here today in the next few minutes.

Coordinator: Certainly Ms. Dan. Thank you.

If you would like to ask a question over the audio line, please press star 1 on your touchtone phone. You'll then be prompted to record your first and last name. Please do check that your phone is unmuted before you record your name.

If you decide to withdraw your request, pressing star 2 will withdraw your line from queue.

Again, press star 1 and your record your name at the prompt. Thank you.

Corinna Dan: Great. So, as we let folks think a little bit more about their questions I wanted to respond to a question that came early on in our webinar.

Someone asked if there is a way to identify those SAMHSA grantees that Dr. Davis was mentioning the TCE-HIV grantees as well as the MIA COC grantees.

I think—I did a quick web search, and I found a listing of the grantees from October 2017 for this new TCE-HIV grant.

And so, I'd say that yes, some astute Googling will get you the list because those are federal grants and they are announced generally on federal websites. And so that information should be available.

However, if you're having trouble and you really need to find a grantee in your area, please reach out to me, my contact information is given out a little bit later on the final slide.

I also wanted to point out that HHS has done work with CDC, HRSA, and SAMHSA because grantees of those organizations can request to use federal funds for certain aspects of syringe services program.

Once that request is received by CDC, then it is acceptable to use federal funds to support some of those comprehensive syringe services programs.

The type that, as Kip mentioned, might be really helpful for people who are not quite ready for medication assisted therapy or other stages beyond that, but really just need to start to get engaged in prevention and counseling, and all of the other services that we like to see provided along with syringe service programs.

So, want to remind folks that if you have identified that the opioid epidemic and infectious diseases are impacting your jurisdiction, please consider what funds may be available to use a little more flexibly than they have been in the past.

And again, please give us—drop me a line if you need more help finding that information.

I understand that CDC is quite timely in the review of the request to determine needs. And we'll be following up with folks who submit that online pretty quickly.

That's been a really smooth process and I want to give credit to CDC for all of their work to make sure that that process is smoothed for folks in the field who are grappling with some of these really challenging problems that require some new approaches.

Had a question for Kip. In Maryland you referenced a plan that you're implementing I think related to your infectious disease response. Is there a name for the Maryland plan that you're working on?

And/or a place where they can find more information on maybe on the Maryland website or a programmed website?

Kip Kaffener: It would be great to have that person just reach out to me directly so I can better understand the question and answer it.

Corinna Dan: Okay. So, we can follow up with the Maryland planned question and the person who had that question and get connected with you directly, Kip. Thank you.

I had another question here—want to check in with the operator to see if anyone has raised their hands on verbal question?

Coordinator: Yes, we do have one participant would you like that question now?

Corinna Dan: That would be great.

Coordinator: Thank you. Annette Miller, American Red Cross, your line is open.

Woman 1: Hi, good afternoon. I'd like to know, what is the role of PrEP (Tech) in this treatment and supportive services for this opioid situation? Thank you.

Corinna Dan: Thank you very much. So, my understanding is that PrEP may be an option for people who are at high risk for HIV infections.

That would be individuals who are potentially being exposed to HIV through unprotected sex, as well as potentially through injecting behaviors or use of unsterile injecting equipment.

My specialty is viral hepatitis. So, I—it would probably be better for me to defer a final answer on the use of PrEP specifically among people who are at risk of HIV to injecting drugs.

However, my understanding is that PrEP is also useful in that population. And so, we'll take a little closer look at that for future and we'll definitely clarify.

But I don't know if other folks on the phone, any of the other speakers would like to weigh in on the use of PrEP.

Or, if that is something that you encourage in the local syringe service programs and the comprehensive programs that you're coordinating or encouraging in the jurisdictions you work with.

Any of the speakers have a PrEP example that you can share for the opioid epidemic?

Dr. Joan Duwve: Hi Karina, this is Joan for Indiana. And yes, we encourage our syringe services programs that have healthcare providers to offer PrEP. And also post exposure prophylactics for those with an exposure to HIV who are not currently on PrEP.

And our syringe exchange programs are encouraged to offer counseling to clients for both PrEP and [unintelligible].

Corinna Dan: Thanks Joan.

Dr. Joan Duwve: Mm-hm.

Kip Kaffener: Similarly, in Maryland we're disseminating, we're standing up PrEP clinics as we stand our syringe services programs. And we do make our syringe services programs have a way to offer PrEP to their clients as well.

They might be ready for that. They may not be ready for everything. But the more services you can co-locate, you know, the better off you are. And the more engagement you're fostering with some sort of healthcare system.

Corinna Dan: Great. Thanks.

I guess I'd like to take the one last question that we've gotten so far. And that is so folks, I guess probably the local folks who presented today, can you describe a little further any efforts that you've been engaged with on expanding hepatitis C screening and treatment access in your state with community health centers, or with other partners that have worked like been effective in expanding hep C screening and treatment.

Dr. Joan Duwve: Hi Karina, this is Joan again. Yes, we have hepatitis C testing initiatives that we have offered to multiple local health departments that have traditionally have higher than state average incidents of hepatitis C.

And now at the School of Public Health, where I'm actually on faculty, we have just started offering a hepatitis C ECHO.

And we have engaged primary care providers in underserved communities to participate and to begin to learn how to treat patients with hepatitis C.

And are working closely with our State Medicaid Office to make sure that those providers have access to prior authorization. There is a protocol that says, if you're participating in an ECHO project as a primary care provider, you can prescribe hepatitis C treatment to patients.

So, as I said we had started that January 18th and it's going well so far. So, we're very hopeful that we're expand the access to treatment landscape.

Corinna Dan: Thanks Joan. So, with that we are coming up at the end—to the end of this session. So next slide, please.

Wanted to encourage everyone one joined us today to sign up, register for the Hidden Casualties webinar, part two, which will be Health Policy Perspectives. We'll be hearing from the Infectious Disease Society of America, NASTAD, the National Association of Community Health Centers, as well as the National Viral Hepatitis Roundtable.

Very excited about that upcoming webinar and hope you will join us for that webinar in two-week time—same time, same station. Next slide, please.

Also, after the webinar, please look for the email containing a link to complete the evaluation.

We very much value your input on all aspects of our webinars and we'll use that feedback to improve how we present information and the work that we do moving forward.

So please take a few minutes and return the evaluation when you get that email. The last slide I think we are done for the—this session.

I do want to thank the speakers who did just an outstanding job today providing us an overview.

I think it really speaks to the comprehensive approach that we're—that we see is really needed to the fact that everyone has a role to play as we work to respond the best that we can to this opioid epidemic.

And just want to note that as Rich mentioned at the beginning, this is an evolving epidemic. And we do see some emerging trends like infectious diseases and other trends that are concerning.

And I think we'll be thinking about how the opioid response needs to evolve over the coming months and years. Hopefully within that time we'll also be able to turn around the opioid epidemic and start to see some real change.

I want to thank the audience for your interest and for participating today. We are constantly looking for opportunities and examples.

So please, don't hesitate to reach out and let us know what you're doing to address the intersection of the opioid epidemic and infectious diseases.

And with that, please remember that you can always follow up with—catch up with us and see what we're doing at hhs.gov/hepatitis. We've got blogs, we've got resources, and follow us at [hhs_viralhep](https://hhs.gov/viralhep).

Thank you so much and have a great evening.

Coordinator: This does conclude today's conference call. Thank you for your participation. You may disconnect at this time.

END